

# Psychotherapy with lesbian and gay clients



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*In 1995 the Division of Counselling Psychology commissioned a study of psychologists' views and practices in working with lesbian and gay clients in psychotherapy. Martin Milton and Adrian Coyle present the key findings and offer some thoughts on future practice developments.*

**B**RITISH psychologists have paid relatively little attention to the issues involved in working with lesbian and gay clients in psychotherapeutic contexts. The British psychological literature on lesbian and gay issues has largely concentrated on the psychosocial difficulties of being lesbian or gay within a heterosexist society and the implications for psychological well-being (e.g. Kitzinger, 1991; Coyle, 1993; Kitzinger & Coyle, 1995; Kitzinger & Wilkinson, 1995; Rivers, 1995a, 1995b). It is only in recent years that British publications related to therapeutic practice with lesbians and gay men have started to appear (e.g. Hitchings, 1994; Ratigan, 1995; Davies & Neal, 1996; Milton, 1996).

The situation is very different in the USA where a sophisticated and sizeable literature on therapeutic practice has developed over the past two decades (e.g. Gonsiorek, 1982; Stein & Cohen, 1986; Brown, 1988; Falco, 1991; Dworkin & Gutierrez, 1992; Hancock, 1995; see also the *Journal of Gay and Lesbian Psychotherapy*). In 1986, a milestone study of American psychologists' psychotherapeutic practice with lesbian and gay clients, commissioned by the American Psychological Association (APA), was conducted with almost 1,500 participants (Garnets *et al.*, 1991). Results suggested that psychologists varied widely in terms of adherence to unbiased and sensitive practice with this client group.

To develop its guidelines for professional practice, the Standing Committee for Professional Affairs of the Society's Division of Counselling Psychology (DCoP) commissioned a replication of this study with British psychologists working in psychotherapeutic practice. This article reports the principal findings and explores their implications for practice.

## Method

The DCoP study shared the aims of the APA study, i.e. to 'elicit instances of biased care as well as examples of beneficial care provided to gay men and lesbians' (Garnets *et al.*, 1991). The APA survey was used with minor amendments. This was designed to be completed by individuals with personal knowledge of the psychotherapy experiences of lesbians and gay men and consisted of demographic questions followed by four open-ended questions. The first two asked participants to describe incidents of biased, inadequate or inappropriate care and incidents of care that demonstrated special sensitivity to lesbian or gay clients. The remaining questions asked what professional practices they thought were especially harmful or beneficial in psychotherapy with lesbians and gay men.

Due to resource limitations, surveys were sent to 25 per cent of Chartered Clinical and Counselling Psychologists within the Society. These groups were chosen because they represent the main providers of psychotherapy among Society members. Of the 578 surveys dispatched, 192 (33.2 per cent) were returned. Of these, 96 (50 per cent) were completed by individuals who met the participation criterion of having personal knowledge of the psychotherapy experiences of lesbians and gay men. The study focuses on this group.

Data were subjected to thematic content analysis. Procedures for maximising the reliability of qualitative analysis were implemented (Miles & Huberman, 1994).

## Results

### Demographic information

Of those participants who stated their gender and sexual identity, 50 (53.2 per cent) were female and 44 (46.8 per cent)

male; 81 (88 per cent) defined themselves as heterosexual, 6 (6.5 per cent) bisexual, 3 (3.3 per cent) lesbian and 2 (2.2 per cent) gay. Participants' mean age was 43.2 years (range 29-64; SD = 6.8). Of those who provided information on their professional status, 75 (81.5 per cent) identified as clinical psychologists, 13 (14.1 per cent) as counselling psychologists and 4 (4.4 per cent) were qualified in both domains. The most common theoretical orientations were cognitive behavioural (37.9 per cent), psychodynamic (21.8 per cent) and eclectic/integrative (14.3 per cent).

## Deficient practice

The over-arching theme in the data on deficient practice concerned problematic views of and assumptions about homosexuality. Some therapists were said to view homosexuality as pathological. This was often attributed to psychodynamic constructions of homosexuality:

*Psychoanalytic/psychodynamic therapy ... pathologizes [homosexual] behaviour, e.g. as a therapist I was informed that a psychoanalytic training would require me to question and change my orientation and lifestyle, despite the fact that I have been in a committed relationship for 15 years.*

One participant described the dissemination of such pathologization in therapy training:

*At a seminar at [a London psychotherapy training centre], gay, lesbian and bisexual people were referred to as 'perverts' and 'ill'.*

Some participants also suggested that opinions expressed during therapy concerning the origins of lesbian and gay sexualities could be problematic, chiefly when they are represented as having arisen from traumatic developmental events. For example, 'lesbian clients' sexuality having been attributed to adverse/violent sexual experiences with men'. This was seen as implicitly representing heterosexuality as the 'default' option, thereby constructing homosexuality as abnormal. Participants suggested that holding pathologizing views might cause therapists to attempt to change clients' sexual orientation, in the belief that 'if therapy "works" they [the client] will become heterosexual'.

It was also suggested that therapists over-emphasize the importance of sexual identity in the presenting problems of lesbian and gay clients. Many participants noted that sexual identity is often assumed to have a pervasive influence on psychological functioning. This, they claimed, means that therapists explain presenting problems partly or wholly in sexual identity terms or sexual identity is defined as the presenting problem. One participant provided the following example:

*Two lesbian friends, seeing different*

*therapists, several times confirmed being asked questions or offered comments which they felt would not have been addressed if they had been heterosexual, e.g. 'If we explore your relationship with your mother we might be able to understand your sexuality'. Neither friend sees her sexuality as a problem.*

Again, this can result in therapists seeing a change in sexual orientation as an appropriate therapeutic goal, as in this case:

*I was aware of work being carried out by my colleague with a gay man in which the psychologist made the assumption that the client's sexual orientation must have been the source of his depression and that if he was helped to understand why he wanted to have sex with men this would allow him to change his behaviour and resolve his symptoms.*

Another problematic factor was the perceived tendency for therapists to work within a framework of heterosexual assumptions and norms, for example, 'when asking about family and relationships and assuming that the client is straight if not stated otherwise'. Other problematic assumptions identified by participants related to the nature of lesbian and gay relationships and sexual activities, such as 'assumptions about sexual relationships of gay men being generally open or that all gay men engage in anal intercourse'. This failure to acknowledge the diversity of lesbian and gay sexualities was held to be problematic and led some to call for therapists to check out their assumptions and interpretations with clients. Even non-pathologizing views about homosexuality were seen as problematic if they are rigidly held and do not take account of the diversity of viewpoints:

*Strong biases of any kind tended to make the therapist overlook important variations or problems which did not fit a world view of homosexuality, whether that be disapproval of an unnatural 'disorder' or a highly politicized view of seeing all problems as a result of 'oppression'.*

As well as providing examples of deficient practice, some participants also offered explanations which shed light upon what might underpin such practice. Some focused on therapists feeling unskilled in this domain. Other explanations invoked therapists' sexuality, centering on the assumption 'that a lesbian/gay client is bound to develop an eroticised transference towards a same sex therapist' and the threat that this might pose for the therapist who would then be prevented from working on counter-transference issues.

## Exemplary practice

The major themes in the data on exemplary practice were focused on therapy

being conducted within a context of accepting and affirmative views of homosexuality, characterized by open-mindedness and delivered by a therapist who is appropriately knowledgeable about lesbian and gay issues.

Accepting views of homosexuality were said to be characterized chiefly by "Normalization" of gay orientation and non-judgemental acceptance of preferred sexual orientation'. The adoption of accepting views was said to have implications for therapeutic practice, particularly in relation to the theoretical models used in therapy. Many participants suggested that theoretical models should be chosen which accept homosexuality as a valid, non-pathological expression of sexuality.

It was suggested that a more active stance could be adopted in therapy to create an atmosphere of acceptance and affirmation:

*Stepping outside therapeutic neutrality can be helpful to young gay people or those just exploring their homosexual side — i.e. to counter some of the common social prejudices with the view that it is possible to be gay and confident/loving/non-abusive of children/a good parent, etc.*

One manifestation of an accepting, affirmative outlook was said by many to involve a refusal to adopt change in sexual orientation as a standard therapeutic aim. However, this was not seen as precluding an exploration of lesbian and gay clients' heterosexual feelings if this were felt to be appropriate.

The related theme of open-mindedness was particularly evident when participants described the importance of the client deciding the focus of therapy, thereby 'allowing that sexual orientation may be irrelevant to the [presenting] problem'. Participants frequently described homosexuality as but one component that may affect the experiences of lesbian and gay clients (albeit a potentially important one) and it was suggested that this should be acknowledged in therapy:

*Gay clients should be treated as if their sexual choice were not the issue, which doesn't prohibit a focus on ... problems that being gay may bring.*

The themes of acceptance and open-mindedness also came together in those responses which highlighted the importance of acknowledging the effects of social attitudes on the experiences of lesbian and gay clients, i.e. taking account of the political context in which lesbian and gay identities are constructed and enacted. These responses often contained caveats centred around the need to avoid making assumptions. For example, one participant pointed to the importance of 'having some knowledge of the lifestyle opportunities and restrictions people experience if they are lesbian or gay, but not allowing that to lead one to make assumptions, i.e. to treat them as an individual'.

Linked to open-mindedness was the issue of the choice of therapeutic modality. It was suggested that therapists could be flexible and offer a modality that meets the needs of the client and others with whom the client has close relationships. For example, one participant described the value of seeing a gay client in their relationship context and drew upon an experience where the client's 'partner was considered and involved in the diagnostic and care programme, which helped them to cope with hostility from their own families'.

Participants' descriptions of lesbian and gay sexualities indicated that many regarded this as a complex domain in which there were gaps in their knowledge and expertise. For example, reflecting on their perceived need to be 'aware of differences and similarities in lifestyles, relationships, attitudes' among lesbians and gay men, one participant said:

*I think that some awareness of lesbian/gay issues during the course of my professional training would have been of value.*

Some participants argued that there is a responsibility on the part of the therapist to be informed about a range of issues and services relevant to lesbians and gay men. One attached a caveat to this point:

*It is important to be aware of local self help, gay helplines and specialist resources/networks and encourage use of these if appropriate, rather than the potentially pathologizing use of mental health services. But also ensure that this doesn't deny client's use of general services if required.*

Linking to the theme of open-mindedness, others spoke of the desirability of combining knowledge with a willingness to amend it in the light of the client's experience, of 'having some knowledge of the cultural issues/norms for those who identify as gay/lesbian and the facility to ask when in doubt'.

The theme of acceptance extended to issues of transference and countertransference, with a suggestion that good therapeutic outcome is facilitated by the therapist's ability to relate directly to the client's erotic material. For example, reflecting on a particular client, one participant felt that 'the empathic handling of a lesbian client's erotic transference by her female therapist' was helpful. However, some participants recognized that stresses might occur when exploring transference and countertransference issues and believed that supervision might prove useful in these circumstances.

Respondents also considered the sexual identity of the therapist, although no consensus emerged on the desirability of matching therapists and clients. It was suggested that good practice meant ensuring the availability of therapists of

the same sexual identity as the client. An alternative argument was that there might be therapeutic benefit in having a therapist of a different sexual identity. It was felt that this could provide the client with 'the experience of being accepted by a heterosexual therapist' and the opportunity of realizing that 'homosexual experience can be empathically understood by a therapist of different orientation'.

## Discussion

To the extent that these accounts provide an accurate picture of therapy with lesbian and gay clients, this study has implications for psychotherapeutic practice, theory and training. Therefore it is worth considering the extent to which the findings do accurately reflect practice. Although only a third of surveys were returned, this is not unusual for a postal study on a sensitive topic (Fife-Schaw, 1995). For a qualitative study, the sample was sizeable, although its representativeness cannot be determined without demographic and other information on all Chartered Clinical and Counselling Psychologists. However, the sample was heterogeneous along key dimensions such as theoretical orientation and can therefore be said to have obtained a range of accounts from diverse perspectives. Client perspectives were not included because these did not form part of the APA study, but the authors are currently undertaking complementary research which explores both therapists' and clients' experiences of 'gay affirmative' therapy.

Considering the implications of the present study, an important theme in the data on practice can be summarized as a difference between 'doing' and 'being'. Many of the examples of deficient practice fell within the 'doing' category, i.e. actions which the psychologist applied to the client such as attempts to change sexual orientation. Instances of exemplary practice were often linked to therapists' 'being', i.e. the personal qualities that the psychologist might bring to the therapeutic relationship. Psychotherapeutic training might therefore ensure that the 'being' qualities of trainees are attended to closely and developed purposefully.

In terms of psychotherapeutic theory, it has been said that there has been a 'shift from predominantly pathology-based (pre-1970s) to predominantly (though not exclusively) lifestyle-based models of homosexuality' (Kitzinger, 1987). Although Hitchings (1994) observed that this occasioned a move towards lesbian and gay affirmative models of psychotherapy, participants suggested that problems remain. While the APA study also identified problematic conceptualizations of homosexuality among therapists, it did so in general terms. In the DCoP study, participants

focused particularly on traditional psychoanalytic theory, which views homosexuality as a perversion and an appropriate 'symptom' for cure (Bieber *et al.*, 1962; Socarides, 1978). Some psychoanalytic writers have suggested that heterosexuality is a major criterion for successful therapeutic outcome and that 'convinced homosexuality' militates against this (Malan, 1976), a view that has been persuasively challenged (O'Connor & Ryan, 1993). Those who operate within a traditional psychoanalytic framework may therefore need to engage in a serious reconsideration of their theoretical position if they are to provide appropriate therapeutic services to lesbians and gay men, although all practitioners should consider the assumptions their theoretical frameworks make about homosexuality.

On the training front, participants' accounts of therapists who feel that they lack the knowledge and skills needed to work with lesbian and gay clients were not unexpected. The APA study reported similar deficits and included accounts of therapists being over-reliant on clients to educate them about lesbian and gay issues. In the DCoP study, where participants did report affirmative ways of working and appeared to have positive attitudes, there was little evidence that this had arisen from their training. Similarly, in their British study of clinical psychologists' attitudes to lesbians, Annesley and Coyle (1995) concluded that many practitioners appeared to have developed positive attitudes through their life experiences rather than through their training.

The promotion of exemplary practice is dependent upon exemplary training. Therefore, consideration needs to be given to psychotherapeutic training curricula. Drawing upon our own experiences and the experiences of colleagues, it seems that if lesbian and gay issues are addressed at all on training courses, this tends to be done by a small number of well-known lesbian and gay psychologists who are invited to provide short, one-off sessions on lesbian and gay issues for trainees.

The APA Board of Professional Affairs has stated that psychotherapy with lesbian and gay clients is an area of special competence that requires specialized training. As all psychotherapeutic psychologists may potentially encounter lesbian and gay clients, teaching staff on basic and post-qualification training courses in Britain need to consider how they can ensure that they foster this special competence among trainees. This will entail staff developing and refining their own competence in this domain and becoming skilled in disseminating it to trainees. It will also involve creating adequate space within curricula to address issues such as lesbian and gay identities, dealing with anti-lesbian and

gay prejudice and violence, and lesbian and gay relationship issues.

If these issues are to be addressed in a satisfactory way, high quality British research in lesbian and gay psychology should be encouraged in order to inform training and to provide psychotherapeutic psychologists with a quality empirical base for their practice. While this evolves, resources are available from the USA to help practitioners develop their expertise (see material cited earlier) to ensure that lesbians and gay men who seek or who are referred for psychotherapy receive a sensitive, unbiased, informed and beneficial service.

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