INTRODUCTION

The chapter is intended to address some of the professional development needs of therapists working in the Person-Centred Approach, irrespective of sexual identity. We feel the issue of psychological contact matters as much in same-sexual orientation dyads as it does where sexual orientation of client and therapist are not matched.

Whilst we have been asked to explore the implications of sexual orientation on psychological contact, our findings and recommendations could probably be extended to other groups where difference exists between therapist and client (i.e. race, ethnicity, class, age, gender, etc.). There are some issues that are unique to sexual minority clients, but one would say that about any of the other groups too. There are probably more similarities than differences though, and the reader is encouraged to try extrapolating from our subject matter to other groups with whom they work. For simplicity we make use of the term ‘sexual minority’ to include lesbian, gay, bisexual and transgender clients, as well as those people who may not identify with these labels but who may nonetheless experience prejudice as a result of having relationships with people of the same gender.

This chapter has been co-written by a lesbian and a gay man. Both of us have been practising in the Person-Centred Approach for a number of years, and one of us (Aykroyd) came out as a lesbian, quite late in life, and brings a unique perspective to this chapter, which is shared with the reader later. The other author (Davies), ‘came out’ in his early twenties and has written extensively on the subject of working with sexual minorities. This is our first writing collaboration together, and we find our views and experiences to be surprisingly similar.

HOW DO I KNOW IF WE’RE IN PSYCHOLOGICAL CONTACT?

When there is psychological contact between therapist and client the flow of experiencing between the two is unhindered. The quality of contact at these times is known by both and is almost taken as a given. Certainly, we accept as a sine qua non that psychological contact is essential for a successful therapeutic relationship. When there is sufficient contact it informs our felt sense of the quality of our meeting with each other. We also find that psychological contact can be
progressive and deepen over time or even at specific moments within a particular session. We understand this to be akin to the ‘relational depth’ proposed by Mearns (1996).

It is probably much easier to be aware of the times when we are not in contact with our clients. The times when the flow of experiencing is blocked in some way are the times when either party may feel bored, uncomfortable or judgemental. Perhaps as therapists, we are aware of feeling inhibited — of not feeling free to be most fully ourselves in relation to our client. We may become aware of holding back, of feeling and being guarded.

These are the times in any therapeutic relationship when the source of this loss of contact needs to be explored. Is it my block? Is it the client’s? Is it something that is happening within our relationship? Therapists may want to ask themselves: What stops me being in contact with all of my lesbian, gay, bisexual or transgender client? Am I willing to explore myself openly in supervision to discover the source of my discomfort, boredom or judgement? Am I willing to explore my own prejudice in relation to sexual minorities? Am I willing to seek out a supervisor who has required this degree of self-awareness of herself and who can therefore fully accompany and facilitate my exploration? It is the therapist’s responsibility to the client to ensure that they do everything they can to establish high quality psychological contact early on in the relationship. Later this may become a shared responsibility.

If the block is my client’s, can I offer acceptance and understanding to him in his fear of contact with me or with aspects of himself in order that this, too, is available for therapeutic exploration? Have I educated myself about the culture of lesbian, gay, bisexual and transgender people in order that I can hear more accurately my client’s unique experience? What do I understand about the nature and effects of institutionalised homophobia? What can I do to examine my attitudes for any trace of heterosexism? Do I have an historical understanding of the experience of sexual minorities? How can I be most fully in psychological contact with my lesbian, gay, bisexual and transgender client?

**HOW CAN I DEMONSTRATE MY AVAILABILITY TO BE IN CONTACT?**

It is thought that clients begin to form a relationship with the therapist even before meeting them. Burgess (2000) describes it thus: ‘as the first call is made and the first intake of breath is heard before any words are uttered by the counsellor, the surge of psychological energy is ignited, activated. It is truly a cataclysmic moment.’ The decision to seek help indicates a readiness at some level, to enter into ‘contact’ with a therapist. However, the client is likely to be wary and watchful for signs that the therapist is trustworthy and able to understand them. Rogers (1951, p. 72) recalls his own experience of reaching out for help: ‘I still remember the warm, acceptant voice of the counsellor and my feeling that it was just a little more acceptant than I could be of the fears I was expressing but not enough different to be reassuring in a threatening way.’

The therapist will want to demonstrate their availability to be in contact with clients. We consider there are four key areas to manifesting this availability. The
SEXUAL ORIENTATION AND PSYCHOLOGICAL CONTACT

four parts are pre-contact, or how you present yourself to the world in publicity and image; the initial contact between you and the client; your working environment which encompasses the physical space you work within and your manner or way of being. In working with sexual minority clients we suggest therapists will need to pay close attention to all four elements as it is highly likely, due to the history of persecution and (mal) ‘treatment’ by ‘helping professionals’ that they will have a hypervigilance to being pathologised as sick or deviant.

Pre-contact

Clients very often arrive in our consulting rooms having checked us out. A current or former client may have referred them, they may have learned about us from a referral directory or register or another counsellor may have referred them. However it is that they find us, clients have often made enquiries of others about our training, our sexuality, and our reputation as a way of ensuring their safety, and in preparation for them to be in psychological contact with us (Davies, 1998). This may account for some colleagues feeling that they rarely see sexual minority clients, and others seeing many people from sexual minorities.

The reader might like to consider the following questions:

• What are your links with lesbian, gay, and bisexual community and voluntary organisations?
• Where do you publicise your practice — do you or your organisation pay for advertising, and if so do you advertise in the gay press?
• If you work for an organisation, does the publicity mention either explicitly or implicitly that you welcome sexual minority clients? Do you, for example, state that you work with ‘couples’ or offer counselling for ‘marital difficulties’? This may lead to some sexual minority clients feeling unable to present if they are in an ‘open’ relationship (i.e. a non-monogamous relationship). It could imply that the therapist holds a belief that extra-dyadic relationships are not healthy or fully functional. The use of the term relationship counselling may be less heterocentric.
• Do you mention your interest in ‘sexual minorities’ or advertise yourself as ‘gay affirmative’ in your referral directory entries and other publicity?
• If you are an experienced gay affirmative therapist have you considered offering consultation and training to sexual minority support groups and organisations? (See Davies and Neal, 1996, 2000, and Neal and Davies 2000 for further reading about gay affirmative therapy.)
• Do your colleagues know that you have an interest in working with this client group and would welcome referrals? If the therapist is also from a sexual minority group, they may have a specific interest in offering their services to other sexual minority clients. However, as we demonstrate in this chapter, they too will have considerable work to do in terms of their personal and professional development before they are ready to work at relational depth (Mearns, 1996) with lesbian, gay, bisexual and transgender clients, as a shared sexual identity is not sufficient preparation for working with sexual minority clients.
CONTACT AND PERCEPTION

Working environment

In discussing the six necessary and sufficient conditions, 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). The reader may care to reflect on how their physical presentation and that of their working environment may impact a sexual minority client. What are the different perceptions and subceptions clients might have of them? (Subception is the subliminal perception or edge of awareness experiencing which is not in our conscious awareness.)

A more defensive therapist may be thinking, ‘What difference does my sexuality make to how I make contact and to how my client makes contact?’ However, we think it is valuable to reflect on ‘how is my (hetero) sexuality in their face?’ To many lesbian, gay, and bisexual clients, my close-cropped hair, and the ring worn on my little finger (or ‘pinkie ring’) gives a clear message of my ‘out’ gay identity. Others may not notice these, or not recognise 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.

We invite the reader to look again at their working environment and try to see what, at a subceived level, does the environment say about them. They may even want to ask a non-therapist friend to give them feedback. How might another person perceive the therapist? As heterosexual? Gay? Married with or without children? Reflecting on the sort of pictures they have on their walls? Do they work in a book-lined study? If so, what might this say about them? Are there books that are positively connoted to homosexuality visible on their shelves? (This might be subceived as accepting of homosexuality.) Or do they perhaps, in an attempt to demonstrate their valuing of other therapeutic models, have books, which come from, for example, a traditional psychoanalytic model, and which may describe lesbian, gay, and bisexual people pathologically? Have they, for example, popular psychodynamic bestsellers like Laufer and Laufer (1984) and Malan (1979), or gay-affirmative analytic texts, such as Isay (1989, 1996), and O’Connor and Ryan (1993)? What sort of magazines are in the waiting area and what might these say about them or the agency they work?

The therapist’s orientation

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 right to choose, 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). Davies (1996, pp. 38–9) has discussed elsewhere some of the implications for therapists being open to a discussion about their sexual identity. There are clear clinical and ethical
obligations in doing so, and therapists should always be willing to enter into such dialogue with clients.

Sexuality and sexual orientation is often seen as a private matter and irrelevant to one's professional practice. Lesbian, gay, and bisexual therapists might sometimes be heard to 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 or our Codes of Ethics 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 (Brauner, 2000). 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 of incongruence.

CLIENT BLOCKS TO PSYCHOLOGICAL CONTACT

There are common themes which affect sexual minority clients and may help our understanding of a client's reluctance or inability to stay in psychological contact within the therapeutic relationship. These are the client's degree of comfort with their sexuality and how comfortable they are about being open about this; their internalised homophobia and levels of shame; the impact of heterosexism and fear of heterosexuals; fearing the therapist's voyeurism and curiosity about their sexuality; and wondering about the therapist attitudes and beliefs.

Client's degree of comfort with sexuality and being 'out'

For some sexual minority clients being 'out', i.e. openly owning their sexuality to themselves and others, is a source of great discomfort and fear. The powerful messages of hatred and disgust that we experience every day inform our conditions of worth and self-concept. Sexual minority clients have grown up with the reality of society's oppression. This inevitably has an effect on their degree of comfort with their sexuality and their willingness to be open about who they are.

In my case (Aykroyd), the result of this fear was that I was out of contact with so much of myself for most of my life. When I first recognised my difference as a child and felt open and joyful, the messages I had in response to my openness about my same-sex attractions were that I would 'grow out of it'. If I didn't, I would no longer be acceptable or accepted, no longer be lovable or loved. That was too fearful for me to contemplate. I knew as an adolescent the reality that gay men were imprisoned for simply being openly themselves. I knew the disgust with which lesbians were reviled. I knew that homosexuality was classed as a mental illness and that gay men were subjected to the most horrific abuses in the name of aversion therapy and 'cure'.

I took the only way possible as an isolated youngster for whom there were no positive images to hold on to. I hid myself away. I built a box for myself and
CONTACT AND PERCEPTION

willingly crawled into it. I began to stick labels on the outside of the box, all of which spoke of my 'normality'. See! I have a boyfriend! See! I'm married! Even my beloved children were to some degree a comforting seal to my heterosexual exterior. And in the deep, dark corners of the box, I was dying. All that was fundamental to my existence, my sexuality, my spirituality, my creativity, was locked away, inaccessible, out of contact. It was only when the last question, life or death, was posed that I dared to choose life and slowly and with enormous fear began to push open my box and crawl into the light. It was a terrifying journey out of my box. Would my children, who were now young women themselves, reject me? Would my women friends no longer welcome my embrace? I risked losing everyone I loved, but if I didn't risk, I would surely die.

My story is not uncommon, particularly amongst older lesbian, gay, bisexual and transgender clients. Even today where more gays, lesbians and bisexuals are 'out and proud', the degree of comfort or discomfort with one's sexuality and the extent to which one feels safe to declare it openly remains an idiosyncratic choice for each client. This may well affect the extent to which a client is able to be openly in psychological contact within the therapeutic relationship.

Internalised homophobia and shame

Sexual minority clients will, at some point in their therapeutic journey, give expression to and become more aware of their internalised homophobia. It is impossible to live every day of our lives in receipt of the hatred and contempt for our difference expressed by this society and by many of the individuals we meet without internalising some of this loathing. Davies (1996, p. 55) suggests that an important part of the therapeutic work with a lesbian, gay or bisexual client is to help them to acknowledge these beliefs and ways of behaving for what they are—a response to 'societal pathologizing of their natural and healthy sexuality'.

Case Example One

James (24) was speaking of a recent visit to his parents where his brother, his wife and their eight-year-old son Ben were also visiting. At one point in the visit, James found himself alone in the lounge with his nephew sitting on his lap watching a video. The other adults were all out in the garden. James spoke of his discomfort when his sister-in-law returned to the lounge and saw her son cuddled up on James' lap. He felt guilty about being 'caught' holding Ben. He had been enjoying the contact, although he had also been anxious about being found with Ben in what could be viewed as a 'compromising' position. Whilst he felt clear about his own intentions, and felt his behaviour to be innocent, he also harboured some shame due to the erroneous linking of homosexuality with paedophilia. His heterosexual female therapist responded: 'I can imagine why you would be worried, I guess it's right to be cautious as I imagine his mother may be anxious seeing you both like that.' This reinforced one of James' configurations of self (Mearns and Thorne, 2000) as 'unsafe' and 'untrustworthy'. A more appropriate response may have been to empathise with each of James' configurations, as another part of him felt angry that he had to censor his
behaviour which could have prevented his nephew getting the affection he sought from his uncle. This barrier to psychological contact, erected by the therapist, took much work to repair.

A client experiencing the force of her internalised homophobia may find it difficult to stay in psychological contact. If she is working with a heterosexual therapist it may be that she feels protective of her lesbian and gay community. When her feelings of shame about her difference begin to surface, it may be safer to withdraw from contact with a therapist whose heterosexuality embodies the source of her community’s oppression. Therapists working with such clients need to be aware and willing to explore openly their understanding of internalised homophobia and to have a high degree of awareness of their own homophobia.

If she is working with a lesbian therapist it might feel too painful or too dangerous to subject her companion on her therapeutic journey to her own homophobic hatred. This again may be a time when withdrawal of psychological contact feels like a safer option to the fear of rejection. Again, it is vital that lesbian, gay and bisexual therapists have explored their own internalised homophobia in order that they are free to be fully with their client in their own unique experience.

**Heterosexism**

Therapists from sexual minority groups may also find that clients are unwilling or unable to enter psychological contact because of their own rigid beliefs that heterosexuality and traditional gender norms are the only acceptable way of being in the world.

**Case Example Two**

The therapist, Jean, has offered a potential new client, Mary, an exploratory session in order that Mary might make an informed choice about working in a therapeutic relationship with her. Jean asks Mary where she would like to start with the exploration. Mary says that it is important to her that her therapist shares her views, particularly relating to her spiritual beliefs. She goes on to explain that as an evangelical Christian she has very firm opinions, backed by biblical teaching, about human sexuality and the evil of homosexuality and sex before marriage. It is important to her that she can trust her therapist and this means that she needs to ask what Jean’s beliefs on these issues are. As an out lesbian person-centred therapist, Jean's desire to respond honestly to Mary's questions means that she owns a different belief, but she lets Mary know that it would be her intention to be with her in her exploration of her own reality and that she feels able to offer that. To Mary’s surprise, Jean continues with the exploratory session as though satisfied with the answer she has received and works at some depth. At the end of the session Jean checks out Mary’s experience of this therapeutic contact and Mary says that she has felt more fully met in this session than by other therapists she has checked out before, but she will not be returning because of Jean’s sexual difference.
This was a particularly painful experience for Jean as the cost of being willing to enter another's reality, which is essentially dismissive and denying of her own, is always felt keenly. In this case her pain was increased by her recognition of Mary's denial to herself of what she had experienced as good psychological contact and a therapeutic relationship in which she felt truly met. Jean realised just how threatened Mary's rigid heterosexist concepts must have been by her willingness to enter Mary's reality and accompany her there.

CLIENT'S FEARS ABOUT HETEROSEXUAL THERAPISTS

Heterophobia

For some sexual minorities there may exist an equal rigidity of belief that all heterosexuals are to be rejected and dismissed. Heterosexual therapists are unlikely to meet such clients. One manifestation of this defence against the experience of homophobia is to avoid all heterosexuals and thus actively discriminate against the hated or feared group. Inter-orientation psychological contact will not be contemplated. For some clients there may exist a less rigid position in which they are willing to work with a heterosexual therapist but in all aspects of the work, because sexuality is such a fundamental of who we are, their belief is 'you can't understand me'. This presents great challenges to the relationship and needs to be openly addressed by the therapist to try to ensure psychological contact is achieved.

For any therapist working with a client who manifests this symptom, it will be vital to recognise the malignancy of internalised homophobia at work. It is a responsibility of therapists working with any gay, lesbian or bisexual client to be alert to and to recognise the manifestations of internalised homophobia and to be willing to work to counter its effect. Understanding these effects will help to conceptualise the client's process when his withdrawal from psychological contact is experienced and will support the therapist in maintaining his 'being' in the therapeutic relationship with real understanding and acceptance.

Fearing voyeurism and curiosity of the therapist

Some sexual minority clients may be wary of the therapist's interest in their lives. This may be a fear of being judged, or misunderstood. They may feel that, for example, discussing their committed, but sexually 'open' relationship will be viewed by the therapist as avoiding intimacy. The client may be reluctant to discuss their sexual practices for fear that the therapist is repulsed or, on the contrary, even aroused by such discussions. Any hindrance to the client being able to discuss any aspect of their lives is an unacceptable barrier to psychological contact and something that needs attention. Therapists should make every effort to have rigorously examined their feelings and attitudes to sexual minority experiences prior to establishing working relationships with this group.

Some clients might be reluctant to express dissatisfaction with either their sexual identity or aspects of the way that the lesbian, gay, bisexual and transgender communities operate. This can be a way of protecting themselves (and the
SEXUAL ORIENTATION AND PSYCHOLOGICAL CONTACT

therapist) from their own internalised homophobia or feelings of shame due to heterosexism. It is our experience that a fruitful discussion can often be had from not only exploring ‘what do you like about being gay’ as well as ‘what do you dislike about it?’

What work has the therapist done on attitudes and beliefs?

The historical legacy of therapy’s relationship to homosexuality is clearly not a secret! Hundreds if not thousands of gay men endured ‘treatment’ by having electro-shock therapy whereby electrodes were attached to their genitals and they received a painful shock if they responded to homoerotic images. Others underwent long-term psychoanalytic psychotherapy with detached and often emotionally punitive therapists. Sexual minority clients have, to borrow a concept from the Jungians, a collective unconscious memory of being labelled ‘bad, mad and dangerous to know’; this is similar to African-Caribbean people’s experience of having been subjected to centuries of slavery. The memories reside in both the unconscious and conscious memory of the community. It is likely therefore that clients will be wondering what we ‘really’ think about them and their lives. Whether we still believe that homosexuality is a mental illness, and since homosexuality was only declassified by the World Health Organisation in 1992 (ICD, 1992) there will be many of us practising today who were trained to see it as a mental illness, a sexual deviation, a perversion or a sin.

Clients are justified in asking their therapist what work they have done on their attitudes and beliefs about sexual minority sexualities and what training they have undertaken to be able to work effectively with them. It is our responsibility to ensure that we are able to offer clients the best therapeutic experience we can.

THERAPIST BLOCKS TO PSYCHOLOGICAL CONTACT

Unresolved sexuality issues in the therapist

It is an insufficient defence to claim that simply because the Person-Centred Approach eschews diagnosis and labels that therapists do not hold the belief that lesbian, gay, bisexual and transgender people are in some way damaged or disturbed. A belief in the actualising tendency and organismic self does not immunise the person-centred therapist from endemic societal and cultural homophobia and heterosexism.

Too often, the authors have heard of person-centred therapists stating words to the effect that: ‘I’m not prejudiced, I accept everyone, we’re all the same underneath.’ This denying of personal prejudice and claiming that sexual minority clients are just the same as them is as offensive as claiming black people are the same as white. It shows a naïve complacency about the insidious and endemic effects of culturally sanctioned discrimination and prejudice. It indicates, just how little awareness the person has of anti-oppressive practice issues and how much they are in need of training.

The absence of implicit prejudice within the approach does not mean that
the person-centred therapist will necessarily be free from unresolved issues around homosexuality or gender issues. It could be that the therapist is envious of some of the freedom from culturally constructed norms in terms of gender behaviour that the lesbian or gay person enjoys. For example, the freedom to openly express affection and the capacity for emotional intimacy with other men that many gay men are able to enjoy and with which it is often much harder for heterosexual men to feel comfortable.

We know that many people have same-sex experiences or erotic feelings during their adult life. It could also be that earlier same-sex sexual experience or crushes perhaps in adolescence or early adulthood have left the therapist with unresolved issues. The different choices they made may impede their availability to work at relational depth with the lesbian, gay or bisexual client for fear of being seduced off the ‘straight and narrow’ path.

**Heterosexism**

‘We’re all the same underneath’ usually also implies a complete lack of awareness that there is a predominant culture in this society that is different from the cultures of sexual minority groups.

When a heterosexual definition of human sexuality is the first assumption of the therapist, there will inevitably be a block to psychological contact with the sexual minority client. This can be particularly damaging to trust in the therapist and therefore in the therapeutic relationship for a client in the early stages of owning their difference — the very time when a trustworthy companion is so vital for the client to work through their fear of rejection.

This attitude can be overtly expressed or it can seep out because it is the unchallenged belief of the therapist. As such it will inform every thought about the client, every response made to the client. When a client refers to their partner and the therapist’s immediate assumption is that this is someone of the opposite gender, the client will know they are working with a therapist who is unaware and is ignorant of the possibility of difference. When a woman talks of her children and the therapist assumes a heterosexual union to be the only possibility for the conception of children, she demonstrates her ignorance. When a gay man talks of his desire for children and the therapist harbours the attitude that children should have a mother and a father, that discriminatory belief will block psychological contact. The list of examples is endless. Do you hear your client only in the context of your own culture? Are you willing to explore your heterosexism?

**Homophobia**

In their book *Pink Therapy*, Davies and Neal (1996) give a clear and thorough description of the ways that the homophobia that is endemic in the institutions of western society is internalised and acted out by individuals. Therapists are not immune from this. Homophobia is always a block to psychological contact with sexual minority clients regardless of the sexual orientation of the therapist.

The client’s response to an experience of homophobic attitudes in their
SEXUAL ORIENTATION AND PSYCHOLOGICAL CONTACT

therapist may vary according to the stage they have reached in their process of self-acceptance. The client who has found a degree of self-love may well be able to experience a homophobic therapist and survive the encounter with their self intact. Such a client is likely to leave this relationship. Clients with self-respect do not expect to be attacked by, or have to educate, their therapist. *The oppressed does not have a responsibility to enlighten the oppressor.*

Far more damaging is the homophobic therapist working with the client who is just beginning the fearful journey towards self-acceptance. A homophobic response to a client whose internalised homophobia attacks them from within will simply affirm all they believe to be true about themselves: that they are disgusting, shameful and perverted. Such affirmation from the very relationship you have entered to seek psychological health is, at best, a block to the therapeutic process and, at worst, can lead to the abandonment that means that to continue to live feels more painful than to end their life for some sexual minority clients.

It is naïve for lesbian, gay and bisexual therapists to assume that because they belong to the sexual minority they have no homophobia. It is worth repeating here that the effect of living every day with the experience of institutionalised homophobia means that inevitably we too, take in some of these powerful messages of hatred and rejection. Our status as gay *and* therapist does not mean we are unaffected. For a gay client to meet with distaste or disapproval for his personal lifestyle, which is not shared by his gay therapist, might be an even greater blow than to meet with it from a member of the oppressing majority. For example, an older gay therapist who is mostly closeted may find himself reacting with distaste and disapproval when confronted by the openness of an effeminate young queen who he feels ‘flaunts’ his gay identity.

**Making generalised assumptions**

Even the modern lesbian or gay therapist may be forgiven for believing the myths created by the media that to be lesbian or gay you need to be in your 20s or 30s, white, middle class and physically able. The visible exclusion of disabled people, people of different social classes, older people, transgender people from the photographs and reports of community events in the gay and straight media, does a major disservice to the diversity of the lesbian, gay, bisexual and transgender communities. If one has little contact with sexual minority communities, we imagine it is even harder to hold the frame that lesbian, gay, bisexual and transgender peoples are everywhere, in every community. Making the assumption of heterosexuality about your client is likely to irreparably alienate you. Assume Nothing!

It should not be assumed that psychological contact between same-sex therapist-client dyads is any easier. Two people are meeting together and both are, to some extent, revealing their vulnerabilities. At a psychospiritual or existential level they are encountering each other. It is likely that the client is more comfortable with some aspects of their sexual minority identity than their therapist is. For example, the client may have come out to their parents, where the therapist has not. The client may be more openly gay, and the therapist may carry greater levels of shame due to heterosexism and internalised homophobia.
than the client may. This may lead the therapist to be more guarded in their ability to be in psychological contact with their client. This can also happen, where there is a concordance with experiencing similar problems, i.e. working with someone on relationship problems or loneliness, when the therapist herself has similar issues.

WAYS TO ACHIEVE AND DEVELOP PSYCHOLOGICAL CONTACT

Supervision by an experienced lesbian, gay and bisexual therapist

One way to ensure that you have support in your journey to increase psychological contact with your sexual minority clients is to seek supervision with someone who has experience and understanding of the issues raised in this chapter. Whatever your sexual orientation, when working with sexual minority clients a supervisory relationship in which you feel free to bring the worst of yourself in your practice, where your inexperience and lack of awareness can be revealed without fear of criticism, is essential in order to ensure best practice. A supervisor who is alert to the subtleties as well as the blatancies of homophobia and heterosexism will be an essential support to you and to your work with your clients.

Such a supervisor will be able to suggest training courses which address the gaps in your knowledge and awareness, and may point you in the direction of relevant films or reading, both fact and fiction, which will increase your understanding of the diversity within the cultures of the sexual minorities in order that you might hear your client’s unique experience more clearly.

Such a supervisor will be willing to share his or her own experience to increase your understanding of the effects of homophobia and heterosexism.

We maintain that addressing the issues and facilitating increased awareness and personal development is necessary to work with professional responsibility with clients from all oppressed groups and should be a core element in all counsellor and therapist training. Until it is, it is the responsibility of therapists to seek out training that helps them to address their prejudice, assumptions, beliefs and knowledge about such groups. When this happens, more gay, lesbian, bisexual and transgender clients will be met more fully and openly in their therapeutic relationships.

REFERENCES


