Current Psychology (2023) 42:19991–19999
https://doi.org/10.1007/s12144-022-03086-y

Minority stress and the inner critic/oppressive sociocultural schema mode among sexual and gender minorities

Bruno Luiz Avelino Cardoso[1] · Kelly Paim[2] · Ramiro Figueiredo Catelan[3] · Ethan H. Liebross[4]

Accepted: 4 April 2022 / Published online: 30 April 2022

Abstract
Several adverse psychological outcomes among sexual and gender minorities (SGM) are well documented in the literature. Notwithstanding the emergence of these data, SGM still receive little attention regarding psychological interventions, which include Schema Therapy (ST), an emerging integrative psychotherapy approach. Even though revisions have been proposed to expand ST's understanding of emotional needs, schemas, domains, and schema modes, there is a gap in our understanding of SGM. Based on that, the main goal of this theoretical essay is to propose a specific ST intervention for SGM, addressing sociocultural aspects aiming at promoting a healthy functioning that can interpose oppression and internalized prejudice. To this end, we will present (a) the minority stress theoretical framework; (b) the ST model applying to SGM clients; and (c) a few strategies of ST intervention for SGM clients, highlighting the need for strengthening individuals' healthy schema mode. It should be noted that, despite clinical work being relevant, there are social variables supporting and maintaining maladaptive structures. We hope the therapeutic interventions proposed promote dialogue on this subject and encouraging positive societal changes.

Keywords Schema therapy · Sexual and gender minority · LGBT · Intervention · Clinical practice

Connection to a social group is one of our most atavistic survival mechanisms as a species. By building peer relationships, individuals begin to understand the rules of a given context and to identify themselves as part of a community. In some cultures, moving away from a well-established group pattern can lead to social exclusion and negative schematic sensations. For example, in some religious contexts, where there are rigid heterosexist norms, certain people are labeled as "wrong" or "sinful" for having non-heterosexual orientations. Experiencing these microaggressions invalidates individuals' identities as they slowly come to internalize societal prejudices (Lomash et al., 2018).

For decades, Western culture has been pathologizing the existence of sexual and gender minorities (SGM) by judging, labeling, and confronting any expressions and identities outside the heteronormative standard, that is, the idea that heterosexual people are superior to non-heterosexuals. Cultural myths regarding "real men and women" are still prolific and predominant in many environments. After the events linked to the Stonewall riots in 1969, in which the SGM community of New York City rebelled against the intolerance and prejudice towards them, social and professional movements in the Psychology and Psychiatry fields began to pressure the American Psychiatric Association to remove homosexuality from the DSM, a decision that took form in 1973 (Drescher, 2015). However, the diagnosis status of homosexuality was only ripped from the World Health Organization's International Classification of Diseases in the 1990s, after mounting pressure from the lesbian, gay and bisexual (LGB) movement (World Health Organization, 1992).

Several adverse psychological outcomes among SGM are well documented in the literature. A meta-analysis of

✉ Ethan H. Liebross
ethan.liebross@stcatz.ox.ac.uk

Bruno Luiz Avelino Cardoso
brunolacardoso@gmail.com

[1] Institute of Theory and Research in Cognitive Behavioral Psychotherapy, Avenida Jerônimo de Albuquerque, n. 25, Edifício Pátio Jardins, sala 417, Cohafuma, São Luís, MA 65.074-220, Brazil

[2] Brazilian Association of Schema Therapy, Porto Alegre, Brazil

[3] Institute of Psychiatry, Federal University of Rio de Janeiro, Rio de Janeiro, Brazil

[4] The Pennsylvania State University, State College, PA, USA

54 studies on non-suicidal self-injury among lesbian, gay, bisexual, and transgender (LGBT) people indicated a high prevalence of this behavior throughout life both in sexual minorities (29.68%) and gender minorities (46.65%). In contrast, the prevalence among heterosexual/or cisgender people was 14.57%, highlighting a significant disparity. The association between being part of a sexual minority – when this variable was isolated or combined with belonging to a gender minority – and self-harming behavior was significant, suggesting that being a SGM individual is a risk factor for self-harm (Liu et al., 2019).

When compared with heterosexual young people, sexual minority young people are 2.94 times more likely to present depressive symptoms or depressive disorders, according to another meta-analysis which analyzed data from 23 population studies (Lucassen et al., 2017). The estimated suicide risk among sexual minority young people can be up to 3.5 times higher when compared to their heterosexual peers (Di Giacomo et al., 2018).

Similar factors are found among older SGM, whose prevalence of depressive symptoms throughout life goes from 24% (Fredriksen-Goldsen, 2011) to 47.9% (Hoy-Ellis & Fredriksen-Goldsen, 2017). When compared to heterosexual individuals, non-heterosexual people over 50 years old are 4.5 times more likely to experience suicidal ideation. Among those who experience suicidal ideation, non-heterosexual people are over 17.2 times more likely to go through with their suicidal plans than heterosexual people (Capistrant & Nakash, 2019).

Other psychological vulnerability features among SGM include worse anxiety symptoms (Björkenstam et al., 2017), post-traumatic stress disorders (Reisner et al., 2016), problematic alcohol use (Slater et al., 2017), and excessive use of other substances (Dyar et al., 2019). The transgender population seems to be disproportionately burdened by negative psychological outcomes, as suggested by a recent Brazilian study, in which 67.20% of the participants presented depressive symptoms, while 67.72% reported suicidal ideation and another 43.12% had attempted suicide at least one time (Chinazzo et al., 2021).

Despite the emergence of these data, SGM still receive little attention regarding psychological intervention protocols. There are still several myths, stereotypes, and distortions about the LGBT population in therapeutic settings, which may lead to different forms of conversion/correction therapy.[1] A Brazilian study found that 29.48% of professionals exhibited corrective attitudes when their clients asked for it, and 12.43% (n = 86) did so unprompted (Vezzosi et al., 2019). A Canadian study (n = 9214) found that 21% of respondents said a person in a position of authority had encouraged them to change their gender identity or sexual orientation; 10% of the respondents had experienced conversion therapy practices (CTP), the highest rates found among non-binary respondents (20%). Notably, 72% of the 910 respondents who had experienced CTP first attended a session before the age of 20, religious/faith-based settings being the most frequent place to which they went to ask for help (Salway et al., 2021). Recent studies like these indicate that there is still much to be done, especially regarding training clinicians to work with SGM properly. These professionals should follow a series of supportive, affirmative, empathetic, and inclusive guidelines to improve their skills and avoid iatrogenic or harmful interventions with their clients (American Psychological Association, 2011; Pachankis, 2018).

Schema Therapy (ST) is a psychotherapy model created by Young and colleagues (Young, 1990; Young et al., 2003) with the purpose of broadening traditional Cognitive-Behavioral Therapy. It was initially developed to treat people with personality disorders (Young, 1990; Young & Behary, 1998). However, ST has been shown to be applicable to a large number of clinical demands, including other mental disorders (Renner et al., 2016), couple issues (Simeone-DiFrancesco et al., 2015; Paim & Cardoso, 2019a), and children and adolescent needs (Loose et al., 2020).

According to the ST theoretical model, early maladaptive schemas (EMSs) are "self-defeating emotional and cognitive patterns that begin early in our development and repeat throughout life" (Young et al., 2003, p. 7). These EMSs originate when basic emotional needs are not attended to throughout a person's development (Young et al., 2003). In line with this finding, some researchers propose EMSs confer an evolutionary advantage. Researchers highlight three specific evolutionary survival coping styles to deal with potential threats: fighting (overcompensation) against the schema; avoiding the sensations that activate the schema; and/or surrendering to the current situation (Young et al., 2003).

Under the umbrella of the ST model are schema modes, which are the simultaneous activation of a set of schemas, characteristic emotional states, body sensations and coping styles triggered by specific situations (Arntz et al., 2021; Young et al., 2003). Working with modes has been an important resource for ST interventions, which can shed light on the different components of an individual's self, making it easier for clients to adhere to the therapeutic process. In doing so, working with modes help increase clinical results especially among those who have been less successful in finding an effective, long-lasting treatment option (Rafaeli et al., 2015).

Even though theoretical revisions have been proposed to explain issues such as emotional needs, schemas,

[1] In this study, corrective/conversion therapies are understood as any attempted therapy, whether subtle or explicit, to modify a person's sexual orientation (Drescher et al., 2016).

schema domains, and schema modes (Arntz et al., 2021; Bach et al., 2017), ST models do not yet properly address the unique features of SGM. While it has been long understood that individuals internalize cultural, societal, religious, peer-group, and family norms, an ST model for SGM clients accounting for these factors is missing from the current literature. Based on that, the main goal of this theoretical essay is to propose a specific ST intervention for SGM, addressing sociocultural aspects aiming at promoting a healthy functioning that can interpose oppression and internalized prejudice. To this end, we will present (a) the minority stress theoretical framework; (b) the ST model applying to SGM clients; and (c) a few strategies of ST intervention for SGM clients, highlighting the need for strengthening individuals' healthy schema mode.

Minority Stress

The literature has been associating negative psychological outcomes among SGM to pervasive experiences of prejudice, which can be defined as a constellation of hostile attitudes towards people who belong to certain social groups based on negative misconceptions regarding those groups (Myers, 2014). Prejudice has (1) cognitive components (negative and stereotyped appraisals, thoughts, and interpretations) that trigger (2) emotional reactions (mostly anger and disgust), which leads to (3) behavioral repercussions (a tendency to attack, harass, and violate). More broadly, social prejudice (e.g., hostile institutional discourses and practices) increases interpersonal prejudice (e.g., interpersonal relationships), enabling victims to experience psychological suffering (Herek & McLemore, 2013). Prejudice can be directed at gender expression, which is visible to perpetrators regardless of a person's gender identity or sexual orientation. In other words, it is not necessary for a person to mention or verbalize their inner experiences to be the target for violence; regardless of their non-normative physical and behavioral features, they can still be victimized.

Minority stress (MS) is an evidence-based model which helps to explain the longitudinal impacts of chronic exposure to prejudice and adverse environmental conditions on SGM individuals' mental health (Meyer, 2003). MS has three main tenets:

1. Minority status increases the exposure to distal stressors.
2. Distal stressors lead to the development of proximal stressors.
3. The association between distal and proximal stressors leads to negative health outcomes among minority people.

Distal stressors (DS) are external discrimination experiences, which include family and social rejection; physical violence; sexual abuse; verbal aggressions; mistreatment in healthcare settings; discrimination in the labor market; bullying at school; exposure to discriminatory political discourse; and restrictive laws towards sexual and gender expression. Proximal stressors (PS) are internal experiences due to chronic exposure to DS. Some examples include internalized prejudice (negative thoughts about one's gender or sexuality); the need to conceal one's gender or sexuality (in order to preserve one's physical and psychological integrity); and rejection sensitivity (high emotional reactivity when faced with the perception of anticipation/expectation of discrimination or rejection). There are PS specific to transgender people, such as gender dysphoria (effect of DS, not only related to intrinsic biological discomfort); "passing" concerns or visual conformity (desire to visually resemble cisgender people or not look like a transgender person); and body rumination (excessively focused attention on the discomfort caused by one's innate biological traits).

ST Strategies Applying to SGM Clients

Unmet basic emotional needs can activate schema modes and particular schemas, leading SGM emotional processing to be more rigid, and regularly influencing negative mental and physical health outcomes. Young et al. (2003) described five basic human needs throughout development: (a) connection, (b) freedom of speech and emotional validation, (c) autonomy and sense of competence, (d) spontaneity and leisure, and (e) realistic limitations and self-control. Arntz et al. (2021), based on studies of ethology and their clinical experience, reviewed these needs proposed by Young et al. (2003) and included other essential human needs such as self-coherence and sense of justice. When not supported by reparenting and affirmative families, SGM may suffer several unique frustrations in meeting these needs (see some examples in Table 1):

Aversive events, as shown in Table 1, happen not only in the family environment, but also occur in outside settings. Negative experiences regularly experienced by SGM are based on oppressive sociocultural rules and norms. For people to develop fully, it's imperative to respect each person's sexuality and gender in a welcoming and affirming environment. Failure to meet these needs could trigger a series of schemas, specific content of which prone non-affirmation of gender identity and sexual orientation, as seen below (Table 2):

In addition to the EMSs presented in Table 2, there is a set of SGM-unique emotional characteristics, especially when a given person is in an environment where they feel they haven't experienced affirmation. Rejection, fear, shame,

Table 1 Basic needs and adverse experiences among SGM

Basic needs	Aversive occurrences among SGM
Safe connections with others (safety, stability, care, and acceptance)	Unstable connections, refusal to accept gender identity and/or sexual orientation, unsafe environment.
Freedom of speech, validation of emotions and needs	Hindered emotional expression, emotional restrictions, emotional invalidation.
Autonomy, competence, and sense of identity	Limited sense of self, fragile identity affirmation, and strengthening of feelings of being incompetent.
Spontaneity and leisure	Limited expressions of leisure and spontaneity.
Realistic limitations and self-control	Excessive emphasis on self-control to hide their gender identity and/or sexual orientation.
Self-coherence	Environments that go against affirmation of gender identity and/or sexual orientation, which may influence the development of confused (or not coherent) view of the self, as if one were not part of the world/context.
Justice	Experiences that reinforce injustices, frequently based on systematic violence.

Source: The authors of this paper

anxiety, sadness, anguish, anger, and inadequacy are some examples commonly reported in the clinical work with this population.

The inner critic (oppressive sociocultural) mode is composed of a series of environment-internalized schemas, emotional states (including stressors), and maladaptive coping strategies (see Fig. 1). These rigid patterns interfere with the way someone thinks, feels, and behaves when triggers are activated, and basic needs are not met. This schema mode is based on the internalization of prejudice/stigma, feelings (specific emotional experiences), and behaviors (coping strategies to deal with SGM-unique stressors).

The closer SGM are to the community, the prouder they feel of who they are, and the better they understand that there is nothing wrong with experiencing their sexual orientation and gender identity (resilience factors), the more probable positive health outcomes are to occur. Alternatively, disconnection from an affirmative context and functioning based on the inner critic (oppressive sociocultural) mode can lead people to physical and mental health problems.

Intervention Strategies

The literature on ST still lacks intervention strategies for SGM clients. However, it can be assumed that there are ST-based techniques that can be adapted and applied to this population. Below, we will present some strategies that can be used with SGM from the perspective of ST.

Work with Schema Modes

Working with schema modes in ST has proven to be a versatile resource (Flanagan et al., 2020). It is one of ST's main clinical tools (Young et al., 2003), which can also be adapted to working with the inner critic (oppressive sociocultural) mode and the healthy adult (affirmative) mode. In addition to these modes, other schema modes previously mentioned in the literature (Young et al., 2007) can also be triggered in the therapeutic process with SGM clients. Each mode can be addressed by specific therapeutic approaches.

Both the vulnerable child mode (e.g., related to loneliness, injustice, rejection, abuse, confusion) and the externalizing child modes (e.g., engaging in sexual activities impulsively in an attempt to fight the inner critic mode and to find recognition and love) can be worked on through the therapeutic process. In these moments, the therapeutic focus will be understanding and validating the unmet emotional needs of the child, and then, meeting them with limited reparenting (Young et al., 2003).

For example: (a) validating the unmet emotional need for comprehension and empathy through a therapeutic relationship: "*Davis, I understand it is really tough to deal with these feelings and thoughts about yourself. I would like to let you know that you can count on me. You are not alone*!", (b) reparenting the vulnerable child mode through mental imagery: Lucy was bullied in their school because of their gender identity. The therapist invites Lucy to an experiential mental imagery exercise. First, Lucy is asked to engage in building a personal secure place; after that, the therapist guides Lucy to visit their school. In the traumatic scene (when their colleagues are mocking about Lucy's gender identity), they ask Lucy to mentally enter the scenario. After the therapist is allowed to integrate the image, they defend Lucy and affirms their gender identity by saying that there is nothing wrong with their gender identity and that their colleagues' behaviors are wrong and discriminative.

Maladaptive coping strategies must be identified and then confronted empathically. In some cases, the compliant surrenderer mode may be present; if this is occurring, the therapist must help the client to understand that their passivity and subjugation were necessary in the past to avoid attacks, violence, and rejection, but now, an affirmative stance is necessary to get closer to their emotional needs. Maladaptive coping strategies

Table 2 Some definitions, examples, and observations on EMSs experienced by SGM

Some EMSs experienced by SGM	Definition, examples, and observations
Abandonment	*Definition:* The belief that they will be abandoned due to being LGBT and that they will have no stable connections. *Example:* "My parents abandoned me because I am who I am, so I'll be abandoned by other people as well." *Observations:* The feeling of abandonment, especially affective, may be a reality for SGM from early on, when it is expected that children behave according to their gender. When this does not occur, the child might feel rejected by their environment.
Defectiveness/shame	*Definition:* The belief or feeling that there is something wrong about themselves due to being LGBT. *Example:* "I'm a mistake, an anomaly." *Observations:* This schema has a strong historical background since being LGBT has been seen as mental disorders. Also, in certain religious environments, having same-sex attraction is treated as an aberration.
Emotional deprivation	*Definition:* The belief or feeling that they are not understood and that no one will be able to offer them affection because they are LGBT. *Example:* "I have no one to love me and understand me and make me feel like I belong." *Observations:* The feeling of deprivation often goes hand in hand with things SGM experience, which makes this schema resistant to change.
Emotional inhibition	*Definition:* The belief or feeling that expressing their emotions and/or talking about their feelings for a same-sex person is wrong and/or unacceptable. *Example:* "It's very wrong to say that I feel something for someone of the same sex as me"; "I must not express my feelings for people of the same sex as me." *Observations:* Emotional inhibition can start from early childhood, when SGM often start to understand that people who express their feelings for same-sex persons suffer a plethora of retaliation.
Social isolation	*Definition*: The belief or feeling that they are different from others because of their sexual orientation and/or gender identity. *Example*: "I'm different from other people"; "I don't fit in and I don't belong." *Observation*: It is common for SGM to experience this schema in a heteronormative and cis-normative society, which contributes to generating a feeling of not belonging to anti-diversity environments.
Approval-seeking/recognition-seeking	*Definition:* The belief that they need approval from other people to properly experience their gender/sexuality. *Example:* "I need to have my parents and others' approval to live my sexual orientation and/or gender identity." *Observation:* Needing social approval goes beyond the concept of schemas and must include the assurance of basic human rights.
Vulnerability to harm or illness	*Definition*: The belief that something catastrophic or harmful will befall them due to their sexual orientation and/or gender identity. *Example*: "I'll be assaulted if I show affection for my partner." *Observation*: Around the world, transgender people are killed, and LGBT people in general get assaulted, which often makes people take moderate precautions to avoid real menaces.
Punitiveness	*Definition*: The belief that they must be punished because they are a mistake. *Example*: "I deserve to go to hell because I'm a mistake." *Observation*: Sociocultural factors are paramount to understand this schema's basis. Believing that one must be punished or that they will "go to hell" for being LGBT is a common belief in certain religious environments.

Source: The authors of this paper

will keep people away from reparenting relationships; it's a therapeutic goal to have them losing strength throughout the process. If the internalized critical/punitive parents' mode is also present, it must be confronted (Paim & Cardoso, 2019b).

Fighting the Inner Critic Mode (Oppressive Sociocultural)

Empowering the client so they can stand against prejudice and discrimination when necessary is one of the SGM-affirmative strategies recommended by the American Psychological Association (2011). The inner critic (oppressive sociocultural) mode causes people to assume the oppressive experience as if it were a problem with their *self*, which might lead to suffering. One should identify specific environment-internalized statements and judgements to analyze how they currently reflect in their lives in order to confront this schema mode. Establishing a separation between the person and their mode is fundamental so the client can vent their resentment and anger. Farrell and Shaw (2020)

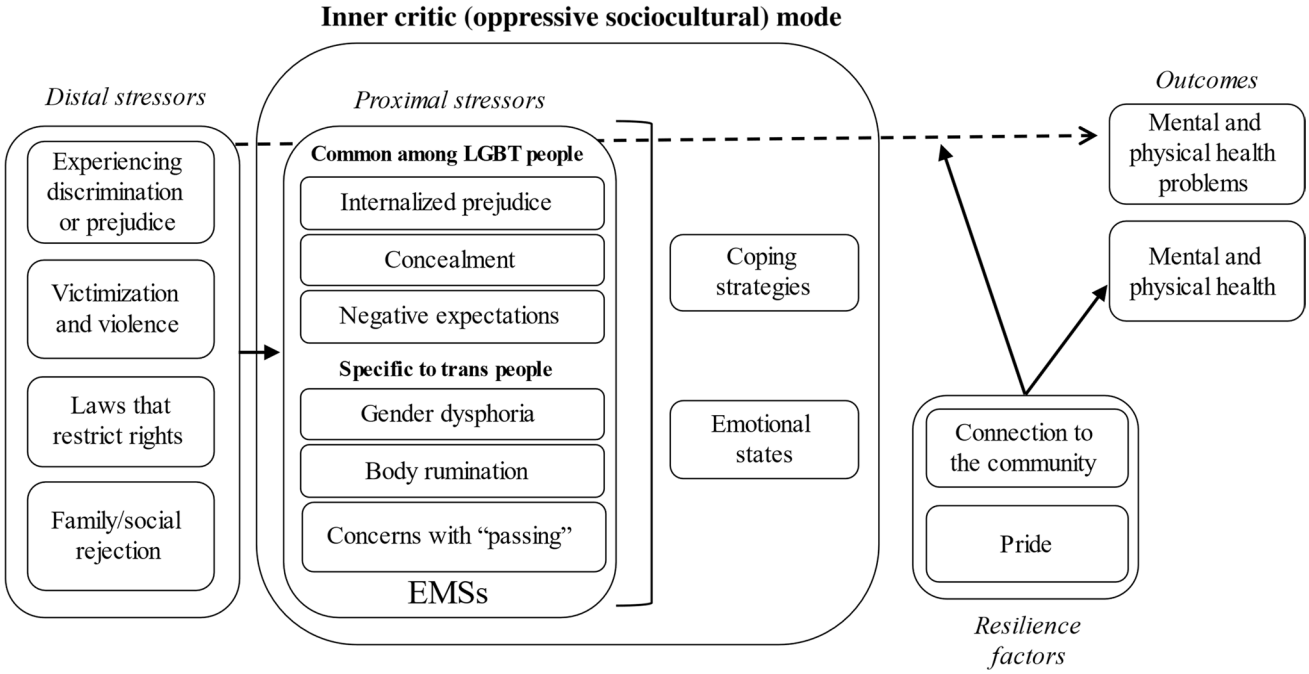

Fig. 1 Inner critic (oppressive sociocultural) mode in SGM. Source: The authors of this paper

suggest that the client should draw or paint their internalized modes on a sheet of paper; by doing that, they can visualize the mode externally, highlighting its dissociation from the person. Another option is to place the mode on an empty chair. Then, the client is encouraged to assume a stance against their internalized negative statements, presenting contrary evidence to these maladaptive internalizations, and to stand strong, assertively, and according to their needs. It is likely that the client will find it hard to assume this kind of stance; if so, the therapist should be the healthy model in this process by going against the oppression, affirming the sexual orientation and/or gender identity of their client.

Strengthening the Healthy Mode

The healthy adult mode (affirmative) consists of the client positioning themselves in such a way as to maintain self-acceptance and stating their sexual orientation and/or gender identity. The therapist can identify the moments when this mode is present and encourage it as a protection of the client's mental health. When in the healthy mode, positive schemas are activated, allowing acceptance and spontaneity to be fostered without negative or internalized judgments.

Limited Reparenting Focused on Affirmation

The limited reparenting strategy aims to partially meet the client's needs. As shown in Table 1, there are several common aversive experiences among SGM. The therapist's role is to provide the client's basic emotional needs by offering a welcoming and affirmative environment in which they could feel free to express their true selves. The therapist also should adopt an encouraging stance, showing emotional support and providing affection and acceptance. Mental imagery techniques can also be used; at this time, the therapist can enter the image corresponding to the client's unmet needs and offer to partially supply them (Young et al., 2003).

Letter to Society

Writing a letter is a traditional ST-technique (Young & Klosko, 2020). However, when adapting to SGM, its use should be extended beyond parents, caregivers, friends, and family. The therapist should instruct the client to write directly to their sociocultural context. At this time, the person can express their needs for gender/sexual acceptance, as well as releasing all the hurt and anger they have felt throughout life.

The following is an example from clinical practice: "*Hello, Society. I was born into you and from early on I have noticed that I am not accepted for being who I am. I've been finding it hard to deal with myself, because with each step I take, I am seen as wrong, inadequate, and a sinner. [...] I would like you to accept me as I am, or at least respect my experiences. Living in this environment that doesn't accept me has caused me a lot of suffering. I think I deserve to be loved and to love, but sometimes I believe that the ways I want to love and be loved are terrible mistakes – which makes me feel ashamed of myself. This is what I learned*

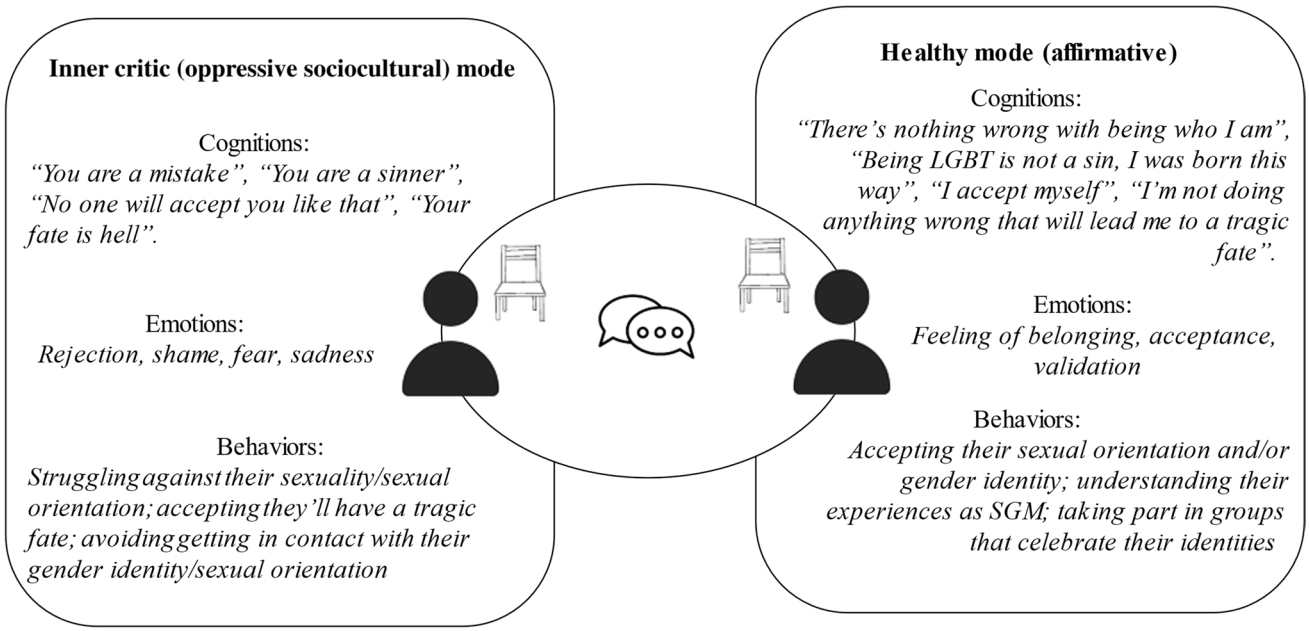

Fig. 2 Chair work with SGM clients. Source: The authors of this paper

from you. […]. I need you not to kill me for being who I am, to respect the relationships I decide to have, and to understand that all I want is to be happy and to live my life without hurting as much as I do." *[…].*

Chair Work

Chair work has been used as an intervention for a series of clients (Kellogg, 2012), including SGM (Boccone, 2016; Herbitter & Levitt, 2021). It consists of enabling the dialogue between two modes: (a) inner critic (oppressive sociocultural) mode and (b) healthy mode (affirmative), as illustrated in Fig. 2.

Figure 2 presents the functioning of each mode ("inner critic mode" versus "healthy mode"), with some specific examples. It should be noted that each person's cognitive, emotional, and behavioral processing can be different. However, these modes may function in the same way. When having maladaptive modes, the client internalizes oppression, judgments, and prejudice from their culture/society. In contrast, adaptive modes promote affirmation, acceptance of one's identity and a sense of belonging. One of the main therapeutic goals of SGM-adapted ST interventions is to strengthen the healthy (affirmative) mode and weaken the negative functioning of the inner critic (oppressive sociocultural) mode. The therapist needs to help the client to foster their healthy mode to become more confident and assertive. In addition, the therapist must always wrap up the exercise while the client is sitting in the healthy (affirmative) mode chair to ensure the conversation ends on a positive note.

Final Considerations

The goal of this paper was to propose some specific ST interventions for SGM clients, addressing sociocultural aspects and promoting a healthy functioning to stand against oppression and internalized prejudice. We recognize the limitations of this theoretical proposition and the lack of specific empirical support for many of the interventions described. We strongly encourage researchers to develop, test, and publish ST adaptations towards SGM and other minorities clients to provide affirmative evidence-based interventions.

Despite clinical work being relevant, maladaptive structures are supported by non-individual-level variables. Therefore, it is important to recognize that some suffering can be addressed in individual therapy sessions, while other problems are socially reinforced. Therapeutic interventions need to go beyond the clinical setting to promote dialogue on the unique needs of SGM and to encourage positive social changes towards these populations.

Acknowledgements The authors of this paper are grateful to Dr. Arnoud Arntz for his comments on a previous draft of the manuscript.

Authors' Contribution This manuscript is original and has not been submitted or published elsewhere. All authors equally contributed to the study conception and writing and have read and approved it before submission. Data sharing is not applicable to this article as no datasets were generated or analyzed.

Data Availability Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

Declarations

Informed Consent An informed consent does not apply to this paper, since its nature is completely theoretical, and no individuals have been part of it. All clinical excerpts are entirely fictional for educational purposes.

Conflict of Interest The authors have no competing interests to declare that are relevant to the content of this article.

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