

The Person-Centered Journal, Volume 5 Issue 2. 1998

Printed in the U.S.A. All rights reserved.

## **THE SIX NECESSARY AND SUFFICIENT CONDITIONS APPLIED TO WORKING WITH LESBIAN, GAY, AND BISEXUAL CLIENTS**

Dominic Davies

Nottingham, England

*ABSTRACT. The six necessary and sufficient conditions (Rogers, 1957) are offered as a conceptual framework for therapy with lesbian, gay, and bisexual individuals. "Gay affirmative" represents a special range of psychological knowledge which challenges the traditional view that homosexual desire and fixed homosexual orientations are pathological.*

### **INTRODUCTION**

The Person-Centered Approach (PCA) has been used with a great many different populations, and this work has been variously recorded. One area of neglect, however, is the value of working from a Person-Centered perspective with lesbian, gay, and bisexual clients. There is such a dearth of material published that I believe it is helpful to return to the most fundamental tenets of the Person-Centered Approach - the six necessary and sufficient conditions (Rogers, 1957, 1990) and see how these may be relevant to working with lesbian, gay, and bisexual clients.

My aim is to demonstrate how tenets of gay affirmative therapy can be integrated with the six conditions and what person] work practitioners of the PCA need to do in order to be able to work affirmatively with lesbian, gay, and bisexual clients. Perhaps it would be helpful to begin this paper with a definition of "gay affirmative therapy," as its very name may be seen as problematic. Some people may feel the therapeutic approach applies only to gay men, as lesbians and bisexual people are not included in the title. I use "gay affirmative" as a convenient contraction and mean to include all people who have a same-sex attraction. The "affirmative" part of the name is also problematic. Who or what is being affirmed? Could it not be experienced as patronizing by clients to have the therapist "affirm" their sexuality? Even the word "therapy" itself may be unhelpful, in that it can imply a distinct and specific therapeutic approach. Maylon (1982, p. 69) describes gay affirmative therapy Thus:

Gay affirmative psychotherapy is not an independent system of psychotherapy. Rather it represents a special range of psychological knowledge which challenges the traditional view that homosexual desire and fixed homosexual orientations are pathological. Gay affirmative therapy uses traditional psychotherapeutic methods, but proceeds from a non-traditional perspective. This approach regards homophobia, as opposed to homosexuality, as a major pathological variable in the development of certain symptomatic conditions among gay men.

My intention in this article is to contribute to the debate around working with different populations from within the Person-Centered Approach (PCA). I hope that by returning to the *fundamentals* of the Approach I can play a part in developing the PCA, as well the application of the PCA to the relatively new field of working affirmatively with lesbian, gay, and bisexual clients. I have begun from the assumption that Rogers' hypothesis regarding the six conditions is correct and that:

No other conditions are necessary. If these six conditions exist, and continue over a period of time, this is sufficient. (Rogers, 1957, 1990, p. 221).

However, I am of the opinion that to work consistently and successfully with lesbian, gay, and bisexual clients, the therapist has to do a considerable amount of re-education and re-evaluation of his/her attitudes, beliefs, values and knowledge. Rogers himself indicated that therapists needed such training when he said:

It seems desirable that the student should have a broad experiential knowledge of the human being in his cultural setting . . . Such knowledge needs to be supplemented by experiences of living with or dealing with individuals who have been the product of cultural influences very different from those which have molded the student. (Rogers, 1951, p. 437)

One recent work which has influenced my thinking for this paper is an examination of culture and the PCA (Singh and Tutor, 1997). A rigorous analysis of the PCA as it applies to working with people trans- and inter-culturally is presented. I am indebted to the authors for the work they have done in this area. The current article is a development of some of Singh and Tudor's ideas applied to the context of sexuality and sexual orientation because, to paraphrase Singh and Tudor (1997, p. 32), sexuality and sexual orientation are "both necessary and sufficient conditions which affect The therapeutic relationship."

I have concentrated on the deficits or differences that might be encountered when working cross-culturally with lesbian, gay, and bisexual clients. I am aware of the danger of generalizing and would want the reader to be conscious that what I have to say may not apply to working with *all* lesbian, gay, and bisexual clients, but suggest there is value in considering the general themes. Just as there isn't a single "black community," there isn't an identifiable "gay community." There are groups and individuals with similar and different interests, experiences, values, and mores.

I have written this paper with heterosexual therapists at the forefront of my mind. This bias reflects the fact that lesbian, gay, and bisexual clients are more likely to be seeing heterosexual therapists by virtue of their greater numbers, and that heterosexual therapists are perhaps more in need of developing the more detailed understandings of lesbian, gay, and bisexual people. However, I do address some of the hidden assumptions of lesbian, gay, and bisexual therapists who might feel they have an easier time in establishing and maintaining the six conditions with lesbian, gay, and bisexual clients by virtue of their matching sexuality.

**The first condition states that: Two persons are in psychological contact (Rogers, 1957, 1990, p. 221).**

Rogers states it is important that "...each person makes some perceived difference in the experiential field of the other. Probably it is sufficient if each makes some 'subceived' difference...." (Rogers, 1957, 1990, p. 221). I want to explore how therapists establish this first condition by looking at pre-contact, the initial stages of contact, and requests for disclosure of the therapist's sexual orientation.

**Pre- contact**

There is some evidence (Budd, 1994; Lemma, 1996) that clients begin to form a relationship with the therapist prior to meeting them face to face. Our publicity material, the reputation of the agency we work in, and our own reputations gleaned from other clients or colleagues are all relevant to the information gathering and careful checking out that many clients report. It is also likely that the client will have tried to establish the therapist's sexuality and attitudes to lesbian, gay, and bisexual people prior to making the initial contact. This may account for some heterosexual therapists feeling that they rarely see gay clients, and others seeing many people from sexual minorities. Therapists might like to consider how their lesbian, gay, and bisexual clients find them. Some of the questions they might ask themselves are:

- What are your links with lesbian, gay, and bisexual community and voluntary organizations?
- Where do you publicize your practice - do you pay for advertising, and if so do you advertise in the gay press?
- Do you mention your interest in "sexual minorities" in your referral directory entries?
- Do you offer support, consultation, and training to lesbian, gay and bisexual helping agencies?

**Initial Contact**

Therapists might like to consider how they present themselves during the initial contact with lesbian, gay, and bisexual clients, reflecting on the different perceptions and *subceptions* clients might have of them. You might think about, for example, "What difference does my sexuality make to how I make contact and how my client makes contact? Is my heterosexuality 'in their face'?" More generally, do you have a policy or practice about meeting and greeting: do you shake hands? Offer cups of tea? Have a particular seat that is yours? Etc. What do these rituals say about you and your approach to the work? To many lesbian, gay, and bisexual clients, my close-cropped hair, "pinkie" ring, and the inter-linked male sign worn around my neck gives a clear message of my "out" gay identity. Others may not notice these, or not recognize them as gay symbols. Many lesbian, gay, and bisexual people have a highly developed sixth sense or "gaydar" and will scan for visible and intuitive references to the therapist's sexuality and attitudes.

"At a subceived level what does my environment say about me? How might another person perceive me? As heterosexual? Gay? Married with or without children? What sort of pictures do I have on my walls? Do I work in a book-lined study? If so what might this say about me? Are there books that are positively connoted to homosexuality visible on my shelves? (This might be subceived as permissive.) Or do I perhaps, in an

attempt to demonstrate my valuing of other therapeutic models, have books, which come from, for example, a traditional psychoanalytic tradition, which describe lesbian, gay, and bisexual people pathologically? Have I popular best sellers like Laufer and Laufer (1984) and Malan (1979), or modern gay-affirmative analytic texts, such as Isay (1989, 1996), and O'Connor and Ryan (1983)? What sort of magazines are in the waiting area and what might these say about me or the agency I work in?"

### **Disclosure**

Clients report that it is often important to know their therapist's sexual orientation. This is rarely as simple as whether the therapist can identify with the issues the client is presenting. Some therapists might experience this desire to know as an intrusive invasion of their personal life. Therapists may assume that if they say they are heterosexual that the client will not want to work with them. Aside from this being the client's choice, it might be that the client is also attempting to establish psychological contact with the therapist, by "being in personal ... contact with each other" (Rogers, 1957, 1990, p. 222).

Sexuality and sexual orientation is often seen as a private matter. Lesbian, gay, and bisexual people might sometimes say "What I do in bed is my own affair," whilst heterosexuals may say a variation of "I don't mind homosexuals as long as they don't flaunt it, or force it down my throat." The professional therapist is encouraged to treat everyone the same. Fear of action arising from a breach of equal opportunities policies can cause therapists to put on their most politically correct bib and tucker and to mind their P's and Q's (policies and quotients?). However, this avoidance of difference and denial of cultural variables can be very damaging for the therapeutic relationship. Clients may spend a lot of time trying to work out the therapist's real frame of reference, and look for subtler signals of genuineness or incongruence. This detracts from the pre-condition of psychological contact (Singh and Tudor, 1997). I shall return to the relevance of the therapist's own sexual orientation later.

**The second condition states that: The first person, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious (Rogers 1957, 1990, p. 221).**

Rogers explains that incongruence is "a discrepancy between the actual experience of the organism and the self picture of the individual insofar as it represents that experience" (Rogers, 1957, 1990, p. 222). Society has sought to distort the "self picture" of lesbians, gay men, and bisexuals through its labeling of same-sex love and affection variously as sinful, perverted, and sick. The colonialization of lesbian, gay, and bisexual mental health has created a vast number of casualties. Some of the "therapies" have included neurosurgery, electric shock therapy, and brain washing through intensive regular, long-term psychotherapy

Singh and Tudor (1997) developed Rogers' tripartite subdivision of incongruence. These three elements, namely, general vulnerability to the possibility of anxiety or disorganization, dim perception of incongruence and anxiety, and sharp, perceived incongruence, provide a helpful framework in considering incongruence which lesbian, gay, and bisexual clients experience.

#### **(a) General vulnerability to the possibility of anxiety or disorganization**

Lesbians, gay men, and bisexuals live with the daily threat of disapprobation and violence at any overt expression of their sexuality. Stonewall (1996) in a recent survey of queer bashing found that 34% of gay and bisexual men and 24% of women experienced physical violence because of their sexuality. In a further study, the same organization (Stonewall, 1993) found that 37% experienced workplace discrimination and almost half the respondents (48%) had been harassed because of their sexuality. One doesn't need to have experienced the discrimination to fear its happening. This leaves almost all lesbian, gay, and bisexual people vulnerable to anxiety and disorganization.

#### **(b) Dim perception of incongruence and anxiety**

Most lesbian, gay, and bisexual people, prior to openly telling others of their different sexuality (coming out), experience a growing awareness of how they are different from others. This stage in their coming-out process has been called 'Pre-Coming Out' (Coleman, 1981/2). The organism has a vague realization that s/he is not like other people, that her or his erotic attachments include those of the same sex. S/he is aware that this is generally seen by Western society to be bad, or wrong, and this leaves the person anxious and conflicted between self-perception and society's perception.

#### **(c) Sharp, perceived incongruence**

Living in modern Britain, lesbian, gay, and bisexual people are likely to experience higher levels of stress as a result of the heterosexism and homophobia inherent in our society (Coyle, 1993). More recent research conducted by Ian Rivers at the University of Luton into the long-term effects of bullying in adolescence

upon the well-being of lesbian, gay, and bisexual adults demonstrates worryingly high levels of suicidal ideation and attempts as a result of being bullied at school (Rivers, 1997). The victimization had a profound effect on respondents' subsequent mental health and self-esteem. Rivers found that 53% of his sample contemplated suicide or self-harm as a result of being bullied at school. Forty percent of the sample made a single attempt, and 30%, multiple attempts. This research not only contributes hard data to our understanding of schools as being unsafe places for lesbian, gay, and bisexual youth, but also increases our knowledge of the incidence of lesbian, gay, and bisexual adolescent parasuicide where previous research (Trenchard and Warren, 1984) found a frequency of 20% of lesbian, gay, and bisexual youth attempting to take their lives. Lesbians, gay men, and bisexuals may have coped by shutting off awareness of their emotions. They may have got caught up in working hard to please others, or in self-medicating their anxiety, depression, or stress through alcohol or drug misuse.

### **Understanding the Development of Mental Illness**

There has been a lot of research to show that it is not homosexuality *per se* that is pathological, but that living within a society that treats people who have same sex-attractions as psychologically disturbed itself causes mental ill health. For a more detailed review of this literature, the reader is referred to Gonsiorek (1977), Hart, Robrack, Tittler, Weitz, Watson, and McKee (1978), and Reiss (1980).

Clearly, some lesbians, gay men, and bisexuals will develop mental illnesses. It is helpful therefore for the Person-Centered therapist to have an understanding of how such mental illnesses might be understood. The prevailing model of psychiatric illness is a medical model supported through a complex nosology resulting in clinicians making diagnosis through the Diagnostic and Statistical Manual (American Psychiatric Association, 1994) or the International Classification of Diseases (ICD, 1992). A Person-Centered perspective on the development of mental illness has been developed by Speierer (1990) in which he identifies five risk factors for psychological illness. One of these, *incongruence between societal and organismic values*, clearly has a relevance to lesbian, gay, and bisexual people. Speierer (1990) promulgates a way of understanding mental illness that has incongruence as a central construct. He suggests that it is possible to see the origins of all psychiatric illnesses as connected to incongruence between the person and their environment. It is the breakdown of people's coping strategies or recognition of this incongruence that causes illness to develop and come to attention through symptomology. The remaining four risk factors (non-socially caused capacity for congruence and incongruence; psychopathogenic relationships between children and their significant others, as well as all persons in relationships of dependency; poor ability to compensate and poor possibilities of compensation of incongruence; and life-change events) can also be seen to feature amongst lesbian, gay, and bisexual people who develop mental health problems. Space does not permit a full explanation of his model, but I do commend Speierer's work to you.

### **The third condition states that: The second person, whom we shall term the therapist, is congruent or integrated in the relationship (Rogers, 1957, 1990, p. 221).**

Rogers describes therapist congruence:

It means that within the relationship he is freely and deeply himself, with his actual experience accurately represented by his awareness of himself. It is the opposite of presenting a facade, either knowingly or unknowingly. (Rogers, 1957, 1990, p. 224).

Rogers makes it clear that maintaining congruence isn't always easy or comfortable and "includes being himself even in ways which are not regarded as ideal for psychotherapy." This level of integration makes enormous demands of therapists in terms of their self-awareness (Rogers, 1957, 1990, p. 224). Tudor & Worrall (1994) take this point further when they say:

It is likely that if as therapists we consistently ignore or deny some of our feelings and experiences we will, out of awareness, communicate such unassimilated, or partially accommodated material to our clients (p. 198)

Therapists have a responsibility to undertake a rigorous re-examination of their attitudes to lesbian, gay, and bisexual people, and it is not uncommon for therapists to feel OK about one of these three groups and uncomfortable with another. A heterosexual woman colleague shared how she felt fine with gay men, but was afraid of being around "butch dykes." Another colleague, a gay man said he didn't "believe" in bisexuality, and wished "they would make up their minds."

### **Self Awareness**

I hope by now it has been clearly demonstrated that therapists wishing to work well with lesbian, gay, and bisexual clients need to have done a considerable amount of personal work on themselves. For heterosexual and lesbian, gay, and bisexual therapists, this work will include re-examining the negative messages they

have received about homosexuality and lesbian, gay, and bisexual people, as well as coming to a deeper understanding of their own sexuality, and attractions. For heterosexual therapists it may also be helpful to explore what Clark (1987) refers to as one's "homosexual component" - that part of most of us that recognizes same-sex attractions, whether in fantasy or through actual behavior. For lesbian and gay therapists, it would be important to explore the corollary of this, their "heterosexual component" - to come to a greater understanding of their own attractions to the opposite sex and their reasons for choosing not to act on them. This awareness is important in helping to address their biphobia, and is intended to increase their comfort with their own homosexuality. For example, some lesbians and gay men have a defensive response to being around the other gender. This avoidance can also lead to stereotyping and prejudice towards the opposite sex and is clearly unhelpful especially when working with this group.

I take it as axiomatic that we can only accompany someone in working at depth if we have had the experience of working at similar depth oneself (Tudor & Worrall, 1994). Heterosexual therapists are more likely to take to therapy issues their own therapist has worked on, has met in others before, or read about in the vast array of textbooks and novels on issues connected with heterosexuality. My experience is that it is extremely difficult for lesbian, gay, and bisexual therapists to explore their sexuality, fantasies, and practices with a heterosexual therapist for fear of judgment or titillation, whereas in heterosexual therapist dyads this is less likely to be the case.

Lesbian, gay, and bisexual therapists may find it more difficult to trust their (heterosexual) therapists' responses to them. They may have to translate aspects of their life and culture for the therapist and self-censor working on certain issues on which they fear they may be judged. One unfortunate consequence of this less-deep work is that they in turn may be less well equipped to serve their own communities.

Heterosexual therapists, however, may be less personally motivated in working on their attitudes and beliefs around homosexuality, preferring to prioritize other issues of greater personal significance. They may be less inclined to make time to learn more about lesbian, gay, and bisexual psychology issues and to stay current with lesbian, gay, and bisexual community issues. This avoidance inevitably will result in their clients receiving a less-informed service. There is clearly a role for both training institutions and practice supervisors in ensuring that gay-affirmative therapy issues get addressed.

To begin considering awareness of one's sexuality outside the therapy context, the heterosexual reader is invited to consider the following questions:

- How comfortable are you with your own sexuality?
- Do you feel OK holding someone of the same sex?
- Would you feel comfortable using the showers at the leisure center at the same time that the gay swimmers or the lesbian hockey team were in the changing rooms?
- What has been your own history with same sex attractions, feelings and experiences?
- How do you feel about your own "homosexual component?"

For both heterosexual and lesbian, gay, and bisexual therapists, the following questions may be useful:

- How do you feel about the sort of sex you are having (or not) at present?
- How do you feel about your sexual fantasies?
- How do you feel about your sexual anxieties and fears?
- How do you feel about your previous sexual history?
- How do you feel about the quality of your current intimate relationships?
- Within the therapy context, how might you feel hearing a client describe a sex life that is exciting, fulfilling, and uninhibited? (This question should not be taken to presume that all lesbian, gay, and bisexual clients have such a sex life or that the reader does not, but it might be helpful to consider how *you* might feel, and what impact this might have on the therapeutic alliance.)

It should be clear from Rogers' description of congruence that to successfully work with lesbian, gay, and bisexual clients, therapists need to feel comfortable with their own sexuality, including any homosexual feelings and attractions. Therapists may choose not to act on these feelings, but should reflect on their reasons for this. One trainee told me that whilst she had some same-sex sexual experiences well into her early twenties, she felt she ought to settle down and get married because she wanted children, and her parents would have difficulty in accepting a lesbian daughter. It is highly likely that her external locus of evaluation and conditions of worth would have a negative impact on any work she might do with lesbian,

gay, and bisexual clients. Another colleague - in this case, a heterosexual male supervisee - told me how he found it extremely difficult to empathize with his gay male client when he spoke of his relationship with his partner. Because of the therapist's own upbringing, which included a fairly tough, hypermasculine family and school life, the idea of two men being in a deeply intimate, sexual relationship was too threatening to contemplate. The supervisee had pushed any possibility of same-sex feelings out of his awareness to the extent that he felt revulsion when working with this client. This supervisee discovered he felt not only uncomfortable but also unsafe working at a deep level in an intimate emotional relationship with this gay man. Consequently, he was unable to enter the "relational depth" (Mearns, 1996) required for effective Person-Centered Therapy.

Lest it be thought that it is only heterosexual therapists who have work to do in feeling comfortable and integrated in their sexuality, it should be pointed out that lesbian, gay, and bisexual therapists have not escaped the insidious and relentless barrage of anti-homosexual propaganda. In fact, they are perhaps likely to have experienced this more negatively than heterosexual colleagues, as it will have had a personal significance. The internalizations of this hatred and prejudice can in some people grow like a cancer and become "intrapsychically malignant" (Forstein, 1988, p. 34). It is practically impossible for a lesbian, gay, or bisexual person to grow up in British society and not to have internalized society's negative messages about his/her sexuality (Davies, 1996a), and so to work effectively lesbian, gay, and bisexual therapists, have to look carefully at their homophobic residues and their defensive beliefs.

**The fourth condition states that: The therapist experiences unconditional positive regard for the client (Rogers, 1957, 1990, p. 221).**

We have all been brought up in a society which tells us that homosexuals abuse children and young people, and that it is homosexuals who have such uncontrolled libidinous drives they want to have sex anytime, anywhere. How can therapists be expected to offer unconditional positive regard to lesbian, gay, and bisexual clients under these circumstances? What might therapists need to do before they can begin to experience unconditional positive regard for their clients?

For example, imagine your gay male client, aged 20, tells you his new 15-year-old lover wants to try anal sex. Your client is anxious about the legal implications, as the current age of consent in Britain for gay men has recently been reduced to 16. How would you be feeling? What might you be thinking? Are you concerned that by offering unconditional positive regard you might be seen to affirm or in legal terms incite the commission of a criminal act (Cohen, 1992)? Might you be worried that the young lover is being "exploited" by your client? If the roles were reversed and the client was 16 and told you he wanted to penetrate ("make love to") his 22-year-old lover, would your feelings be any different?

How might you offer unconditional positive regard for your client if every cell in your body is repulsed by the idea of anal sex? It is not an adequate justification to use congruence as a reason for your conditionality- "my behavior is how I am." Some practitioners may believe the Person-Centered Approach requires therapeutic neutrality. For instance, to affirm feelings of attraction or desire may imply conditionality, i.e., agreement or support versus acceptance or affirmation. It is my view that "neutrality" does not convey *positive* regard (warmth, love, prizing) and is not sufficient to counteract the negative internalized messages of shame and self-loathing which inevitably reside in most lesbian, gay, and bisexual people. However, therapists need to be watchful of putting a liberal facade on their negative beliefs as reflected, for example, by going out of their way to demonstrate enthusiasm and 'warmth' for lesbian, gay, and bisexual clients.

Furthermore, therapists need to be watchful for the 'love the sinner, hate the sin' type of attitude expressed by so-called "Christian Counselors."

Gay clients have no desire to be confronted by therapists who warmly offer to help them make the best of a poor situation. In fact, such an attitude is one of the subtler forms of homophobia. Therapists who are unable to accept homosexuality as a positive and potentially creative way of being should recognize this fact and not treat gays, because their fear, anxiety and ambivalence will inevitably be conveyed to their clients (Woodman & Lenna, 1980, p. 14).

Therapists holding negative views of homosexuality have an ethical responsibility to work on these attitudes prior to working with lesbian, gay, and bisexual clients. The recent revisions to the BAC Code of Ethics for Counselors makes it clear that anti-discriminatory practice is a basic requirement for ethical practice:

Counselors must consider and address their own prejudices and stereotyping and ensure that an anti-discriminator approach is integral to their counseling practice (BAC 1998: A.2).

Counselors work in ways that affirm both the common humanity and the uniqueness of each individual. They must be sensitive to the cultural context and world view of the client, for instance whether the individual, family or the community is taken as central (BAC 1998: B.2.1).

Counselors are responsible for ensuring that any problems with mutual comprehension due to language, cultural differences or for any other reason are addressed at an early stage (BAC 1998: B.2.3).

Counselors have a responsibility to consider and address their own prejudices and stereotyping attitudes and behavior and particularly to consider ways in which these may be affecting the counseling relationship and influencing their responses (BAC 1998: B.2.4).

British readers are encouraged to consult this new Code of Ethics as it contains much to support gay affirmative therapeutic principles.

**The fifth condition states that: The therapist experiences an empathic understanding or the client's internal frame of reference and endeavors to communicate this experience to the client (Rogers, 1957, 1990, p. 221).**

Lesbians, gay men, and bisexuals are a cultural minority with a long history of being oppressed and stigmatized because of whom they love. Unlike some other minorities, for better and for worse, they are sometimes able to hide who they are, Blacks, who are unable to hide their identity, are usually raised by parents who affirm their cultural identity. This is seldom the case for lesbian, gay and bisexual people. African-Caribbean people have a collective consciousness of the history of slavery and oppression. Many are hyper-vigilant as a result. Despite their ability to hide, lesbians, gay men, and bisexuals have a collective consciousness of being thought of as mad, bad, and dangerous to know. They too have a hyper-vigilance to maltreatment and prejudice.

In order to establish empathy, the therapist needs to understand something of the environment in which lesbian, gay, and bisexual people live: the prejudice they experience daily; the constant decisions about whether to come out and to whom; the possible consequences of coming out; the risk of violence lived with; the possibility of having their home damaged because of being gay; the possible career implications of coming out; etc.

An analogy I developed some years ago and use in training workshops to describe the shift in frames of reference required by heterosexual therapists is that my gayness is akin to my being born speaking a different language. I am capable of thinking, speaking, and behaving in "Heterosexual" - I used to be almost fluent in it - but it is not my mother tongue. My mother tongue is "Gay," and I think, feel, and behave more spontaneously and naturally in that language. When I am in the "country" of heterosexuals, then everything I think, say, and do has to go through an internal translator; this can reduce my spontaneity especially with emotions, and result in my being quite guarded and defensive. Translating also takes a lot of energy, which is why I need time with my own "nationals" to rest and recuperate.

It is as important for heterosexual therapists, as it is for lesbian, gay, and bisexual therapists, to be acquainted with current issues and the different perspectives held within the lesbian, gay, and bisexual communities, i.e., models of relationships (open and closed, multiple and single); attitudes to sex; coming out to parents and at work; issues around body image and lifestyle; drug and alcohol use; spirituality and religious issues. This will mean that therapists can begin to tune in quicker to what the client is saying as they become more familiar with the different gay perspectives on these issues and as they set aside their own assumptions.

### **Experiential Learning for Heterosexual Therapists**

Some suggestions for deepening your empathic understanding might include doing one (or more) of the following activities and writing down the details of this experience in your personal journal describing what you were feeling:

Purchase a gay or lesbian magazine or book and read it in public.

- Wear a pro-lesbian, gay or bisexual T-shirt or badge.
- Hold hands with someone of the same sex in public.
- Keep your heterosexuality in the closet for one week by not disclosing it to anyone. This could

mean when talking about what you did during the weekend with your partner, you are careful not to name him or her or mention his or her gender.

- Challenge heterosexist jokes or epithets.
- Initiate a serious discussion on the topic of heterosexism.

Adapted from Blumenfeld (1992)

### **Experiential Learning for Lesbian, Gay, and Bisexual Therapists**

Following my earlier point that there is no single gay community but rather a number of different groups and individuals with different experiences, interests, and affiliations comprising what could be loosely defined as a “gay culture,” lesbian, gay, and bisexual therapists are not necessarily any better placed to be able to empathize with all members of their communities. Therefore lesbian, gay, and bisexual therapists might want to consider the following questions in therapy, supervision, training contexts, or personal reflection.

- How do I feel about members of my community wanting to get ‘married’ or celebrate their relationship publicly?
- How do I feel about parenting and children?
- What are my attitudes and beliefs about monogamy or open relationships?
- How do I feel when I work with a client who has lost a partner after twenty years of living together, when perhaps my own friends are sick?
- What are my beliefs about recreational drug use in club culture?
- How do I feel about gay and bisexual men engaging in anonymous casual sex?
- How do I feel about bisexuals remaining married and in the closet? Is this any different than being closeted and lesbian or gay?
- What makes me frustrated or angry about lesbian, gay, and bisexual people?
- What beliefs underpin my views on sadomasochism, drag, and intergenerational sex?

It may be that the exercises in both lists will be helpful and relevant to heterosexual and lesbian, gay, and bisexual therapists.

**The sixth condition states that: The communication to the client of the therapist’s empathic understanding and unconditional positive regard is to a minimal degree achieved (Rogers, 1957, 1990, p. 221).**

Therapists might wish to consider how they gauge how others see them. How can we know whether our empathic understanding and unconditional positive regard are communicated to our clients? How do we show warmth and understanding? Do we need to consider any other ways in which we can convey these conditions to our lesbian, gay, and bisexual clients?

When I am involved in training therapists in gay affirmative therapy, I often open a training session with a warm-up exercise where participants are invited to say their names and how much time they spend around lesbian, gay, and bisexual people. The aim is to help me gauge where to pitch the workshop, based on participants’ familiarity and contact with the issues. I am always interested when therapists say, “I don’t see many/know many homosexuals.” I wonder what this says about them. I am struck by the use of the word “homosexual,” when I used “lesbian, gay and bisexual,” and what this means. I am aware that I feel alienated that the name chosen by my communities to describe us has been altered to a former clinical diagnosis. It is important for therapists to pay attention to the language they use when working across cultures (Tudor & Worrall, 1994). This seems to be an example of the sixth condition not being met.

Therapists might like to consider for themselves how often they see lesbian, gay, and bisexual clients. Do they have close personal friends who are lesbian, gay, or bisexual? How do they relate to their lesbian, gay, and bisexual relatives or family members? Should gay clients seek to work only with gay therapists? I think these are interesting questions, and there are no simple answers.

### **Heterosexual or Gay Therapists?**

#### **Heterosexual Therapists**

One of the advantages for a client of working with a heterosexual therapist - a member of the dominant group - is that the client may experience the therapist’s acceptance and concern as somehow more valid than acceptance from a lesbian, gay or bisexual therapist. The client’s reaction to being accepted by a gay therapist may be, “Well, you would say that, wouldn’t you?” This unconditional positive regard from the heterosexual therapist can be particularly powerful for clients who are deeply conflicted about their sexuality and who have internalized shame messages because of heterosexism (Neisen, 1990), or perhaps for those

who are early in their coming-out process (Stages I and 2) (See Davies, 1996b for a fuller explanation of coming out.) It may also be helpful for someone who is married and just coming out to work with a heterosexual therapist, if the therapist can be genuinely interested in the well being of the client first and foremost and not be worrying on behalf of the spouse and any possible children.

### **Lesbian, Gay, and Bisexual Therapists**

Lesbian, gay, and bisexual therapists are much more likely to be familiar with current community issues, although it will be important that they be able to set aside their own political affiliations in order to enter into the world of their clients. The therapist will also need to watch out for possibilities of over-identification. Lesbian, gay, and bisexual therapists are also perhaps more motivated to explore their personal experience of homophobia and shame due to heterosexism, and to learn more about lesbian, gay, and bisexual psychology issues.

A further advantage to some clients might be the therapist as educator and role model. The lesbian, gay, or bisexual therapist's knowledge of gay affirmative self-help literature might well be better, and so *bibliotherapy* (Kus, 1989) can become a useful adjunct to therapy.

Working within one's own community poses particular challenges for therapists regarding the management of dual relationships - socializing and working within the same social space as their clients. This can be both beneficial and problematic to the therapeutic alliance, and is the subject of a separate article (Gabriel and Davies, 2000).

I therefore think that lesbian, gay, and bisexual therapists might be particularly useful for clients who are new to entering the lesbian, gay, and bisexual communities (Stage 3 and beyond in their coming-out), and for lesbians, gay men, and bisexuals whose presenting issues are unrelated to their sexuality *per se*, but who want a therapist familiar with lesbian, gay, and bisexual psychology issues.

## **CONCLUSION**

This paper demonstrates a way of being able to integrate Rogers' (1957, 1990) six conditions with gay-affirmative therapy tenets. Each condition has been explored in relation to issues therapists need to be aware of if they are to work successfully with lesbian, gay, and bisexual clients. There is much to commend the Person-Centered Approach to working with lesbian, gay, and bisexual clients. However, for effective and culturally sensitive work to be done, therapists have quite a lot of re-education and re-evaluation to do. Work on their own attitudes and values will, for most, be the starting place; others will want to understand more about lesbian, gay, and bisexual psychologies. Further study will also be necessary in becoming familiar with some of the common clinical issues experienced by this population.

## **REFERENCES**

- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders*. 4th edition. Washington, DC: American Psychiatric Association.
- Blumenfeld, W. J. (Ed.). (1992). *Homophobia: How We All Pay The Price*. Boston: Beacon Press.
- Budd, S. (1994). Transference revisited. In S. Budd & U. Sharma (Eds.). *The Healing Bond*. London: Routledge.
- Clark, D. (1987). *The New Loving Someone Gay*. California: Celestial Arts.
- Cohen, K. (1992). Some Legal Issues in Counselling and Psychotherapy. *British Journal of Guidance and Counselling*, 20(1), 10-26.
- Coleman, E. (1981/2). Development stages of the coming out process. *Journal of Homosexuality* 7:31-43.
- Coyle, A. (1993). A study of psychological well being among gay men using the GHQ-30. *British Journal of Clinical Psychology*, 32, 218-220.
- Davies, D. (1996a). Homophobia and heterosexism. In D. Davies & C. Neal (Eds.), *Pink Therapy: a guide for Counsellors and therapists working with lesbian, gay and bisexual clients*. Buckingham: Open University Press.
- Davies, D. (1996b). Coming out. In D. Davies & C. Neal (Eds.), *Pink Therapy: a guide for counsellors and therapists working with lesbian, gay and bisexual clients*. Buckingham: Open University Press.
- Forstein, M. (1988). Homophobia: an overview. *Psychiatric Annals*, 18(1), 33-6.
- Gabriel, L., & Davies, D. (2000). The management of ethical dilemmas associated with dual relationships between gay therapists and gay clients and lesbian therapists and lesbian clients. In C. Neal and D. Davies (Eds.), *Issues in Therapy with Lesbian, Gay, Bisexual and Transgender Clients*. Buckingham: Open University Press.
- Gonsiorek, J. C. (1977). Psychological adjustment and homosexuality. *Social and Behavioral Science Documents*, MS 1478. San Raphael. CA: Select Press.
- Hart, M., Robrack, H., Tittler, B., Weitz, L., Walston, B., & McKee, E. (1978). Psychological adjustment of nonpatient homosexuals: critical review of the research literature. *Journal of Clinical Psychiatry*, 39: 604-8.
- International Statistical Classification of Diseases and Related Health Problems (ICD). Tenth Revision (1992). Geneva: World Health Organization.*

- Isay, R. A. (1989). *Being homosexual: Gay men and their development*. New York: Avon Books.
- Isay, R. A. (1996). *Becoming Homosexual: the journey to self-acceptance*. New York: Pantheon Books.
- Kus, R. J. (1989). Bibliotherapy and the gay American men of Alcoholics Anonymous. *Journal of Lesbian and Gay Psychotherapy*, 1(2), 74.
- Lemma, A. (1996). *Introduction to Psychopathology*. London: Sage.
- Laufer, M., & Laufer, E. (1984). *Adolescence and developmental breakdown*. New Haven: Yale University Press.
- Malan, D. (1979). *Individual psychotherapy and the science of psychodynamics*. London: Butterworth.
- Maylon, A. (1982). Psychotherapeutic implications of internalized homophobia in gay men. In J. C. Gonsiorek (Ed.), *Homosexuality and Psychotherapy*. New York: Haworth Press.
- Means, D. (1996). Working at relational depth with clients in Person-Centered Therapy. *Counselling* 7 (4), 306-311.
- Neisen, J. H. (1990). Redefining Homophobia for the 1990's. *Journal of Gay and Lesbian Psychotherapy*. 1(3), 21-35.
- O'Connor, N., & Ryan J. (1993). *Wild desires and mistaken identities lesbianism and psychoanalysis*. London: Virago Press.
- Reiss, B. F. (1980). Psychological tests in homosexuality. In J. Marmor (Ed.). *Homosexual behavior: A Modern Reappraisal* New York: Basic Books.
- Rivers, I. (1997). *The long-term impact of peer victimisation in adolescence upon the well being of lesbian, gay and bisexual adults*. Paper presented at the Vth European Congress of Psychology, University College Dublin, Eire.
- Rogers, C. (1951). *Client-Centered Therapy*. London: Constable.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21(2), 95-103.
- Rogers, C. (1990). The necessary and sufficient conditions of therapeutic personality change. In H. Kirschenbaum & V. L. Henderson (Eds.), *The Carl Rogers Reader*. London: Constable. Original work published in 1957. See full ref. *op. cit.*
- Singh, J., & Tudor, K (1997). Cultural conditions of therapy. *Person-Centered Journal*, vol. 4.
- Speierer, G. W~ (1990). Towards a specific illness concept of client-centered therapy. In G. Lietaer, J. Rombauts & R. van Balen (Eds.). *Client-centered and experiential psychotherapy in the nineties*. Leuven: Leuven University Press.
- Stonewall. (1993). *Less equal than others: A survey of lesbians and gay men at work*. London: Stonewall, 16 Clerkenwell Close, London EC1R OAA.
- Stonewall. (1996). *Queer bashing: a national survey of hate crimes against lesbians and gay men*. London: Stonewall. 16 Clerkenwell Close, London EC1R OAA.
- Trenchard, L., & Warren, H. (1984). *Something to Tell You*. London: London Gay Teenage Group.
- Tudor, K., & Worrall, M. (1994). Congruence reconsidered. *British Journal of Guidance and Counselling*, 22 (2), 197 – 206.
- Woodman, N. J. & Lenna, H. R. (1980). *Counseling with gay men and women A guide for facilitating positive lifestyles*. San Francisco: Jossey Bass.