'Do No Harm' – Working with Women In Conflict With Same-Sex Attraction

By Janelle Hallman, MA, LPC

Not every individual who receives psychotherapy finds the help they were hoping for or concludes therapy with a positive attitude or experience. So it should not be a surprise that some men and women in conflict with same-sex attraction (SSA) have reported negative or unhelpful experiences within reparative therapeutic settings. Collectively, they have described such things as an increase in shame and self-loathing, self-contempt, confusion, depression, and even suicidal ideation. The seriousness of these claims and the extent of the damage may be arguable, but since reparative therapy is under constant scrutiny, the allegations are worth reviewing. Women in conflict with SSA can be damaged by:

Janelle Hallman, MA, LPC

Negative Attitudes About Homosexuals Or Homosexuality

It is not essential (and probably not possible) that a mental health or pastoral professional completely purge his or her self of any and all personal bias or prejudice before they can effectively work with people. But it is important that professionals practice self-awareness, evaluate the impact that an identified bias towards men and women with SSA may have on the therapeutic process, and be willing to seek professional accountability to explore and resolve the source and cause of the bias. Krajeski (1984) explains that:

> Many gay patients, because of previous experiences, are quite sensitive to any signs of rejection or bias and will readily note minor indications of discomfort on the part of the therapist. For example, one patient stated that he was sure that his psychiatrist was homophobic because when he discussed issues connected with homosexuality, the psychiatrist changed positions in his chair, his face reddened slightly, and there was some alteration in his voice. (pp. 81-82)

Regrettably, when it comes to the issue of homosexuality, it is perhaps the mental health community itself that has been the source of a great deal of bias and misunderstanding. For example, historically and even into this present day, homosexual men and women have been referred to as being sick, mentally ill, neurotic, perverted, psychotic, pathological, deviant, and inverted, among other things. These terms are categorically offensive. Yet, when these terms were first introduced into the field more than 50 years ago, they were technically (medically) defined and used to psychoanalytically describe a variety of other conditions. Unfortunately, the general public was never privy to these technical definitions and continued to understand the common use of these terms as inherently negative.

To effectively work with women who have SSA, it is also important to continually challenge any inner moral bias that asserts that homosexuality is a greater wrong than any other human condition, temptation, or sin. Faith-based women with SSA often hear that they are the beyond redemption, contemptible, hated by God, and condemnable. A woman can be irreparably damaged by the toxicity of the sentiment of these terms and beliefs. The amount of time needed for a woman to heal, trust, and begin to assimilate positive words of affirmation about her personhood, will depend on the quantity of years and the extent to which a woman has been exposed to such derogatory words and attitudes, and the authenticity of her therapist's care and unconditional acceptance.

Misinformation And Insensitivity In The Use Of Terms

Over the years, I have learned to be extremely cautious in my communications with my clients. For instance, one person describes her deep discouragement after being told by her therapist that she had "chosen" her homosexual feelings:

> I felt more depressed after I did the therapy. The negative aspect was that I really felt it was all up to me, a choice I had made, and because of that choice I was condemned to being in this pain forever. This need for unnatural affections. (Shidlo & Schroeder, 2002, p. 254)

While a discussion regarding self-determination may be appropriate at some point in the future as a client explores her same-sex feelings and behaviors, a blunt statement suggesting that she simply "chose" homosexuality is neither helpful nor true. Nor is it true that all homosexuals can easily "change" their sexual orientation or that homosexuals can never have a meaningful relationship. On the other hand, the message that all "homosexuality" is biologically based or core to a woman's true identity or that all homosexual people should be fully self-actualized and satisfied as a homosexual is equally damaging.

Margo Rivera, a gay-affirmative therapist, after emphasizing the extremely complex nature of human sexuality, the development of sexual preference and the lack of concrete or scientific "proof" as to the causes or roots of one's sexual orientation, offers this exhortation to any therapist working with a gay, lesbian, or transgendered client:

> It is our responsibility to educate ourselves so that we do not promote or reinforce simplifications, and so that we are able to be a helpful and challenging travelling companion if our clients choose to explore the territory beyond simple answers

and soothing rationalizations. (1996, p. 206)

I also use sensitivity with respect to applying terms specifically related to a woman's struggle with SSA. A client may be initially vague as she first describes the thoughts and feelings that lead her to believe she may have SSA. I listen closely to the words and metaphors she uses to express herself, knowing that she may use the word "lesbian" for lack of a better descriptive word or in a spirit of confession while still not actually identifying with it. The best way to approach terminology is to discuss it with the woman. If I believe it would aid my client to "name" a struggle, I will explore options with her. Terminology should always be adjusted as the woman finds more fitting words.

And finally, I am also very careful in my use of any generalized label, diagnosis, or terminology that would "box-in" or rigidly categorize my clients. Any word that carries the sentiment of a label often adds to a woman's sense of shame or may become a permanent stigmatized label, potentially paralyzing her to further open up or progress in therapy (Hall, 1994a, p. 241).

Believing All Of A Woman's Problems Arise Out Of Her SSA

Clients have been misled to believe that many personal or interpersonal problems and difficulties such as depression, financial stress, or conflict with their boss, will be resolved once their same-sex feelings or behaviors are "changed." Not only is this assertion untrue, it places an unbearable burden on a woman to "fix" an aspect of her life that is not even directly "fixable."

Asserting That Behavioral Management, Alone, Will Curtail SSA

Some counselors have misguided and profoundly disappointed their clients by implying that one or more of the following recommendations, often in and of themselves, will "change" or alter SSA or a same-sex orientation:

- Aversive shock as a client views homosexual pornography
- Visualizing an aversive image (such as getting AIDS) when the client experiences a same-sex arousal
- Abstaining from masturbation
- Experimenting sexually with a member of the opposite sex
- Immersing themselves in work (as a means of distraction from their homosexual impulses)
- Reading the Bible or praying (implying that strengthened spir ituality alone will conquer unwanted SSA)
- Curtailing "masculinized behavior" and replacing it with frequenting the mall or beauty salon

Many behavioral and cognitive methods are effective for a variety of issues that my clients address in therapy, but I would not use nor recommend any of the above interventions as a "solution" to their unwanted SSA or any other issue, for that matter.

Making False Promises Or Exaggerated Claims

"To try to encourage me they said, 'I know you can change because others have,' and 'Just think, some day you might even get married!' But these things didn't help. I'm not like everyone else and besides, if you don't like men or are not attracted to them, the thought of marriage does NOT sweeten the deal." — Rebecca

Many men and women with SSA have reported substantial shifts in their same-sex arousal patterns, behavior, fantasy, desire, and even overall sexual orientation. But if you listen to them closely, most of them admit that from time to time, they still experience same-sex feelings or temptations, succumb to a same-sex fantasy, and may even act out a same-sex related erotic behavior. (MacIntosh, 1994; Nicolosi, Byrd & Potts, 2000a, 2000b; Spitzer, 2003).

Many of the women with whom I have worked start therapy with a conscious or unconscious hope that eventually (and the sooner the better) they will no longer struggle with any residual SSA, fantasy, or desire. Usually about one to two years into therapy, the women begin to discover that many of their same-sex erotic desires are literally woven into their legitimate need for emotional closeness and friendship with women, so that to extinguish their same-sex desire would require them to exterminate their natural and healthy longing and need for female relationship. Sometimes this can become a very discouraging point in therapy.

They realize that to commit themselves to non-sexual friendships with women may require them to continually confront and challenge their tendency (habit) to eroticize their longings for and experience of female warmth and closeness. It is not uncommon at this point for some women to decide to reintegrate and embrace their eroticized same-sex desires, believing that the level of change they originally desired is simply not possible. The work and effort required may be too destabilizing in their overall life and is no longer justifiable in terms of the cost, time, and energy required continuing in a life altering process. Other women, at this stage of self-realization, renew their commitment to continue to do whatever it takes to live a life free from the ultimate control of their same-sex struggle.

When I begin therapy with a new client, I have no idea how she might respond to crossroads, such as these. I, therefore, cannot make any promises or claims in terms of the extent of "change" she may experience in her SSA or future opportunities for marriage and family. I can give her assurance, however, with respect to my positive attitude or commitment to her, but I can't promise how she will respond or benefit from my involvement and presence. I do not say the trite words: "Yes you can change if you work hard in therapy" if the word "change" is interpreted as meaning she will no longer be oriented towards the same-sex but fully oriented to the opposite-sex.

Negative Attitude Towards Client's Parents And Friends

Some men and women report that their relationships with their parents deteriorated during therapy since they were told that their parents were the cause of their SSA. This simplified explanation of SSA is false. Many children experience inadequate parenting but do not later struggle with SSA. I have had the privilege, over the years, to meet hundreds of mothers and fathers of daughters

struggling with SSA. In the great majority of cases, they loved their daughters wholeheartedly and did the best job they could in raising them. As with other clients, when it is important for my client and myself to address the difficulties and imperfections that did exist in her family, I do so with respect and a spirit of grace towards her parents and other family members. Other men and women with SSA also report being forced to "cut off" same-sex relationships and long-term friendships with homosexual friends.

> A friend told me of a lesbian, dying of cancer, being advised by her therapist to cut off all relationships and contact with lesbian friends in order to reconcile with her religion and find peace in herself. (Garnets et al., 1991, p. 967)

First, unless a client is in danger, mandating that a client "cuts off" any relationship violates the principle of client autonomy. Such a life-altering decision needs to be ultimately made by the client. Second, it is dangerous and extremely inadvisable to make such a recommendation during the initial stage of therapy. It will, more often than not, launch a woman into an overwhelming isolation, loneliness, and sense of hopelessness, often creating such an internal crisis, that hospitalization may be required. Third, it will most likely create a sense of threat rather than trust within the client. If I initiate the subject of redefining or ending a relationship, I do so respectfully, sensitive to a woman's ability to consider such events.

Forcing Disclosure To Others

Disclosure is a very individual and sensitive topic. It should never be taken for granted or assumed to be an automatic piece of a client's journey. More often than not, there will be a time and place within a woman's process for some disclosure, but it will rarely be at the beginning of the therapeutic process. Any disclosure should be made purposefully and with as much preparation as possible. A woman should be encouraged to process what she is going to say, how and when she is going to say it and to consider the possible reactions of the folks with whom she will be speaking (including husbands, pastors, and other family members). It is never wise to assume how certain people will react. It is also important that she first establish a sense of trust with her therapist so that she can access their support and care if her disclosures result in negative reactions and rejections. Every therapist embarking into this challenging work should regularly consider the ethical mandate of "do no harm" while they negotiate a client's evolving therapeutic goals or treatment plan. ●

Bibliography

Beckstead, A.L. & Morrow, S.L. (2004). Mormon client's experiences of conversion therapy: A need for a new treatment approach. *The Counseling Psychologist,* 32(5), 651-690.

Garnets, L., Hancock, K., Cochran, S., Goodchilds, J. & Peplau, L.A. (1991). Issues in psychotherapy with lesbians and gay men: A survey of psychologists. *American Psychologist*, 46(9), 964-972.

Hall, J.M. (1994a). Lesbians recovering from alcohol problems: An ethnographic study of health care experiences. *Nursing Research,* 43(4), 238-244.

Krajeski, J. (1984). Psychotherapy with gay and lesbian patients. In E. Hetrick & T. Stein (Eds.), *Innovations in psychotherapy with homosexuals* (pp. 75-88). Washington D.C.: American Psychiatric Press.

MacIntosh, H. (1994). Attitudes and experiences of psychoanalysts in analyzing homosexual patients. *Journal of the American Psychoanalytic Association*, 42(4), 1183-1205.

Nicolosi, J., Byrd, A., & Potts, R. (2000a). Beliefs and practices of therapists who practice sexual reorientation psychotherapy. *Psychological Reports,* 86, 689-702.

Nicolosi, J., Byrd, A., & Potts, R. (2000b). Retrospective self-reports of changes in sexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports*, 86, 1071-1088.

Rivera, M. (1996). Treating the lesbian and gay survivor of abuse. In M. Rivera (Ed.), More alike than different: Treating severely dissociative trauma survirors (pp. 190-208). Toronto: University of Toronto Press.

Shidlo, A. & Schroeder, M. (2002). Changing sexual orientation: A consumers' report. *Professional Psychology: Research and Practice*, 33(3), 249-259.

Spitzer, R. (2003). Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior,* 32(5), 403-417.

'Gay Liberation Movement' Founder Frank Kameny's Papers Archived By Library Of Congress

Frank Kameny, a pioneer of gay liberation in the 1970s, was honored at a ceremony on October 6 in Washington, DC, where his collected papers are being transferred to the Library of Congress.

On October 7, Kameny and Barbara Gittings traveled to New York City where they became the first recipients of the American Psychiatric Association's John M. Fryer, M.D., Award recognizing their contributions to fighting against what is referred to as "homophobia." Kameny, 81, is retired but still active in the Gay and Lesbian Activists Alliance in Washington, DC. Kameny was interviewed in the October 5, 2006 issue of *MetroWeekly*, DC-based online newspaper.

Dr. Jeffrey Satinover's paper, "The Trojan Couch" describes Kameny's historic role in lobbying the American Psychiatric Association to remove homosexuality as a mental disorder from the DSM in the 1970s. Dr. Satinover writes:

"Progressive psychiatrists, gay psychiatrists, and outside activists planned a disruption and sought the services of left-wing activist Frank Kameny, who turned for help to the New Left and non-accommodationist Gay Liberation Front. Kameny's cadre, with forged credentials provided by allies on the inside (some at the very top) [of the APA], broke into a special lifetime service award meeting. They grabbed the microphone, and Kamney declared 'Psychiatry is the enemy incarnate. Psychiatry has waged a relentless war of extermination against us. ... We're rejecting you as our owners. You may take this as our declaration of war.'" ●