Issues for effective therapy with the gay and lesbian population

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Issues for effective therapy with the gay and lesbian population

Abstract
Sexual orientation has been defined in various ways. Homosexuality in the earliest times was viewed as a sin. In the mid 19th Century, it was viewed as a mental illness. The "stonewall" uprising in New York in 1969 was the first time the gay and lesbian community took an assertive stand for their identity and their civil liberties (Woodman & Lenna, 1980). This began the gay liberation movement which increased the number of people who identified themselves as gay and lesbian (McDonald & Steinhorn, 1990). In the past 10-15 years psychotherapists have changed their treatment of homosexuality from looking for a cure to today's approach of gay-affirmative therapy, which values both homosexuality and heterosexuality equally as natural and normal attributes (Barrows & Halgin, 1988).
ISSUES FOR EFFECTIVE THERAPY
WITH THE GAY AND LESBIAN POPULATION

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Sexual orientation has been defined in various ways. Homosexuality in the earliest times was viewed as a sin. In the mid 19th Century, it was viewed as a mental illness. The "stonewall" uprising in New York in 1969 was the first time the gay and lesbian community took an assertive stand for their identity and their civil liberties (Woodman & Lenna, 1980). This began the gay liberation movement which increased the number of people who identified themselves as gay and lesbian (McDonald & Steinhorn, 1990). In the past 10-15 years psychotherapists have changed their treatment of homosexuality from looking for a cure to today's approach of gay-affirmative therapy, which values both homosexuality and heterosexuality equally as natural and normal attributes (Barrows & Halgin, 1988).

The term **homosexuality** has been defined as "an attraction for a person of the same sex within one or more dimensions of affection, fantasy or erotic desire" (Barrows & Halgin, 1988, p. 396). According to this definition homosexuality is a type of attraction. The term homosexuality has developed a negative connotation. It is a diagnostic label that addresses only sexual orientation. Many homosexuals prefer the term **gay** or **lesbian**. The terms gay and lesbian have both cognitive and behavioral components including emotion, affection,
life-style and a political perspective as well as sexual orientation (Beane, 1981; Barrows & Halgin, 1988). The term gay then refers to a life-style and not just a desire. The gay community also prefers to refer to the heterosexual community as non-gay. This cites the absence of a quality without implying bias (Woodman & Lenna, 1980). The term homophobia is defined as "an irrational fear of homosexuality or fear of one's own real or potential homosexuality" (Beane, 1981, p. 223). This term is used much like the terms racism or sexism. Homophobia has a major impact on the psychological adjustment of gay men and lesbian women and can have a negative impact on the therapeutic process.

Coleman (1987) proposed that to define sexual orientation by one's gender and the gender of the individuals one is attracted to is an oversimplification. Over 30 years ago, the Kinsey scale attempted to define sexual orientation on a continuum rather than as a dichotomy. This was not accepted by the helping profession and sexual orientation is still dichotomously labeled. Coleman stated that sexual orientation is not static and has difficulty accepting the labels used today. Coleman argued that these labels are simply social constructs and not representative of true sexuality. At the same time,
it was noted that these labels are meaningful to one's identity in today's society. Therapists, according to Coleman, need to recognize and value the complexity of sexual orientation. Along these lines, Chapman & Brannock (1987) noted that there is a need to distinguish between sexual orientation and how it is labeled. Broadening the view of sexual orientation is important in establishing gay-affirmative therapy.

According to the theory of gay-affirmative psychotherapy, it is important for the gay or lesbian individual to develop a positive gay identity (Miranda & Storms, 1989). This is defined as an acceptance of and satisfaction with one's sexual orientation. In a study they conducted, it was found that a positive gay identity leads to increased psychological adjustment.

According to Rudolph (1989) two to four times as many gay men and lesbian women as heterosexual men and women seek counseling. At the same time a larger percentage of gay men and lesbian women report dissatisfaction with treatment compared to heterosexual men and women. This seems to be linked to some extent to therapist biases and lack of knowledge about the population. Garnets, Hancock, Cochran, Goodchilds and Peplarr (1991) conducted a survey among psychotherapists on biases in psychotherapy with
gay men and lesbian women. The results showed 58% of the psychotherapists knew of negative incidents of inadequate or inappropriate treatment relating to biases. The same survey showed that 99% of psychotherapy service providers questioned reported having at least one lesbian or gay client. These statistics illustrate the need for the development of guidelines for psychotherapy with gay men and lesbian women clients.

Given the fact that a large number of gay men and lesbian women are seeking treatment and are receiving unsatisfactory treatment, it appears that psychotherapists need to be more responsive to the special needs, experiences, conflicts and concerns of the gay and lesbian population. It seems therapists need to begin with educating themselves and becoming aware of the gay and lesbian culture and the issues they face such as discrimination, feelings of being different, pressure to conceal their identity and fears of being rejected. Along with this, therapists working with this population need to take inventory of their own values, beliefs and biases about sexual orientation. Therapist biases can influence the effectiveness of the therapeutic process. The purpose of this paper is to raise the awareness of therapists of the issues faced by gay men and lesbian women and to present
some guidelines for therapists to consider in order to increase the effectiveness of therapy with the gay and lesbian population.

Gay and Lesbian Issues Important for Therapist Awareness

Myths, Stereotypes and Discrimination

Several explanations for homosexuality have been based on certain myths or stereotypes. For example, the belief that a homosexual has been treated cruelly by or involved in an incestuous relationship with the opposite sex parent. Another example is the belief that homosexuality is contagious and therefore a person can be seduced into becoming a homosexual. Homosexuals are also seen as being attracted to young boys, predatory and unable to form non-erotic relationships. Homosexuality has been explained as an expression of rebellion, wanting to become the opposite sex or hating the opposite sex (Garnets et al., 1991). These mythical theories are based on the broad belief that everyone is born heterosexual and certain people become homosexual at some point. As a result of these beliefs homosexuality is viewed as illegal, immoral, sinful and unacceptable. It is viewed as an illness that needs to be cured. These myths and stereotypes contribute to the discrimination that homosexuals experience.

The gay and lesbian population experiences
discrimination in several ways. Because the homosexual relationship is not recognized as legitimate and homosexual marriage is illegal in most states, gay men and lesbian women face denial of insurance benefits, hospital visitation and decisions about care. No statutes exist to prevent discrimination against gay men and lesbian women. Therefore, they often experience discrimination in employment, housing and child-custody suits. Certain sexual practices preferred by gay men and lesbian women are illegal to perform in some states as well. Another form of discrimination is the anti-gay violence experienced by many. Such discrimination has a major impact on gay men and lesbian women.

Every minority group is unique in various ways. The homosexual population is unique in two ways. First, unlike other minority populations, most homosexuals do not have a family heritage to base their homosexual identity upon. Homosexuals have very few role models and usually will not even have the support of their families. Second, the gay and lesbian population is virtually invisible which can have both positive and negative effects. This population does not have the identifiable physical features such as skin color, shape of the eyes and nose, and such, that some minorities possess. Therefore, this population
can remain hidden if they choose. This may help them avoid discrimination to some extent but it also keeps them from revealing their true identities and prevents them from dealing with the issues involved. For the individual to pretend to be someone he or she is not and to live in fear of being discovered as gay or lesbian, has a strong emotional impact on the individual.

Homophobia, stereotypes and discrimination can affect gay men and lesbian women in various ways. They may become lonely and isolated socially, cognitively, and emotionally. Often they lack support from family and friends which results in no sense of community as well as other emotional stressors. If the homosexual identity issues are left unresolved, gay men and lesbian women may experience anxiety, depression, alienation, self-hatred and demoralization. Homophobia and discrimination influences the development of social, personal and sexual identity.

To cope with the discrimination and homophobia gay men may develop social patterns in which they restrict social interactions to a sexual nature rather than delaying the sexual interaction until the social interaction has reached another level. Lesbian women may cope through fusion in which they will restrict interaction and socialization to only one partner. These coping strategies
result in a deprivation of social learning (Hetrick & Martin, 1987). Another coping strategy may be to remain in the closet in order to avoid negative experiences. This results in a psychological cost to the individual. Inhibiting thoughts, feelings and behaviors in order to remain in the closet, interferes with the ability to be intimate, spontaneously sexual and affectionate and leads to detachment (Berzon, 1989). Gay men and lesbian women may also internalize society's negative concepts of homosexuality resulting in a negative self-image, guilt, shame, sexual dysfunction, or substance abuse (Barrows & Haltin, 1988). Therefore, the myths, stereotypes and discrimination have a major impact on the psychological adjustment of the gay and lesbian population.

Identity Development

Developing a gay or lesbian sexual identity appears to be a long and difficult process critical to one's psychological well being. It seems important that the therapist be aware of the issues gay men and lesbian women face during this process. The primary task for gay men and lesbian women as they develop their homosexual identity, according to Hetrick & Martin (1987), is to adjust to a socially stigmatized role. Browning, Reynolds & Dworkin (1991) identified a positive gay identity as increased
contact with the gay community and a broadened definition of homosexuality. A negative gay identity results when the person has difficulty establishing and maintaining healthy homosexual relationships.

Several studies have looked at gay identity development in stages (deMonteflores & Schultz, 1978; Beane, 1981; Coleman, 1982; Cass, 1979). The process is described by deMonteflores and Schultz (1978) as a restructuring of the self-concept, a reorganization of one's sense of history and an altering of one's relations with others and society. Cass (1979) organized identity development into the following six stages: 1) Identity Confusion, 2) Identity Comparison, 3) Identity Tolerance, 4) Identity Acceptance, 5) Identity Pride, 6) Identity Synthesis. The other stage theories seem to follow Cass' model to some extent. The first stage of identity development, according to the stage theories, is when the person becomes aware of homosexual feelings to some extent, conscious or pre-conscious. At this time, the individual has difficulty accepting the idea that he or she has these feelings due to their own, as well as society's, homophobic ideas. The individual must re-evaluate his or her introjected values based on society's negative attitude and change the meaning of homosexuality for him or herself.
The individual will be confused at this stage as he or she maintains a heterosexual image to others while privately struggling with a homosexual identity. Clients at this stage of identity development will often enter treatment with generalized problems.

Cass (1979) identified several strategies that gay men and lesbian women may use to deal with the incongruity they feel in this first stage of identity development. They may attempt to control homosexual ideas by inhibiting behaviors and information about homosexuality, deny the personal relevance of such information, become heterosexually hypersexual or asexual, seek a cure or join an anti-gay crusade. Another strategy used is to reject the meaning or context of any homosexual behavior they have participated in by disowning responsibility for homosexual behaviors, such as claiming they were just experimenting, they were drunk or it was an accident. Another strategy used in this stage is to seek information to decide if they are homosexual.

After increased acceptance of homosexual identity, according to the stage theories, the individual moves on to the second and third stages of identity development. Cass (1979) stated the second stage was for the individual to make contact with the gay and lesbian population and
develop a support system of gay men and lesbian women. Then the individual begins the process of coming out to self and to others, the third stage. Coleman (1982), however, reversed these stages stating that the individual will go through the coming out stage and then make contacts with the gay and lesbian community. The fourth stage, according to Coleman, is establishing the first homosexual relationship. Cass (1979) described this fourth stage as the development of a sense of pride in one's homosexual identity and becoming an activist to some extent. The final stage of identity development is identity synthesis, a process of integration in which the self is seen as fully functioning in society. In the identity synthesis stage the individual no longer divides the homosexual population and the heterosexual population into opposing camps and one's gay or lesbian identity is now integrated with the rest of the self.

**Coming Out**

One of the primary tasks of the identity development process is coming out which is the self-recognition of a gay or lesbian identity as well as sharing this identity with others (McDonald & Steinhorn, 1990). The coming out process consists of changes in thoughts, feelings and behaviors. In coming out one is able to recognize, accept
and value his or her identity and adjust in a heterosexual society (Coleman, 1982). The coming out stage is precarious in that the old support system is gone and yet no new support system has been developed. The individual is discovering something about him or herself and at the same time fears rejection if others find out. The individual has a new sense of self while at the same time experiences the loss of the old self-identity. Coming out is important for intimacy in relationships, confirmation of identity and self-actualization. The response the individual receives from society when he or she does come out, has a great impact on the person's subsequent actions. If the client receives a positive response, he or she will be better able to reach self-acceptance. If the client receives a negative response the client faces further stress. To avoid disclosing, however, results in an affirmation of internalized homophobia.

When gay men and lesbian women avoid coming out to self they often experience intrapsychic conflict in which their sexual feelings are separated from their sexual identity. This leads to a lack of continuity and integration of self images. When gay men and lesbian women avoid coming out to others they often experience interpersonal conflict between society's demands and
internal feelings (Miranda & Storms, 1989). Coming out is a self-validating process in which one is relying on him or herself for a sense of worth. Another benefit of coming out is that it forces the person to deal with the issues of sexual orientation. Self-disclosure establishes contact with the real self and makes the public self and the real self congruent. The choice, then, for the gay man or lesbian woman is between acceptance by society and personal authenticity.

**Therapist Guidelines and Intervention Suggestions**

**Guidelines for Effective Therapeutic Relationship**

Sophie (1987) outlined some important guidelines to follow in order to establish and maintain an effective therapeutic relationship with gay or lesbian clients. It is important to convey acceptance of homosexuality without minimizing the real obstacles involved. The client's struggle is real and should be taken seriously. The therapist can model acceptance, valuing human differences and acknowledging negative attitudes while not agreeing with them. Sophie also suggested that disclosure to the therapist is difficult and the therapist's response is important. It is important for the therapist to respond with non-judgmental acceptance. If the therapist responds with silence, the client may perceive this as
negative in that the therapist is either too uncomfortable with the issue or uninterested. It may be helpful to simply acknowledge that having this information will prevent obstacles in the therapy process (Garnets et al., 1991). In considering if the therapist should reveal his or her own sexual orientation, Sophie stated that this should only be revealed when asked directly. The therapist can then proceed to explore the meaning of the response.

The identity development process is slow and confusing, therefore the therapist and the client need to be aware that it is unrealistic to expect to determine sexual orientation in one session. Also, the outcome is unpredictable, therefore the therapist should make it clear that there is no guarantee that the client will not discover that he or she is gay or lesbian. If the client expresses a desire not to be homosexual, the therapist can explore the client's concerns around this issue.

It is important that the therapist be aware of his or her own biases and homophobic ideas. According to Buhrke and Douce (1991), the therapist has an idea of what they should believe, that being non-homophobic ideas. But, in reality, the therapist's own values have been established through socialization and experiences that often conflict with non-homophobic beliefs. The therapist,
then, may deny homophobic values and beliefs because he or she knows as a therapist it is not right. The result of this is that the denied values come out in the form of fear and distance in the therapeutic relationship, inconsistency in treatment and interventions, or premature termination by the therapist or the client. The therapist needs to be aware of lack of knowledge as well as biases to identify his or her limitations and make appropriate referrals. The therapist also needs to explore his or her own feelings and attitudes about intimate homosexual relationships, gay sexuality, and how comfortable he or she is discussing gay sexual techniques and safe sex (Barrows & Halgin, 1988).

Garnets et al., (1991) investigated biases in psychotherapy with gay men and lesbian women. The following are just a few of the biases revealed: assuming the client is homosexual or discounting the client's self-identification as gay or lesbian, trivializing or demeaning homosexuality, abruptly transferring the client upon disclosure, inappropriately using a heterosexual frame of reference, and teaching inaccurate or prejudiced information. Bias in psychotherapy can have a negative impact on the therapeutic relationship as well as the effectiveness of the therapy process.
Suggestions for Effective Therapy

Garnets et al., (1991) also identified guidelines for effective therapy with gay men and lesbian women. In helping the client develop a positive gay identity, first, the therapist needs to understand that homosexuality is not a form of psychopathology. Recognition that societal prejudice and discrimination creates additional problems for this population that may need to be addressed in therapy is also important. Along with this, the therapist needs to be aware of the myths and stereotypes that exist and at the same time possess accurate information about homosexuality in order to help the client overcome negative attitudes about homosexuality. Recognition that ethnic minority gay men and lesbian women experience compounded prejudice and discrimination is also important.

For gay affirmative interventions, according to Garnets et al., (1991), it is important that the therapist does not pursue sexual orientation as the problem. Nor should the therapist attempt to change the client's sexual orientation. The therapist's role is to help the client be freer to explore sexuality, not to determine sexual orientation. McDonald and Steinhorn (1990) stated that the therapist can help the client deal with the pain and problems they experience from the belief system they hold
about sexuality and can then help the clients accept who they are. The therapist needs to be aware of certain gay and lesbian subculture issues. For instance, an awareness of the diversity in the nature of gay and lesbian relationships and the importance of alternative families as opposed to traditional nuclear families. The families of origin of these clients may need education and support as well.

A very important part of effective intervention with the gay and lesbian population is familiarity with relevant community, mental health and educational resources for referral of gay and lesbian clients. Many groups exist to offer social support and opportunities to learn communication skills, explore irrational beliefs and expectations, role play and rehearse issues, and to validate one's identity (Browning, 1987). Other resources include gay volunteer helplines and bibliotherapy. Finally, another important guideline for therapists is to educate professionals and others about gay male and lesbian issues and actively counter misinformation and biases about homosexuality.

Sophie (1987) identified six intervention strategies useful when working with gay and lesbian clients through the identity development process. The first is cognitive
restructuring which is changing the meanings associated with a gay or lesbian identity, as well as the meaning of self-concept, religious beliefs, values and expectations of the future. It is important to eliminate internalized homophobia so that the client can consider a homosexual identity without loss of self-esteem. To begin this process the therapist may ask the client what is bad about being gay, enabling the client to examine the realities of living a gay life rather than accepting misconceptions.

The second strategy is focused on avoiding a negative identity. Sophie (1987) suggested encouraging the client to leave the question of identity open while the client explore the possibilities for him or herself. In this way, the client can stay away from the tendency to dichotomize sexuality into heterosexual or homosexual. The third strategy focuses on adopting an identity label. Some clients may choose to label themselves bisexual at first to avoid the stigma and a negative identity. The meanings of labels such as "lesbian" and "gay" are personal. Therefore, it is useful for the therapist to stay open to the client's definition and definitely avoid pressuring the client to label him or herself. Sophie cautioned therapists using this strategy to challenge the negative connotations that may be preventing the client from labeling
self and also to be aware that if the client delays labeling for too long it may prevent the client from entering the gay and lesbian community which is important for establishing relationships and peer support.

The fourth strategy identified by Sophie (1987), looked at helping the client self-disclose his or her sexual orientation. The therapist can help the client evaluate the risks of disclosing and to whom to disclose. It is important that the therapist respect the decision the client makes of who to tell. Important variables to explore are the strength of the relationship with the person being considered, if this person is open to differences, if this relationship has survived difficult times in the past, and if the person will keep the secret. The therapist can help the client be sensitive to the timing, needs and circumstances of the recipient (Shannon & Woods, 1991). Also, the therapist can help prepare the client for possible reactions and how to deal with them. For example, it is common for the recipient to experience grief at the loss of the person they thought they knew. It may be useful to make the client aware that initial reactions can change with time and effort. It is important to prepare the client for possible results of coming out. For example, often the relationship with the recipient ends and therefore
the client may pass through various stages of the grieving process depending on the significance of the relationship, and the emotional maturity and ego strength of the client.

Other helpful interventions in working with a client who is considering coming out are to discuss best and worst scenarios, longer term implications, role playing or using the empty chair technique. It may be helpful to make the client aware that the recipient may also need to go through the cognitive restructuring process to change his or her definition of homosexuality.

The fifth strategy for working with gay and lesbian clients through the identity development process identified by Sophie (1987) encouraged therapists to help gay men and lesbian women to meet other homosexuals who feel good about being homosexual in order to provide positive role models contradicting negative stereotypes. The sixth strategy suggested relates to helping the client become habituated to his or her sexual identity by encouraging the client to become involved in the gay community possibly by joining a support group or volunteering. This results in a sense of belonging for the client and increased self-esteem. The development of relationships with other homosexuals leads to habituation and identity synthesis.
Conclusion

Gay men and lesbian women are indeed a hidden minority, as labeled by Fassinger (1991). They must deal with many issues that are unique to this population. They face discrimination and prejudice that interferes with their identity. Indeed, they must go through the process of identity development and face the idea that they may not be accepted for who they truly are. The result of which may include both internal conflict and external conflict. It is important that therapists be aware of the issues faced by the gay and lesbian population as well as the subculture in which they live. It seems important for the helping profession to develop a set of guidelines for therapists to follow when working with gay and lesbian clients in order to insure the most effective treatment.

Other issues that the gay and lesbian population face that therapists need to be aware of include AIDS, occupational and career decisions, couple issues, the impact of aging, antigay violence, spiritual and existential issues, substance abuse, domestic violence and sexual abuse, and not having traditional rites of passage into adulthood such as marriage (Shannon & Woods, 1991). Further research and advocacy is needed to influence society to become a more supportive environment for gay men and lesbian women.
to grow to their full capacities (Browning, 1987). Research is needed in areas such as the daily life challenges faced by gay men and lesbian women, an understanding of the process through which biases are developed, ways to identify bias on sexual orientation in the treatment process, and ways to change society's attitudes to eliminate homophobia and reduce bias in psychotherapy (Browning, 1987; Garnets et al., 1991). According to statistics, a large number of clients seeking psychotherapy are from the gay and lesbian population. Therefore, therapists need to evaluate their level of awareness and biases on gay and lesbian issues in order to effectively meet the needs of these clients. Unacknowledged biases tend to be revealed indirectly in the therapeutic relationship. In such cases, awareness and education on homosexual issues may be negated resulting in unsatisfactory and ineffective therapy for the gay and lesbian population.
References


