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Theorising Lesbian and Gay Affirmative Psychotherapy: A Grounded Analysis.

A thesis submitted for the degree of

Doctor of Counselling Psychology

By

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ABSTRACT:

This thesis presents the findings of a qualitative research study exploring lesbian and gay affirmative psychotherapy. The participants comprised two sets of people. The first are lesbian and gay male clients, the second are lesbian, gay male and heterosexual female therapists. These therapists are accredited Clinical and Counselling Psychologists, Registered Psychotherapists and Accredited Counsellors and identify as lesbian and gay affirmative practitioners. The study explored accounts of lesbian and gay affirmative psychotherapy to see in which ways it is qualitatively different from other forms of therapy with a view to theorising the process of lesbian and gay affirmative psychotherapy. In-depth interviews were conducted and a grounded theory methodology was undertaken. This is discussed in terms of method and epistemology. The findings are represented in diagrammatic and text forms and outline process models of lesbian and gay affirmative therapy. While some of the findings have suggested that lesbian and gay affirmative therapeutic practice might be characterised by particular stances or practices, many of the findings can be incorporated into a range of psychotherapeutic perspectives. Knowledge, training and contextual factors are discussed.

Keywords: Psychotherapy; Lesbian and Gay; Grounded Theory.

CHAPTER 1

INTRODUCTION

Introduction.

Current psychological literature highlights a number of important issues that face psychology and psychotherapeutic practitioners at the turn of the century. These include the fragmentary nature of our discipline (Strawbridge and Woolfe, 1996). The fields of applied and therapeutic psychology contain diverse stances to knowledge, people and practice. They also contain diverse stances towards methods of accountability in practice (both clinical and political) and the manner in which the professions are able, or not able to consider the contextual issues in the latest part of the 1900s (Palmer and Varma, 1997). The four chapters that make up this thesis consider a range of these important issues and are linked by the theme of political and personal issues in the practice of therapeutic psychology. In this thesis the term 'political' is used to recognise those structural and legislative practices that govern human experience and social position *as well as* the resultant identities that people experience. When considering contextual issues in psychology, it is important to recognise that they are embedded in all aspects of the profession and they influence the values of researchers and the resultant research questions and methodologies. The social and political beliefs of practitioners often guide the formulations and interventions that are made and providers of psychological services are influenced by these factors and also by such overt political factors as governmental fiscal policy as well as the current ethos of clinical governance and evidence based practice.

This thesis explores a number of related factors in several ways, with each of the chapters taking a different methodology. Chapter two is a literature review, chapter three a qualitative empirical study and chapter four a case study. A common theme within these studies is a consideration of therapeutic relationships, particularly when

the therapist and client embody different social power positions. Examples of this would include an unemployed client and a well paid therapist or a heterosexual therapist and a lesbian or gay client. Another influential aspect is that of the organisational context. Contexts are also influenced by, and create different political experiences. To run a psychology department in the National Health Service (NHS) is a very different endeavour to that of a lone practitioner operating in a private practice context. In addition, some political material is brought directly into the consulting room in the form of reflection on contemporary political events, or through clients' experiences with oppressive political regimes. These are all political aspects of psychological practice that in some respects are independent of the practitioner.

When exploring these issues, it is not enough to address the political issues 'out there', in an abstract view of the profession, or as an issue located exclusively in government.

Psychological practice is influenced by the political experiences of the therapist or of the researcher and the sense they make of these experiences. In the context of this introduction it is important to consider how these issues may have influenced this thesis. For example, the fact that I am a gay man living in a predominantly heterosexual world will have an impact, as will having lived in a changing South Africa, the United States and in Britain. These will all have provided a number of experiences and understandings that would not have been open to me had I had a different history, for example had I been a black man in South Africa or a heterosexual man. The studies in this thesis must also be influenced by my experience of working in such diverse settings as residential units, outpatient psychology and genito-urinary medicine. Experiences within these different settings mean that I am able to draw on my professional experiences of forming working relationships with children, adolescents, adults and the

elderly, the wealthier and the poorer socio-economic groups, people of different racial groups and with people of diverse sexual identities. Participating in, and reflecting on, all these situations increased my awareness of the impact of the political context on the way in which people experience themselves and how psychological practice is affected. These studies have also helped me reflect on how these different positions might impact both my research (Bola et al., 1998) and therapeutic activities.

My professional training is also another relevant influencing factor. I trained prior to the establishment of the British Psychological Society's Division of Counselling Psychology. My route to accreditation and Chartered Status as a Counselling Psychologist was via the 'Grand-parenting Route'. This was a process whereby an applicant's training was scrutinised by the British Psychological Society Division of Counselling Psychology to see whether it was equivalent to the Society's Diploma in Counselling Psychology. For me, this process involved outlining the content of my South African Bachelors and Honours degrees taken at the University of Natal (1982-1985) and the University of South Africa (1988-1991) respectively. I also needed to outline the content of my graduate training at the School of Psychotherapy and Counselling at Regents College as well as participation in other conferences, short courses and my experiences of personal therapy. In addition to this I engaged in further training which enabled me to gain registration with the United Kingdom Council for Psychotherapy as an Integrative Psychotherapist. Any and all of these experiences and social positions allow me different interpretive possibilities that may have influenced the following chapters. These chapters are now introduced.

The question as to whether or not psychology is a neutral activity has been discussed at length in a wealth of literature and it is generally recognised that psychology is both

affected by political phenomena and influences it (Billington et al., 1998; Strawbridge and Woolfe, 1996). Recognising this, chapter two, *'Politics in Psychotherapy: Therapists' responses to political material'*, is a literature review which focuses on politics in psychotherapy. There are two clear signs that this is an area that has not received a great deal of attention. Firstly, one sign is the dearth of literature addressing issues of technique with political material. The second sign is the accounts that exist of therapists' struggles to engage with clients' political material. In chapter two, approaches to psychological therapy are considered for the way in which they attend to overt political material that comes into therapeutic sessions. This requires a consideration of epistemological underpinnings of knowledge. Approaches that have traditionally focused on the individual and their 'inner' worlds are considered, as are more contemporary approaches that increasingly focus on social constructions and their place within individual and group experiences. The manner in which therapists intervene is the primary focus, but reference is made to the role of language and how it might structure our professions individual and intra-psychic focus by foregrounding such terms as 'therapy'. The review ends with reflections on how practitioners might usefully be developing ways to draw upon different strands of knowledge to develop a more comprehensive approach to psychotherapy.

This is a theme that is also highlighted by participants in the research. Therefore, the thesis extends the exploration of these issues in chapter three, *'Theorising Lesbian and Gay Affirmative Psychotherapy: A grounded analysis'*. The chapter is a large-scale qualitative study into the nature of lesbian and gay affirmative psychotherapy. There is an obvious political dimension to working with any group that has experienced wide spread marginalisation, and the issue of sexual identity in contemporary society is no

exception. This research considers the experiences of a number of therapists (n=14) who feel that they work from a lesbian and gay affirmative stance and a number of clients (n=18) who feel that their therapist addressed issues of sexuality in a sensitive, respectful and beneficial manner. This is a self-selected sample with lesbian and gay male clients represented, as are heterosexual female therapists and lesbian and gay male therapists. Despite calls for participants being placed in arena that were available to them, no heterosexual male therapists responded to calls for participants. This is one of the limitations of the study, but one that can be addressed in future research. Possible factors in this absence are considered in chapter three. The participants have been anonymised in the written report and in publications (Milton and Coyle, 1999). This research is original in its attempt to outline characteristic aspects of lesbian and gay affirmative psychotherapy based on research evidence rather than on opinion or clinical experience alone. A grounded theory approach, a rigorous qualitative methodology, was taken to the research as grounded theory allows the researcher to engage in a collaborative and rigorous study of the psychological experiences of the participants. The advantage of these stances is that processes remain close to the data and can be at least descriptive, but where similar local conditions exist they result in a theory with an ability to be predictive. Thus, grounded theory manages to attend to the difficulty that exists in practitioners' use of traditional research that is rigorous but does not address the reality of working with heterogeneous populations; a tension between rigour and relevance (Gelso, 1979).

Chapter four, *'Depression and the Uncertainty of Identity: An existential-phenomenological exploration in just twelve sessions'*, is a case study which describes a time limited approach to existential-phenomenological therapy where depression is

the presenting problem. As the client, 'Graham' (pseudonym) is a gay man; the case study highlights some of the issues and processes raised by the research. While having been exposed to several different models of psychological therapy both during and after my training, an existential-phenomenological approach to therapy enables an integration of insights and practices from these various models and is underpinned by a critical realist position. A critical realist position is one that recognises that reality exists, but which also takes into account the constructed nature of our experience and the meanings we ascribe to the world. An existential time limited therapy has been outlined in the literature (Strasser and Strasser, 1997) although it has yet to be subject to scientific study. Due to the links between the research and the client, the case study allows a consideration of the degree to which existential psychotherapy is a lesbian and gay affirmative psychotherapy and sensitive to the contextual nature of human experience. Chapter four is structured so as to outline the approach as well as to subject my own client work to scrutiny in an effort to consider the value or difficulties in this way of working. Issues of power and potential harm were considered and all steps have been taken to anonymise the client used in this study.

Science is a cumulative and evolutionary process. Science must consider current knowledge, build on this and develop related knowledge, break down knowledge that can be disproved and aim to develop knowledge further. This is therefore an aim of this thesis – both in terms of how the chapters relate to each other, and also how the thesis relates to the professional and scientific literature. Different methodologies and different approaches to knowledge have aided this as the thesis acts as a series of separate studies that review, consider and describe applied psychological practice with an awareness of the diverse political dimensions that relate to it. The series extends and

tests these issues in three different ways, and thus may be read as three distinct pieces of work, or equally as a meta-consideration of the political dimension of psychotherapy. In this manner it is clearly scientific. More pragmatically it is useful when science and practice are clearly related to each other and these studies are clearly based in the psychology of practice.

This thesis will be seen as useful in that it identifies the reasons why political dimensions are important to the practice of therapy, how we currently engage with these issues and how these issues may be further developed within practice.

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CHAPTER 2 CRITICAL LITERATURE REVIEW

Politics in Psychotherapy: Therapists' Responses to Political Material

POLITICS IN PSYCHOTHERAPY: THERAPISTS' RESPONSES TO POLITICAL MATERIAL.

Introduction

Applied psychology has increasingly begun to consider the political dimension of practice, both in research and therapeutic activities (Pilgrim, 1990). The term 'Political' has a range of meanings with one dictionary definition referring to 'political' as: "of, or relating to the state, or government, the body politic, public administration or policy making" (Collins, 1979:1134). The Oxford English Dictionary defines 'politics' as the 'science and art of government' (cited in Obholzer, 1989:55).

When considering 'government' and its relevance to psychotherapy, consideration must be given to what it is that is actually governed. When considering this it becomes clear that it is often *interpersonal interactions* that are governed. Interpersonal interactions are also subject to legislation, for example in the case of burglary or violence, attacks on the grounds of racial origin, gender or sexual identity, the regulation of resources and opportunities or the international financial and arms industries. These phenomena all have an emotional reality and are frequently present in the material that clients bring to therapists.

The Literature

Such political factors have been increasingly recognised in the literature that considers psychotherapy and its political dimensions. This literature includes the personal and political experiences that clients present in their discussions with therapists, the resultant identities that are experienced (e.g. Oguntokun, 1998), as well as the experiences of overt political processes that exist in modern societies (e.g. Allen, 1999;

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Davies, 1995). This paper considers accounts of how therapists work with political material in therapeutic interactions with clients e.g. in references to such events as local or general elections, the effects of the Budget, and the changes that have been made in the disability benefit system.

This paper explores more than therapy as a political phenomenon, but accounts of therapy as both a therapeutic and a political act. As the literature on the relationship between political material and psychotherapy is limited, it is also useful to consider literature relating to:

1. The political issues in the therapeutic relationship when the therapist and client embody a social power differential, e.g. male therapist and female client (Chaplin, 1988, 1998), white therapist and black client (Thompson, 1991; Alleyne, 1998) or lesbian or gay client and heterosexual therapist (Leitman, 1995).
2. The political dimension of the therapeutic organisation, e.g. special hospitals and other organisations whose clients are not free to enter into or terminate the therapeutic process by way of an independent decision (Parker et al., 1995) or the 'counselling of detainees' in apartheid South Africa (Parker, 1994; Straker, 1988).
3. Clients' experiences of political events, such as the effects of war on the experience of the individual (Frankl, 1985).

An important issue to clarify is that of language. The term 'therapy' is used throughout this thesis as it is a widely used shorthand for the professional activities we term psychotherapy, counselling and psychological therapy. However, this term is not without its difficulties. The term 'therapy' is related to natural science and medical models that locate problems within individuals. In this context therapy is seen as a

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means to 'cure' this problem. The term 'therapy' may therefore focus even the most socially aware practitioners on relieving the individual of 'pathology' or individual distress. The term 'therapy' may therefore be problematic and such implications give rise to the question as to whether a reflective psychological profession should be considering the use of deconstruction *within* psychotherapy (in work with a small number of clients) or deconstructing the profession as a whole (Parker, 1998). This has received a lot of attention (Parker, 1997; Kitzinger and Perkins, 1993) and while this is an influential literature, it can not be the focus of this chapter.

The foci mentioned above are evident in a range of academic disciplines, including some aspects of the psychological literature. However, it is an issue with which many psychotherapeutic practitioners struggle. The struggle highlights the difficulties experienced in responding to political material in a manner that is therapeutic for clients (Coyle, 1995; Deurzen-Smith, 1995; Heenan, 1995; Samuels, 1993a; Waterhouse, 1993).

This struggle is evidenced in two ways. The most obvious manner is in statements that provide accounts of a tension that is experienced by individual practitioners in responding to political material while remaining engaged in a therapeutic encounter. Another important manifestation is the hesitant manner in which the literature has attempted to consider the relationship between psychotherapy and politics. Indeed, it seems it has been easier to highlight the issues that can arise when working with particular groups of people. This is evidenced by literature on working with clients from different social classes (Bromley, 1995; Kearney, 1996; Palmer, 1996), women (Chaplin, 1988), lesbians, gay men and bisexuals (Davies and Neal, 1996), race (Per, 1992; Timimi, 1996) and HIV status (Crawford et al., 1991). Such a focus appears to

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be easier than discussing the manner of therapists' engagement and intervention. This may be due to the ease with which essentialist descriptions of client groups can be developed as opposed to the complex and constructed understandings of relationships between clients and therapists. This literature often focuses on the problem or the process of the 'Other', and ignores the position and the processes of the therapist. The result of this is that as professions, counselling, psychotherapy and psychology have often focussed on the experiences of the majority groups in society and frequently ignored the issues and experiences of 'social class, ethnicity, religious orientation and sexual orientation' (McLeod, 1994: 14).

Although the political dimension has received attention more recently (Gordon, 1995; Obholzer, 1989; Samuels, 1992, 1993a) an issue of concern is the limited literature that is based on empirical research focusing directly on the process of therapy with political material. Much of the literature relies on opinion or clinical experience. One notable exception is Samuels (1993a) international postal survey, in which he acknowledged an expectation that is evident in some of the literature and this is that therapists are most likely to interpret political material in a symbolic manner, viewing political material as transference material. However, the results of the study suggest that therapists also relate to political material as 'reality'.

This chapter argues that the difficulties therapists experience in practising a politically aware therapy – or engaging with political material at all - are rooted in socio-political contexts and the approach taken to knowledge, particularly the epistemological foundations of therapeutic theory. The chapter specifically looks at the approaches to knowledge. This will occur by initially focussing on approaches to individual psychotherapy that are based in traditional models of the 'individual' which are still

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influential and the difficulties that bedevil such practices. The chapter then moves on to address some of the ways in which contemporary models are trying to address the problems identified.

Traditional Therapies

This term is used to refer to those approaches that have an important place in the historical development of the psychotherapies. These therapies tend to be those approaches that are clearly based in essentialist notions of the individual and which view people and experience as independent of the context. Thus, emotions are thought to exist independently of their context, psychopathology becomes an independent, real entity that someone 'has' and there is such a thing as 'Truth', actions are categorically right or wrong, and answers are possible (Billington et al., 1998; Burr, 1995; Spinelli, 1994; Strawbridge, 1996). These views are represented by traditional psychodynamic, cognitive-behavioural and humanistic approaches to psychotherapy now and at their initial stages of development. While each may foreground different aspects of the therapeutic relationship, human experience or psychological intervention, all three paradigms assume that distress is at least partly located within the individual. In addition, each of these paradigms assume that aspects of the individual's emotional life are the *cause* of psychological difficulties and each views individual attention as a route to alleviating that distress. For example, in cognitive or cognitive-behavioural therapy, clients are encouraged to recognise *their* faulty thinking (Beck, 1976; Padesky, 1994; Trower et al., 1988). In psychoanalytic theory symptomatic relief is thought to come when clients are able to recognise *their* projections and to see how this colours their perception of the world (Casement, 1985; Jacobs, 1986; Janssen, 1994). The humanistic focus is on the actualisation of the drive to good health that each *individual*

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has (Mearns and Thorne, 1988; Rogers, 1951). Such assumptions support the view that the difficulty and the solution are located within the individual.

The themes evident in early psychotherapeutic writings are not just aspects of the therapeutic theory; they are also evident in the practices and views of the times. While this does not equate to a causal link, it does highlight the fact that the political and the psychological bear some relationship to the issues and dynamics of the time (Markowitz, 1996). For example, in the early days of psychoanalytic development the world was experiencing massive European colonialism, the First World War, and women were politically disenfranchised. The analytic models developed a dualistic view of human experience where conflict is central and incorporated a social and gender biased view of human experience, development and distress. Frankl's consideration of the notions of will and meaning in a person's life were attributed to his experience of War, the struggle of the concentration camps and his ability to reflect on this from an insider's perspective (Frankl, 1967). Rogers developed his client centred therapy at a time when the humanistic values of human growth and potential found a resonance with views that were present in the values of the time (Garfield and Bergin, 1994). Cognitive psychology and cognitive therapy came about at a time of technological advancement and the availability of technological metaphors for understanding human experience, learning and interventions.

It has been argued that, as well as a relationship between the therapeutic and social views, social structures and policies allowed for some therapeutic professions to come into being. For example, the profession of Clinical Psychology was able to establish itself in the United Kingdom because of the positivistic and empiricist values in Britain in the 1950's (Pilgrim, 1990, 1996). Equally in the United States, psychology and

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counselling developed as professions in the aftermath of the war as there weren't enough of the traditional therapeutic professionals, i.e. psychiatrists, qualified or in training, to respond effectively to the growing demand (Bergin and Garfield, 1994a, 1994b). The establishment of Counselling Psychology in the UK and the separate profession of Counselling may have been possible due to the 'manpower shortfall' in clinical psychology (Manpower Advisory Service to the NHS, 1989). These examples show that the values of a time are related to the stances that models and theoreticians are able to take to knowledge of the individual and hence the nature of the practices that develop. However, it is not possible to explore the nature of that relationship in full in this chapter.

Knowledge

All therapeutic approaches take pride in their knowledge. Much of the wealth of psychodynamic theorising is based on clinical work, cognitive-behavioural therapy is based on an overtly 'scientific' stance and the core conditions of congruence, empathy and unconditional positive regard are revered in the humanistic literature and by humanistic psychotherapists. While having pride in knowledge is not necessarily problematic in itself, difficulties have arisen when the practitioner sees theory as providing an all-encompassing explanation of the client's experience - seeing theory as being reflective of reality. When this occurs, problems may be encountered as certain views are privileged and others are silenced, e.g. when a psychoanalytic therapist works with a young activist in apartheid South Africa, the issues of racism are considered. However, a rigid view of the primacy of intrapsychic structures limits the therapist to using the history of racial exploitation as a metaphor whereby the client was maintaining psychic conflicts (Per, 1992) rather than allowing that there is also an

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external reality needing attention. Alternatively, the cognitive-behavioural therapist may only understand the depressed house bound single mother's difficulties as being attributable to her faulty thinking (Rentoul, 1995) and silence the political factors that maintain her difficulties.

These theories often present the techniques of therapy as having universal application to those clients that are amenable to psychological intervention. The trainee is expected to learn the theory and applications *properly* in order to be equipped to work in the same way with a wide range of clients. The assumption is that the method is suitable across context and experience. This stance also means that attempts to incorporate contextual or political understandings into therapeutic practice are deemed unnecessary or problematic. In fact, psychoanalysis has considered such adaptations as a 'collapse into the sociological' (Ellis, 1997: 370). Another form of rhetoric that is used to disqualify attempts to amend theory and practice is by viewing politically informed practice as moving into the realm of consciousness raising (Strawbridge, 1994) which is often not seen as a valid aspect of therapeutic practice. While it would be useful to further elaborate the ways that these models engage with the political, this is not possible as it is frequently absent from the literature. This may mean that the material is not recognised or is not deemed important to the therapeutic process. However, there are currently a number of critiques of this situation in the psychotherapeutic literature, and these include the psychoanalytic (Ellis, 1997; Heenan, 1998; O'Connor and Ryan, 1993), humanistic (Kearney, 1996; Waterhouse, 1993) and cognitive-behavioural writers (Bond, 1993; Hays, 1995), as well as those from other orientations and disciplines.

Interventions

As outlined above, therapeutic knowledge is related to the socio-political context and so this chapter now turns to the manner in which therapists actually respond to, or work with, political aspects of the therapeutic endeavour. The limited attention that political material has received in the psychotherapy literature has generally been by way of case study publications. While these are important, several difficulties exist. When writing for an academic audience the therapist (of any therapeutic orientation) has to select relevant aspects of the case. This often leads to a partial and biased review. This is obviously different to a 'comprehensive' understanding of the clinical experience and the criticisms possible are limited due to the dearth of information. This gives an inevitably biased view of the clinical intervention.

Psychoanalytic case studies are reported in the literature and where they describe attempts to accept external reality, they also see context as structures and receptacles for psychic drives. The concept of transference is just one example of how practitioners can be limited by theory in relation to political material. In analytic practice, interpretations are sometimes made which substitute the therapist and the client in the place of the story about racial disharmony (Per, 1992; Timimi, 1996) or that more generally use the political narrative as a metaphor for the clients internal world and the therapeutic relationship. By using this strategy and developing interpretations, the 'inner' world is privileged over that of the external world. While this is common, it is not the only possible type of intervention. Another is where practitioners attempt to take a political understanding further and consider the internal and external worlds as equally significant aspects of experience. In some ways the 'inner' and 'outer' worlds can be seen as equally important, both in formulation and in

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interpretation. Where this strategy is taken, material such as the collapse of the USSR, the Gulf War, executions of European politicians can be seen as meaningful in themselves and also as indications of the clients' internal world (Ratigan, 1995).

From a humanistic perspective, much therapeutic practice reflects on the emotional experience of the individual client and the relationship that can be developed between the therapist and the client. By focussing on the 'here and now', the relationship with the therapist is cast as being of central importance. In doing this, the therapist risks maintaining a very narrow and prescribed focus which in turn may effectively result in a denial of the wider context and its influence (McLeod, 1996; Waterhouse, 1993). This is obviously the case for cognitive-behavioural therapies as well, although their central concept would be the thoughts of the client rather than the emotion of the client or the relationship. However, it has been argued that both the humanistic and the cognitive-behavioural therapies are politically neutral, and have been offered to groups generally seen to have limited social power with beneficial results (Bond 1993; Hays, 1995; Kearney, 1996).

Despite this awareness being crucial in the development of politically sensitive therapeutic practices, the awareness of political experience is not particularly developed *per se*, in any of these models, nor in the theories of psychological health, or in the writings about technique. This situation raises the question as to whether this is more than just the political not being privileged, but whether it is a deliberate attempt to continually go beyond the phenomena to a hypothesised intrapsychic/individual reality.

Criticisms

As discussed above, one of the main criticisms of the traditional therapies is that they remain tied to 'essentialist' views of people and human experience. Political discourse is generally absent from, rather than an aspect of, essentialist accounts of therapeutic practice and theories of experience. This may be because when tied to notions of the client and therapist, or the therapist and the theory being independent from each other, it is possible to consider the theory as relatively complete in itself. By seeing the difficulties located within the individual the possibility of seeing political determinants of experience are minimised, often both to the therapist as well as the client. This results in a greater potential for psychological reductionism. It has been argued that at best this may not offer the client a clear, realistic and understandable formulation of their difficulties, it may lead to inappropriate therapeutic interventions or it may lead to a replication of the external political situation (Waterhouse, 1993). Alternatively it has been suggested that at worst it may be seen as *creating* isolation and distress (Kitzinger and Perkins, 1993; Szasz 1961).

When thinking in terms of an essentialist 'self contained individual' (Strawbridge, 1996), practice can be constructed in a manner which is unrelated to the cultural issues that affect clients (and therapists) everyday (Billington et al., 1998; Strawbridge, 1996). This is particularly evident in the humanistic and the cognitive-behavioural literature where efforts to work with clients political concerns are absent (Beck, 1976; Dryden and Rentoul, 1991; Rogers, 1951; Scott et al., 1989; Trower, et al, 1988). Practitioners from a psychodynamic model are writing more extensively about their attempts to engage with political material and the difficulties they experience when trying to incorporate these ideas into clinically relevant practice (Gordon, 1995).

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Contemporary Issues

It is only in the recent history of psychotherapy that attention to relational and contextual factors can be seen as an important focus of theory and practice. This is resonant with recent and current economic, intellectual and political changes. At the turn of the century a much greater and regular focus is evident on context, and the recognition that competing sets of knowledge often are useful, valid and relevant in different circumstances. This view recognises the limitations of dualistic thinking. This is also a time when sweeping political change is experienced as ever present. It is present both nationally and internationally as is evidenced by the regular changes in the management of the health service, the recent change of government, political values, and the changing structure of Europe over the last few decades.

Access to therapy is an issue that is influenced by political initiatives as well as therapeutic theory. In the United States, thought regarding the inequitable access to therapy has been highlighted by political bodies such as the Joint Commission on Mental Illness and Health that was appointed by the US Congress in the mid-1950's (Garfield and Bergin, 1994). The British government commissioned *the Strategic Review of the Psychotherapies in the NHS* (Parry and Richardson, 1996) and a review of the psychotherapy outcome literature (Roth and Fonagy, 1997). These political driven reviews have and will continue to influence the development of psychotherapy services and methods of practice. These examples highlight the overt link between political and psychological practices and how it affects the provision of psychological therapy.

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The impact of the context within which therapy is provided is also important. After the Second World War the demand for psychological therapy could not be met in its original form of individual long-term psychotherapy. In Britain, military psychoanalysts began working with group therapy and the beginnings of therapeutic communities (Burton and Davey, 1996; Millard and Oakley, 1994; Pilgrim, 1996). Relationships between particular professions and contexts continue today. A current factor in the development of short-term approaches to psychotherapy is the growing demand for psychological therapies as well as a recognition of the limited resources available to fund healthcare. Where psychotherapy is provided in state funded settings or managed health care settings, brief therapies become the modal form of therapy (Garfield and Bergin, 1994; see chapter four). The growing demand for integration in the psychotherapy field (Bergin and Garfield, 1994a; Garfield and Bergin, 1994) is also a reaction to the proliferation of theory and the demand for evidenced based practice. As such, it is not purely a scientific phenomenon; it is also political.

Therapeutic Theory

The inclusion of relational and intersubjective factors in theory and practice is one of the clearest examples of how political factors are being attended to in psychotherapy. These strategies include the relationship of individuals with significant others, the developments of family therapy and thoughts on the effects of the wider context that we live in, such as poverty, gender role, sexual and emotional identity, etc. Contemporary theory often takes a constructionist stance to these issues and recognises that human experience is embedded in contexts (Bor et al., 1996; Deurzen-Smith, 1996; McNamee and Gergen, 1992; Spinelli, 1989, 1994). This stance is sometimes taken so far that a systems model eschews an underlying theory of

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development and assessment procedures due to the fact that the person and their experience cannot be separated out from their environment (Bor et al., 1996; Jones, 1998). These views recognise that identities, emotions and behaviours are co-constituted and that the resultant stories are both structured by and become a part of the interaction (Heaton, 1997; Swan, 1998). This view of human experience is also extended to understanding the process of psychotherapy. In this regard the concept of reflexivity is important in order to take one's own impact on the therapy into account. It has been argued that the impact of the therapist will be influenced by their own life history (Annesley and Coyle, 1995; Garfield and Bergin, 1994), personal values (Deurzen-Smith, 1997; Garfield and Bergin, 1994), the impact of training (Samuels, 1993b), the type of questions/interpretations offered (Simon and Whitfield, 1995) and the model subscribed to.

Interventions

One frequently seen change in stance is that attention is given to the manner in which the therapist is able to reject the stance of the expert, at least temporarily. This is done in a variety of ways, for example through:

- Encouraging irreverence towards theory (Cecchin et al., 1992). This is a strategy whereby the therapist uses questions that challenge assumptions and knowledge in order to allow the client to experience a challenge to beliefs about the necessity of specific forms of relationship, family structure, etc.
- The phenomenological method, (Spinelli, 1989). The method requires the therapist to encourage descriptive statements, the withholding of significance and the holding back of theory. These steps aim for a clear description of clients' realities to be developed outside of implicit or formal theories of reality. In doing so, it is

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hoped that the client might experience the multiple meanings that any phenomenon might hold. This method is central to existential psychotherapy and is outlined further in chapter four.

- Reflexive thinking about the impact of the therapist and the intervention upon the story generated (Andersen, 1992; Simon, 1996). Rather than assume that there is a reality that the objective therapist can uncover, the therapist is required to recognise that therapy is a co-constructed experience and that the nature of the intervention can result in specific narratives and stories from the client.
- Understanding the problem as outside of the problem (Bor et al., 1996). By taking a stance such as this, clients may be challenged on the nature of their difficulties, and on the ways in which reality is co-constructed in relationships, families and more contextually.
- Plural interpretations (Samuels, 1993a) The advantage of plural interpretation is that by using the uncertainty of the therapist, not only is the possibility for multiple, or diverse meanings allowed, but the therapist engages in a more democratic interaction with the client. In this regard, a plural interpretation might be seen as a political response in itself.
- Socio-cultural interpretations (Strawbridge, 1994). Interpretations may be offered that highlight factors that are clearly located in the 'external' world, thereby allowing that the experienced is influenced by social and political factors.

The development of these ideas has run in parallel with new and contextually focussed research methodologies such as grounded theory (Pidgeon and Henwood, 1996; Strauss and Corbin, 1990), feminist research (Griffin, 1995) and Discourse Analysis (Dickerson, 1996). Different views on the nature of science have also been considered

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(Burman, 1997; Garfield and Bergin, 1994). The approaches to practice mentioned above recognise that it is important for therapists to be able to consider the personal *and* the political in their therapeutic practices, neither privileging nor underplaying either dimension. Two examples are now given.

Plural Interpretation: When hearing of political material in a client's narrative, it might be possible to highlight the range of things the material refers to, rather than the therapist being the one to privilege the personal or the political dimension. An example from my own practice might be useful to illustrate an attempt at a plural interpretation.

My client, who was living with MS related difficulties, related her distress about government intentions to tighten up on disability benefits. She described how this might either put her at risk of severe financial hardship or at best involve her in a period of difficult and worrying form filling. Her own thoughts had turned to how awful this would be, as she didn't know if physically she had enough energy to go through such a process. After talking of this she reported feeling more depressed than usual. On hearing this, I was aware of a number of factors that might have some relevance. One was her own tendency to focus on the negative meanings that might be associated to experiences, a tendency that was evident throughout her history. Another was that a number of my clients had health-related difficulties and had also mentioned similar concerns. In a situation like this the therapist is faced with a dilemma about which focus is going to be more beneficial. To choose either one was to take a stance as an expert and also to take responsibility.

A different intervention might be plural interpretation. This might be structured along the lines of: "I think this material refers to such and such *and also* such and such, but I am not sure which path we should explore" (Samuels, 1993a: 68). Rather than choose

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for the client I attempted a plural interpretation. I said:

"It seems to me that this is related to both the way in which you find it hard to believe that you will be able to survive difficult exertions, and also the fact that some changes to the benefit system might entail some difficult experiences for people. I'm not sure which focus would be more useful for us to think about".

On this occasion the client decided that while it was true that the changes might be very difficult for her (and others) to bear, but it was also true that a personal response she knew well was operating here and that deserved some attention.

Cultural interpretation: A heterosexual couple in therapy is describing an area of conflict. The woman has decided to return to work and the male partner feels that this is unnecessary. As in all therapeutic work the therapist is faced with a choice of intervention. Should the therapist address this in terms of the insecurity of the husband or the insecurity of the wife? Or might the therapist address this issue in terms of the insecurity of the couple? Alternatively the therapist might enquire about the expectations of marriage that each party grew up with? (Strawbridge, personal communication, August, 1997). The former intervention might lead to consideration of the problem as located 'in' one or the other, whereas the latter may lead to a consideration of the difficulty in terms of both socio-political *and* the couples' experiences. The cultural interpretation is therefore one that is able to include an understanding of the politics of the client's identity and experience and as such is contextual rather than reductionistic (Strawbridge and Woolfe, 1996).

In the strategy outlined above, contemporary approaches to therapy seem to be making a shift away from 'Grand Theory' as an aim in therapy, to the valuing of local

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experience and meaning. Thus, therapists are moving from a position of unassailable expert, to the position of co-constructors of therapeutic processes and meanings. Taking political material as political *and* as individual. There are a number of important factors in this process and these include: the telling of the clients story, the therapist hearing the narrative in a number of possible ways, the recognition that the story is valid, and allowing this story to be reworked or 're-authored'. In this regard identities are rehearsed for interaction with the wider community (Epston et al., 1992; Palmer, 1996; Smail, 1996; Strawbridge, 1994).

Criticisms

Despite these developments and the benefits that can be seen in the contemporary therapies, it is important not to be naïve and assume that by incorporating an awareness of the context into therapy, all the difficulties are overcome. One criticism might be that therapists might fall into the trap of being *too* contextual in that, individual factors may be ignored and every manifestation of distress be put down to socio-political factors. This would also risk creating a dis-empowering experience for clients, disallowing the possibility of an individual making a meaningful change in their life.

In addition, contextual focuses may slip back into politically naïve and unresponsive practices becoming too focussed on an aspect of the context. Systemic therapies have been accused of only seeing the problem as being centred in the family (Parker et al., 1995; Pilgrim, 1997), having too narrow a contextual focus (Bor et al., 1996) and often a western, heterosexist view of the family at that. This means those wider political issues such as sexism and heterosexism can remain unaddressed.

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There are also difficulties in the incorporation of an intervention that addresses relevant aspects of the political dimension. For example, plural interpretations are not unproblematic. Therapists must consider such an interpretation and how the client might experience it. Such an interpretation might be confusing to clients as they do not offer neat and tidy explanations (Samuels, 1993a).

These difficulties are not dismissed in the literature. This particular issue has been addressed with the possibility of either spacing out differing interpretive views or considering whether as clients we can only handle clear-cut messages. Any form of interpretation risks imposing an understanding onto the client. This is always an issue for scrutiny by therapists, as it is inevitable that each person will see, hear, and understand phenomena differently (Kruger, 1979; Moustakas, 1994; Sartre, 1995, Spinelli, 1989; Wilkinson and Campbell, 1997).

Future Directions

As outlined above there is some evidence that both contemporary and traditional therapies are attempting to integrate contextual issues into practice while not losing their therapeutic focus. This is evident both in the work of individuals and also in the work of the professional bodies as a whole in the development of guidelines for professional practice (Division of Counselling Psychology, 1995, 1998). These efforts may be assisted by the availability of epistemological positions that allow for a growing recognition that theory is relative, it is not 'Truth'. A stance such as this allows for the responsibility of practitioners to be flexible, critical and reflective with theory. These factors are leading to a new focus on the integration of therapies (Bergin and Garfield, 1994) as well as the suggestion, that in the hands of reflective practitioners, even

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traditional models of therapy can be applied in a politically sensitive manner (Bond, 1993; Hays, 1995; Kearney, 1996).

The current and future aims of psychotherapy appear to incorporate both personal and political understandings into therapeutic processes (Garfield and Bergin, 1994; Palmer and Varma, 1997). This requires careful consideration of the range of dimensions of experience, tentativeness towards language and the ability to make formulations that address both the personal and the political. Considerations such as these are seen across theoretical orientations and the literature suggests that such reconceptualisations are possible. There seems to be evidence of a move away from a strict allegiance to any one therapeutic theory, moving beyond 'schoolism' (Clarkson, 1997) and towards a 'pluralism' (Samuels, 1997) in an effort to develop more integrative approaches to psychotherapy. It should also be noted that this is a trend in other areas of contemporary Western society. The expert is being challenged in all its guises, whether it be more democratic forms of child rearing, demands for more open and transparent political leadership styles or more egalitarian gender roles. In the United States, studies suggest that some form of integration or eclecticism is preferred by most therapists (Begin and Garfield, 1994) and in a recent survey for the Division of Counselling Psychology an eclectic or an integrative stance was the third most popular identification (Milton, 1998).

Another challenge is whether we can develop well-researched integrative therapeutic interventions that can be open to scrutiny, provide evidence that they are therapeutic and that there is a benefit in their application. This will be important as we try to integrate aspects of experience which are often seen as paradoxical, the rational and the intuitive, the overt and observable with the subjective and the hypothesised. This

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discussion also has implications for the training of therapists and for the environments in which we practice. There is a developing literature on the training of therapists and the difficulties inherent in attending to political issues satisfactorily (Samuels, 1993b; Wheeler and Izzard, 1997) and the need to have more than a purely psychological, clinical focus. This is particularly important, when psychotherapists are usually representative of society's dominant groups and therefore may know very little about the experiences of discrimination at first hand (Ward, 1997). We therefore need to consider very carefully how we relate to those around us. (Parker et al., 1995; Strawbridge, 1994; Timimi, 1996) and to consider how we might go about getting and teaching a sensitivity to this experience.

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CHAPTER 3

EMPIRICAL STUDY

THEORISING LESBIAN AND GAY AFFIRMATIVE PSYCHOTHERAPY: A GROUNDED ANALYSIS

THEORISING LESBIAN AND GAY AFFIRMATIVE PSYCHOTHERAPY: A GROUNDED ANALYSIS

Abstract:

This chapter presents the findings of a qualitative research study exploring lesbian and gay affirmative psychotherapy. The participants comprised two sets of people. The first are lesbian and gay male clients, the second are lesbian, gay male and heterosexual female therapists. These therapists are accredited Clinical and Counselling Psychologists, Registered Psychotherapists and Accredited Counsellors and identify as lesbian and gay affirmative practitioners. The study explored accounts of lesbian and gay affirmative psychotherapy to see in which ways it is qualitatively different from other forms of therapy with a view to theorising the process of lesbian and gay affirmative psychotherapy. In-depth interviews were conducted and a grounded theory methodology was undertaken. This is discussed in terms of method and epistemology. The findings are represented in diagrammatic and text forms and outline process models of lesbian and gay affirmative therapy. While some of the findings have suggested that lesbian and gay affirmative therapeutic practice might be characterised by particular stances or practices, many of the findings can be incorporated into a range of psychotherapeutic perspectives. Knowledge, training and contextual factors are discussed.

Keywords: Psychotherapy; Lesbian and Gay; Grounded Theory.

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THEORISING LESBIAN AND GAY AFFIRMATIVE PSYCHOTHERAPY: A GROUNDED ANALYSIS

1. Introduction

As outlined in the abstract, this chapter details a qualitative research study that explored lesbian and gay affirmative psychotherapy. While greater details of the participants and the methods adopted are provided later in the chapter, it is important to mention that one of the strengths of the study is that it explores the experiences of two sets of people. The first are lesbian and gay male *clients*, the second are lesbian, gay male and heterosexual female *therapists* – all of whom were accredited Clinical and Counselling Psychologists, Registered Psychotherapists and Accredited Counsellors. The therapists also identify as lesbian and gay affirmative practitioners. As well as exploring the accounts of lesbian and gay affirmative psychotherapy, the study aims to identify ways in which it is qualitatively different from other forms of therapy and to generate a coherent theoretical account of the process of lesbian and gay affirmative psychotherapy. The findings are represented in diagrammatic and text forms. Before describing the study itself in any greater detail however, it is important to address the key concepts ‘lesbian’ and ‘gay’, as well as looking at the existing work relevant to this study.

In some ways the terms ‘lesbian’ and ‘gay’ have multiple meanings especially when considered over time and context. This means that the field is an evolving and dynamic one. In some ways these terms are recent terms only having come into regular use in the last three decades. Prior to these, the term ‘homosexual’ was the main noun used to describe those sexually attracted to members of their own sex.

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It has been suggested that homosexuality as a concept (with its current meanings of identity) has only come in to being in the last century (Weeks, 1989) and there is debate about when this term was first used in psychological and psychiatric discourses. Foucault (1978) suggests that homosexuality was first mentioned in an article in 1870. Spencer (1995) notes that the term “homosexuality” was first used in English about twenty years later in the translation of R. von Krafft-Ebing’s *Psychopathia Sexualis*.

This turn in the literature, this production of a noun to describe a person, meant that ‘homosexuality [] was transposed from the practice of sodomy onto a kind of interior androgyny, a hermaphrodism of the soul. The sodomite had been a temporary aberration; the homosexual was now a species’ (Foucault, 1978:43). This meant that the ‘nineteenth century homosexual became a personage, a past, a case history, and a childhood, in addition to being a type of life, a life form, and a morphology, with an indiscreet anatomy and possibly a mysterious physiology’ (Foucault, 1978: 43).

Therefore our current professional literature with its uses of the term ‘homosexual’ and newer terms such as ‘lesbian’ and ‘gay’, has become possible with the discursive developments that have occurred over time.

Currently, like the terms ‘race’, ‘ethnic group’ and ‘culture’ (Atkinson et al., 1989), the terms ‘lesbian’ and ‘gay’ are used to indicate a variety of different things. Different authors use the same term to refer to specific types of people (‘the lesbian’ or ‘the gay man’), particular behaviours (‘gay sex’) and/or personality types (‘gay lifestyle’). This diversity of terminology and meaning alerts us to the fact that different authors hold different views about the nature of sexual identity and this can be confusing for the clinician searching the literature to assist them in their work with lesbian and gay

clients.

2 Characteristics of the Relevant Literature

It has been suggested that the psychological literature has, and still does, tend to look at the world through 'heterosexual eyes' (Denman and de Vries, 1998: Kitzinger and Coyle, 1995; Malley and Tasker, 1999). This process is termed 'heterosexism' and is evident in psychological texts (Kitzinger, 1989, 1993), as well as the media (Clarke, 1999), the political domain (House of Lords, 1999) and in everyday discourses. One impact of this is evident in the professional psychological literature, where researchers exploring the experiences of non-heterosexual people primarily focus their attention on lesbians and gay men with attention to other sexual identities being very limited. Indeed it has been noted that in line with a hetero-patriarchal view 'bisexual orientation has received little serious attention, and often persons with some homosexual erotic imagery or behaviour are combined with the more exclusively homosexual sample. In short the focus is: Why isn't everyone heterosexual?' (Garnets and Kimmel, 1993:109).

As well as omissions the therapeutic literature is characterised by much conflict about same sex sexuality (Wolf, 1997) and the implications for therapeutic practice. Indeed there seems to be a lack of clarity or consensus about the meaning of the term 'Lesbian and Gay Affirmative Psychotherapy'. This has created difficulties for therapists working with lesbians and gay men – especially if their aim is to work in an affirmative manner. While the writing in this area is limited and, of the literature that does exist, Schwartz (1995) has suggested that it has taken three different forms in relation to same sex sexuality and these form a historical progression. The first might be termed

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the pathologising (Schwartz, 1995), the second the liberal (Sullivan, 1995) and thirdly, more recently, the affirmative. These dimensions of the literature will be considered below outlining the characteristics of both the current, and earlier literature.

2.1 Absence of literature

Some of the psychotherapy literature is problematic when thinking about lesbian and gay clients, due to the ignoring of lesbian and gay sexualities. This is evident in a review of both historical and contemporary psychotherapy. Phoenix (1987), when addressing a similar phenomenon in regard to the literature on working with race, called the experience one of ‘normalised absence/pathologised presence’. This has been noted across a number of schools. Even where some schools have virtually no literature attending to same sex sexuality they have still been able to pathologise same sex sexuality. Indeed, it seems that some of the most enthusiastic to take up a ‘correctional’ focus were the behaviourists who perfected techniques of aversion therapy during the 1950s and 1960s. (Weeks, 1989).

The Jungian literature is another example of an approach characterised by an absence of attention to lesbian and gay sexuality, with the term ‘homosexuality’ featuring only seventeen times in the Complete Works of Jung (Hopcke, 1989). This is also the case in many psychoanalytic concepts and theories, for example the Oedipal Complex, where only one outcome (achieved heterosexuality) is deemed to be healthy (O’Connor and Ryan, 1993).

A review of the cognitive-behavioural and humanistic literatures also illustrates this lack of attention, which permeates thought and practice to the current time. This is evident in the appeals of both schools to a ‘universal methodology’. In cognitive

behavioural training, practitioners are expected to learn the methods correctly (Beck, 1976), while in humanistic models, trainees are encouraged to develop the ability to provide the 'core conditions' properly (Rogers, 1951). Without overt consideration of contextual and identity factors, the theory does not draw therapists attention to the specific needs of lesbian and gay clients, nor a correction to therapists own socialised homo-negativity. The universal views are inherent in what has been described as a 'woolly liberal' (Kitzinger and Perkins, 1993) stance taken by many therapists when they state, 'I'm not prejudiced, I treat everybody the same'. By taking this stance difference can be ignored and the distinct experience of the 'Other' may be denied. The literature also includes questions as to whether this stance benefits lesbian and gay clients – an obvious example is the area of sex therapy where the difference may be important but appears to be denied (Cooper and Read, 1998).

2.2 Literature addressing same sex sexuality

While same sex sexuality and sexuality more generally has been explored in a number of related fields (e.g. developmental psychology (Patterson, 1995; Tasker and Golombok, 1995), social psychology (Coyle, 1991; Kitzinger, 1987), and sociology (Weeks, 1989)) the focus in this section is on the psychotherapeutic literature that does exist. This is provided in order that the findings of this study can be considered in relation to the field as a whole. The literature suggests a field in chaos, with many different perspectives – which at times seem contradictory. One feature to note is that much of the available literature is located within a psychoanalytic perspective; this perspective is therefore a substantial part of the introductory considerations.

2.3 Early interest and confusion

When looking back over the development of the psychological literature, Freud (1977) was one of the first therapists, who early in the twentieth century, considered the experience of sexuality and raised it as an issue that requires analysis. In doing this Freud was faced with scorn and derision from the medical establishment (Weeks, 1989). The impact of this is that over time Freud was seen as someone who ‘subverts the category’ of homosexuality (Spencer, 1995:95).

Both homosexuality and psychoanalysis seemed to be controversial and confusing to the established professions early in the century. The literature has looked upon Freud’s contribution to debates about homosexuality in a number of ways, and this led Spencer to argue that Freud’s contribution, while influential, was ‘highly equivocal’ (1995:319). His contribution may have been crucial to the development of a climate where the pathologising of same sex sexuality was possible. The opposite has also been suggested, that by considering human sexuality as polymorphously perverse, Freud problematised sexuality in general (Cohn, 1997). This argument is based in the notion that once sexuality had been problematised different positions would be legitimate to consider and this allows consideration of specific sexualities as problematic, benign or valuable and potentially positive.

2.4 First wave – problematising same sex sexuality

The literature highlights that therapists after Freud did indeed begin to think about sexuality and the first, most prominent waves of thinking developed the notion of same sex sexuality as problematic. Spencer notes that ‘in the 1940s and 1950s American psychoanalysts such as Bieber, Bergler and Socarides mobilised an almost McCarthyite

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zeal in labelling homosexuals as sick, inadequate personalities, and “grievance collectors”” (1995: 321). Same sex sexuality became much more problematised than heterosexuality or other forms of sexuality such as prostitution, masturbation and other forms of non-reproductive sexual behaviour.

An example of how these thoughts and debates are fluid and translate into therapeutic practices is evident in an examination of subsequent editions of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. In line with the thinking in the 1940’s and 1950’s, the first edition of the DSM listed homosexuality among the ‘sociopathic disorders’. ‘By the next revision, DSM-2, issued in 1968, homosexuality was moved to the category of “other non psychotic mental disorders”’ (Miller, 1995:249). This fluidity and change has occurred throughout the DSM’s history. These differing views of the phenomenon mean that approaches to lesbian and gay clients would vary depending on which formulation was accepted. This meant that therapists could become less than clear on appropriate therapeutic interventions with their lesbian and gay clients.

The earliest wave of explicit attention to lesbian and gay sexuality problematised it by understanding same sex desire and practices as examples of perversion or pathology, an example of incomplete development or an indicator of psychological immaturity requiring change (Freud, 1977). The various views of the processes by which homosexuality came to be seen by some as an abomination or an illness needing cure has been explored at length (Miller, 1995; Spencer, 1995; Sullivan, 1995).

When trying to understand these views the literature has suggested that they are not surprising as they lead on from the roots of psychoanalysis in an essentialist bio-reproductive epistemology (Spinelli, 1996, 1997) and its overtly biological focus into

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the 1960s and 1970s (Weeks, 1989). This hypothesis is also supported by the analytic literature that frequently invokes concepts related to 'Natural law' (Sullivan, 1995). An example is 'The male-female design is anatomically determined' (Socarides, 1995a) or Rayner's view that gay male sexuality 'involves the playing of 'male' and 'female' roles in sexual partnerships with the anus standing in for the vagina as often as not' (1986:179).

Another characteristic feature of the early literature is that consistent with essentialist views of the times, lesbian and gay sexual identities were seen as fixed entities. In addition these were frequently conflated with gender (as seen above in Rayner's quote). This is particularly evident in the Jungian literature (Hopcke, 1989; Kulkarni, 1998) where Jung suggests that male homosexuality is an identification with the feminine archetype. Lesbianism can also be considered as a woman's identification with the masculine archetype (Hopcke, 1989).

These characteristics are not only evident in psychodynamic approaches to same sex sexuality. Another author to note writing at a similar time is Medard Boss (1949), who is located within an existential framework. While Boss attempts to recognise the relational possibility inherent in all forms of sexuality, he views heterosexuality as a definite default position, the benchmark for sexual maturity. Thus, as in much traditional psychoanalytic writing, Boss felt that homosexuality was an arrest of development and used the term 'perversion' to describe it.

A natural outcome of seeing same sex sexuality as a perversion is the requirement for the therapist to attempt to change the sexual identity of their lesbian and gay clients and this is evident in the literature (MacIntosh, 1992, 1997). In fact, heterosexuality has become a key indicator of successful psychoanalytic psychotherapy (Klein, 1932)

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with a number of analysts seeing homosexuality as a counter-indication to therapy at all (Malan, 1976) or a counter-indication to psychoanalytic training of lesbian and gay therapists (Ellis, 1994). Weeks (1985) notes that these views spread further than the relatively narrow halls of psychoanalytic institutes as, in the 1950s and 1960s, other disciplines showed a similar understanding in their adoption of practices that focused on the adjustment to social norms. Indeed, 'a modified psychoanalysis became a dominant element in social work during the 1950s, producing various techniques for that adjustment to emotional reality' (Weeks, 1989: 235). A number of stories were available which suggested that therapeutic case work could assist women in 'making astonishing moves towards femininity', ... and men 'overcoming homosexuality, achieving new status in work, and doubling their earning capacities' (Weeks, 1989: 236).

Despite these examples, the literature as a whole suggests that the issue is problematic.

Freud wrote that:

'In actual numbers, the successes achieved by psychoanalytic treatment of ... homosexuality ... is not very striking ... In general, to undertake to convert a fully developed homosexual into a heterosexual isn't much more promising than to do the reverse' (cited in Sullivan, 1998:99).

The more contemporary literature concurs with this view (Isay, 1989; Lewes, 1995).

Thus, attempts to eliminate same sex desire, as well as attempts to foster heterosexual identities, are evident in the literature (particularly the early literature) as well as criticisms of this approach. These efforts are evident in disciplines other than psychotherapy and the literature illustrates this with examples of psychosurgery with gay men (Schmidt and Schorsch, 1981), psychiatric attempts at 'masturbatory shaping'

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(Kellett, 1998) and hypnotherapy on lesbians (Roden, 1983). Aversion therapy with the use of nausea inducing drugs and slides occurred as early as the 1930s for this same purpose (Spencer, 1995). All these practices are attempts to 're-direct' sexuality from same sex partners to partners of the other sex. Thus, for the purposes of this study it is important to note that while this perspective is particularly evident in the early literature, it is *not* just an historical phenomenon - many 'reparative' theorists (Nicolosi, 1991; Socarides, 1978, 1995a, 1995b) still advocate this perspective today. It is also not exclusively a US phenomenon with British analysts contributing to this view (Limentani, 1994; Rayner, 1986; Zachary, 1997). These views are actively propagated by such organisations as the National Association for the Research and Therapy of Homosexuality in the United States (Sullivan, 1998).

Thus, the clinician working with lesbian and gay clients may be influenced by a substantial literature that advises the therapist to reject the sexuality of their lesbian and gay clients. This is not the whole picture however.

2.5 Moving to a liberal acceptance of same sex sexuality

Following on from the initial formulations of same sex sexuality, a more liberal 'acceptance' of homosexuality began to appear. As mentioned above, it is possible to locate Freud's writings in a more liberal perspective than those initially developed. Freud's "Letter to an American Mother" is often used to illustrate a non-pathologising stance to male homosexuality (see Davies, 1996c; Isay, 1989, Spinelli, 1996; Sullivan, 1998). Freud wrote:

'Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness ... Many highly

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respectable individuals of ancient and modern times have been homosexuals, several of the greatest men among them (Plato, Michelangelo, Leonardo da Vinci, etc). It is a great injustice to persecute homosexuality as a crime, and cruelty too' (Freud, 1947: 786-7)

Schwartz notes that this relatively liberal stance is evident in the work of other such psychodynamic authors as Friedman (1988). Schwartz suggests that this understanding is captured in a view that saw same sex sexuality as a disturbance but one that should not be judged 'by the same standards as heterosexuals who benefited from normal gender identity development' (1995: 118). In addition to this, other analysts, such as Meltzer (1998), have deemed homosexuality to be 'pointless' but reject any need to change it.

Other models are similarly characterised. While it is possible to position the existentialist Boss in the previous perspective (as pathologising), Cohn (1997) suggests there is another perspective. Cohn (1997) points out that in using the term perversion, "Boss does not imply dismissal or condemnation, he sees the various sexual 'perversions' as attempts to achieve loving relationships in situations where the capacity to realise them fully is inhibited or crippled" (95). Thus, less overtly pathologising than originally viewed.

Sartre (1981) is one of the few existential authors to use an example of 'the homosexual' and he used it in a more accepting manner. Rather than to theorise about the nature of same sex sexuality, he uses it to illustrate his concept of 'Bad Faith'. His view was that to live as *an* identity (homosexual, heterosexual, waiter, etc) is limiting and removes us from the full experience of ourselves existing in the world – and that

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this is an issue for anyone regardless of which identity it is that is privileged. The existential literature thus addresses a concern about foregrounding ‘sexuality’ over ‘orientation’ (Binswanger, 1963; Foucault, 1978; Sartre, 1981). More recently, du Plock has suggested that the implications of this are that in an existential model;

“A sexual orientation ... becomes ... an orientation, a choice regarding being-in-the-world, just as sexual relationship is a choice regarding how to relate in the world. We pay too little attention to this ‘orientation’ of sexual orientation, falling into the trap ... of foregrounding sex to the detriment of any other analysis of the surrounding culture and the power relations in this culture” (1997:69).

As well as the debates in the psychotherapeutic literature the professional psychological/psychotherapeutic bodies have also contributed to the more recent debates. They have published position papers or research reports on psychological therapy with lesbian and gay clients that stress the need for acceptance of lesbian and gay sexuality and denounce attempts to change sexual identity (American Psychological Association, 1991; Garnets et al., 1991, 1997; Milton, 1998). The debates surrounding this issue led to the American Psychiatric Association formally removing homosexuality per se from its list of diagnostic categories in 1973 (Bayer, 1981). ‘Ego-dystonic homosexuality’ (the experience of one’s homosexuality being at odds with one’s sense of self and creating psychological distress) was subsequently removed (American Psychiatric Association, 1994).

2.6 Addressing the difficulties

As has been illustrated above, the developing views allowed debate in the psychotherapeutic literature on the nature of sexuality as well as on how the therapist might be expected to respond to it. The debate is not complete and difficulties still exist. For example, one contribution by psychoanalysis to the debate has been to engage with its ambivalence towards lesbian and gay sexuality (Flaks, 1993; Gordon, 1995; Roughton, 1993; Sullivan, 1998). While this is an important insight, psychoanalytic insiders argue that psychoanalysis' lack of attention to its counter-transferential response to same sex sexuality limits any possible benefit to clients or to therapists and therefore needs attention (Kwawer, 1980; Lewes, 1995; Ryan, 1998). Some analysts have risen to this challenge and their contributions are located within a more contemporary affirmative stance to understanding lesbian and gay sexuality and accompanying practices. It is to lesbian and gay affirmative psychotherapy literature that we now turn.

2.7 Recent developments - Lesbian and gay affirmative therapy

More recently, there are a number of texts that explicitly attend to the term 'lesbian and gay affirmative psychotherapy'. As this is the literature most relevant to this study it is important to consider it in detail. The literature in this vein has developed in parallel to a proliferation of texts that address other factors such as race (Essandoh, 1996; Palmer and Laungani, 1999) and gender (Seu and Heenan, 1998) in therapy. It is interesting to note that not only do these domains address these issues but they also provide a forum for those who used to be silenced and written *about* to speak themselves. Thus, lesbians and gay men, people of colour and women are finally being

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accepted as providing valid insights to contribute to or critique pre-existing literatures (see Alleyne, 1998; Domenici and Lesser, 1995; Dupont-Joshua, 1998; Ratigan, 1995; Ryan, 1998).

It has been suggested that the roots for this shift extend into the past. Miller credits Evelyn Hooker with being the 'first member of the mental health professions to challenge the notion that homosexuals were 'sick' through clinical research of her own' (1995: 254) which she began with a grant from the National Institute for Mental Health in 1953. Since then, a substantial literature has developed that takes a more thoughtful and critical stance to theories of lesbian and gay sexuality. This literature can be seen to have developed over the last two decades in the US and in the last decade in the UK (Rivers, 1997).

This more critical stance is evident in therapeutic psychology and it is not limited to any particular theoretical position. In depth psychology, there is the work of Domenici and Lesser (1995), Isay (1989), O'Connor and Ryan (1993) and Samuels (1993a). Cohn (1997), du Plock (1997) and Spinelli (1996, 1997) have written on sexual identity from an existential-phenomenological perspective and Davies and Neal (1996) and Hitchings (1994, 1997) from humanistic therapeutic perspectives.

The psychoanalytic literature is again evident, bringing up to date the journey it has taken 'from Freud's sceptical insights in the early part of this century to the magisterial condemnations of homosexual pathology in the 1950s, to the humane defence of homosexual normality in the 1990s' (Sullivan, 1998: 94).

It is important therefore to notice the range of perspectives that make up psychoanalysis. The literature includes a number of authors who criticise previous

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psychoanalytic understandings of lesbian and gay sexuality. Lewes suggests that “the view of homosexuals as necessarily damaged and unhappy people possessed no coherent theoretical or clinical justification” (1995: 95). His writing also includes statements to the effect that “way too many analysts have violated basic norms of decency in their treatment of homosexuals” (Lewes, 1995: 9) a point supported by Isay (1989) and O’Connor and Ryan (1993). Thus psychoanalytic literature can be seen as challenging of itself.

As well as criticisms, the psychoanalytic literature also contains contributions from a number of practitioners who are engaged in attempts to ‘update’ psychoanalytic theory. One characteristic of this literature is that it often attempts to include more contextual focuses. These attempts give rise to both non-pathologising essentialist views (Isay, 1989) and constructionist views (Ellis, 1997). There is also important and useful work in psychoanalytic attempts to reconsider identities more generally and this theme is evident in work on gender identities (Chodorow, 1994) and sexual identities (Herron et al, 1985; McHenry and Johnson, 1993; O’Connor and Ryan, 1993). The literature states that a re-conceptualisation of such basic concepts as the Oedipal complex is required (Isay, 1989; O’Connor and Ryan, 1993).

However, affirmative stances in the practice of psychoanalytic psychotherapy (Herron et al., 1985) seem not to be a straightforward enterprise. When amendments to psychoanalytic technique are attempted, practitioners are sometimes accused of being non-analytic and of ‘collapsing into the sociological’ (Ellis, 1997). This dynamic is reminiscent of reactions to the challenge of feminist theory to models of psychoanalysis which give rise to debates about whether or not the resultant theory remains psychodynamic (Schoenewolf, 1997). It also leads to a consideration of whether it is

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unproblematic to assume you can just delete aspects from or add elements to a theory (Kulkarni, 1998; Lewes, 1995).

Other schools of thought have also been engaged in considering issues relevant to lesbian and gay sexuality with new perspectives being developed in the past decade. In the Jungian world, in the US this is evident in the development of more modern essentialist approaches that value a range of different sexual identities equally (Hopcke, 1989; Hopcke et al., 1993; Kulkarni, 1998). In the UK Jungian theorising appears to take a stance that entertains essentialist and constructionist possibilities and considers the inter-relationship between the individual and culture in reworking traditional theories of identity development (Samuels, 1993a; Schaverien, 1998).

While lesbian and gay affirmative practice is not definitively described in the Jungian literature, a strong argument is made in some parts of the literature that anything less than affirmative practice with lesbian and gay clients amounts to anti-lesbian and gay prejudice. Wirth (1993) has gone so far to say; “heterosexist biases in psychotherapy constitute an abusive soul murder” (205). The pressure is therefore present for Jungian therapists to practise affirmatively. A question remains however, regarding the degree to which these views are influential – especially in light of a limited consensus about what the term ‘affirmative’ means.

The understanding of same sex sexuality is also being addressed in contemporary existential writings. In a recent chapter, Cohn (1997) has criticised Boss for having moved away from the phenomenological position he espoused, to one that is based in a normative and medical framework, rather than an existential understanding based on intersubjectivity. As well as criticising previous views, Cohn (1997) begins to develop

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existential formulation where homosexuality cannot be a 'condition' 'caused' by specific factors, but rather it should be seen as a way of being – with the 'givens' of existence being intimately related to our own choices and actions. This being the case, Cohn also notes that 'phenomenologically, the attempt to find a particular 'cause' to explain an imprecisely defined area on the wide spectrum of sexuality is quite meaningless' (1997:94).

The current debates in the existential psychotherapy literature contend that sexuality and the experience of sexual identity must be understood as constructed phenomena. Identity is not a result of history or biology but rather we hold an identity because of the meaning it holds for us (Spinelli, 1996, 1997). In holding this view the existential approach challenges *both* the homophobe and the affirmative therapist alike. 'To distinguish this particular means of disclosure as inherently different, unique, problematic or perverse has no basis – other than at the level of an interpretive bias that must be challenged rather than condoned' (Spinelli, 1996: 13).

A school of thought with some relationship to existential-phenomenological psychotherapeutic understandings is that of the social constructionist therapies. This paradigm has recently been developed in the psychotherapy literature and is seen to be important in the contemporary thinking about same sex sexuality and therapy. The fact that social constructionist writers have not focused on lesbians and gay men as a particular group is not problematic (as it is in the cognitive behavioural or humanistic therapies) because this absence does not represent a denial of difference. Instead a social constructionist view would be that to construct lesbians and gay men as *an* entity or *a* special group is counter to a process of identity mediated by social factors. The focus on socially mediated identities allows a radical constructionist position to

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view identities as speaking positions within discourses (Burr, 1995). Social constructionist literature therefore argues that experience and identity are never individually developed and defined, but are co-constructed by an individual and their context (Kitzinger, 1987, 1989) – thus allowing for diverse experiences of lesbian or gay identity. This same literature notes that identity development does not result in a fixed identity, and ‘sexual orientation seems especially shifting in terms of identity politics’ (Lather, 1994:104). The social constructionist approaches include an awareness of the need for therapists to work with the specific challenges such a view poses - challenges such as the effects that fluidity, change, uncertainty and social constraints of time and context have on our identities and understandings thereof (Billington et al., 1998; Foucault, 1978; Weeks, 1989).

2.8 Affirmative interventions

As before, we can note that the contemporary attempts to understand lesbian and gay sexuality more accurately are leading to contributions being made as to how therapists might interact with their clients. Within the Jungian literature for example, is the recent notion of ‘plural interpretation’, which has been described as an interpretation that overtly offers the client a double possibility of meaning, and allows for the therapist to acknowledge their own lack of certainty regarding the significance of particular meanings. Plural interpretation attempts to do this by saying “I think this material refers to such and such *and also* such and such, but I am not sure which path we should explore” (Samuels, 1993a: 68). Discussion of plural interpretations did not originate in the domain of lesbian and gay affirmative psychotherapy per se, but rather in a wider re-evaluation of the relationship between psychotherapy and people’s socio-political lives. In relation to sexual identity, it may be that a plural interpretation can

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attend to both a developmental hypothesis and a socio-political one. A plural interpretation has the advantage of acknowledging the reality of different influences on experience, being open to diverse possible meanings and challenging therapists' unwarranted power as experts.

The contemporary existential-phenomenological therapy literature advocates that, to *accept* the client's creation of sexual identity is an important starting point for all therapies as this allows the therapist to help the client determine the meaning of their experience for themselves and this is what is central to therapeutic practice. An existential-phenomenological approach to therapy must challenge any approach that forecloses on possible meanings prematurely, both the homophobic and a simplistic, essentialist view of a lesbian and gay affirmative stance (du Plock, 1997; Spinelli, 1996, 1997).

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The recent social constructionist therapies argue for therapy to move from a study of definite entities to a focus on how identities are formed and influenced (Andersen, 1992; Shotter and Gergen, 1989; Tasker and McCann, 1999). Kvale has described it as a move from an 'archaeology of the psyche to the architecture of cultural landscapes' (1992:1). These approaches acknowledge that by engaging in a conversation with a client, the therapist has accepted an invitation from the client to be in language about the same topic (Anderson and Goolishian, 1988). This is important as when a client chooses to talk about their experience of their sexuality the therapist legitimises both the client's choice to speak and the topic of conversation, thus allowing space for multiple meanings of sexuality to be discussed. Legitimacy is also provided by considering each topic relevant 'if the participants consider it so, with the context of the conversation given an equal value to the content' (Lax, 1994:79).

When working with any client, but particularly with members of oppressed groups, the social constructionist literature reminds us to engage in reflexive practice. This requires therapists to continually look for what is in the words and the behaviour of the client and also in the words and the actions of the therapist or in the context that is bringing forth the particular descriptions from the client (Simon, 1996; Simon and Whitfield, 1995). Particular techniques may be used in social constructionist therapy, techniques such as deconstruction (Parker, 1998; Polkinghorne, 1994) i.e. continual attention to the meanings of the client's assumptions and attention to the meanings available in the specific contexts. It has been noted that when deconstructive techniques are applied to modernist discourses, the discourses can be 'exposed as simply an ungrounded, historically situated conversation' (Polkinghorne, 1994:148). When applied to therapeutic narratives, this can be a useful strategy that may result in the client being

able to challenge their acceptance of an ill-fitting essentialist identity.

2.9 Overall qualities of the lesbian and gay affirmative therapy literature

Overall it is evident that the psychotherapeutic literature is, and has been, characterised by a diverse set of reactions to lesbian and gay sexuality, with many areas remaining unclear and without consensus. At times the literature appears to ignore same sex sexuality (Coyle et al., 1999), while at other times being indifferent to, rejecting or accepting of it.

This lack of consensus is also evident at an epistemological level where a tension between essentialist and constructionist views of identity can be noted. Some writers conceptualise lesbian and gay affirmative therapy as either a distinct way of working, with particular stances that must be taken (Clark, 1987) or where writers might advocate a more flexible approach, a number of particular practices are still advocated (Hitchings 1994, 1997; Isay, 1989; Leitman, 1995). These essentialist, affirmative stances include the therapist having explicit agendas of, for example, raising experiences of oppression to consciousness and deprogramming and undoing conditioning associated with negative stereotypes of lesbians and gay men (Clark, 1987).

An alternative stance is evident in the writings of other contemporary writers, where lesbian and gay affirmative practice is conceptualised as a non-discriminatory, contextually aware attitude that can be incorporated into mainstream psychotherapy theories and practices (Davies and Neal, forthcoming; Ellis, 1997; Shelley, 1998). The challenge this poses to psychotherapy theory and practice is to 'update' our established therapeutic models or develop new theories and practices that attend to the diversity of

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experience of sexual identity (Malley and Tasker, 1999). Where affirmative practice is considered in this way, there are likely to be differences in how easily it can be incorporated into the different theoretical orientations that have existed as can be seen by the nature of the debate and conflict within psychoanalysis.

Within the lesbian and gay affirmative psychotherapy literature as a whole, there is a theme that suggests a range of qualities (rather than specific behaviours) is required for therapy to be considered lesbian and gay affirmative. It is noticeable that many of the qualities discussed are also evident in the literature on working with issues of race and culture (Burman et al., 1998; D'Ardenne and Mahtani, 1989; Eleftheriadou, 1994; Kareem and Littlewood, 1992; Krause, 1998; Moodley and Dhingra, 1998). The fact that these issues are present in these distinct literatures may indicate that the experience of an often-marginalised identity gives rise to particular issues for psychotherapists when working with these client groups.

One quality noted in the lesbian and gay affirmative therapy literature is the therapist's ability to view lesbian and gay sexuality as normal, natural and as healthy as any other sexual orientation (Davies, 1996a; Hitchings, 1994, 1997; Isay, 1989; Young, 1995).

The literature suggests it is important that the therapist be of the opinion that sexuality per se is not the cause of psychological difficulties (American Psychological Association, 1991; Garnets et al., 1991, 1997; Milton 1998). This focus however, does not negate the possibility of attending to the difficulties that people experience in relation to their sexuality, whether they are lesbian, gay, bisexual or heterosexual. Indeed, the literature notes, that when working with lesbians and gay men, it is important for therapists to recognise that difficulties may be related to the problems of managing the development, expression and maintenance of socially devalued

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sexualities with limited support from significant others in a heterosexual social world (Ryan, 1999).

Matching clients and therapists together on the basis of similar sexual identities is another topic upon which there is a lot of debate and various opposing conclusions. Matching is often discussed as a way to facilitate understanding of the experiences of the client, particularly those that highlight the differences between lesbian/gay and heterosexual people (Leitman, 1995; Liddle, 1996; Moon, 1994). It is suggested that attention to these differences may be crucial to the ability to establish a working alliance between the client and therapist. One example is, if the therapist is unfamiliar with gay vocabulary they are likely to be perceived as:

“too straight’ by a gay client to be of any help. Like other minority groups, lesbians and gay men rely on culture specific language to express their experience. It is likely to be preferable to have a therapist who can ‘grasp these emotions without further translation into Standard English’ (Atkinson et al., 1989:20).

Leitman (1995) has discussed this point and questions the degree to which heterosexual therapists can understand the lesbian or gay client.

As with ethnic matching (D’Ardenne and Mahtani, 1989; Moodley and Dhingra, 1998; Tomlinson-Clarke and Cheatham, 1993), the lesbian and gay affirmative therapy literature recognises that matching is not a singular and simple issue. Rather, it recognises that more is needed to facilitate ethical and effective therapy with lesbian and gay clients than membership of a particular group (Davies and Neal, 1996; Liddle, 1996; Milton, 1998). In fact where a client/therapist dyad embodies a number of

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dimensions of identity, the literature raises questions as to which dimensions would need to be matched. For example what if a black gay man accorded greater salience to his black identity than to his gay identity (Deverell and Prout, 1995; Lawson, 1997)? Again it is clear that at this point in time the literature is not clear on how to assess the degree of impact the sexual or racial identity of the therapist will have on a their ability to provide lesbian and gay affirmative psychotherapy.

It has been argued, in the mainstream psychotherapy literature, that the ability on the part of the therapist to empathise with the experience of the client is important as it is a way of increasing the therapist's understanding of the client. This is different to having had the exact same experience or being of the same group. This ability to empathise is thought important whether it is in general terms (Beutler et al., 1986), in terms of ethnicity (Dupont-Joshua, 1998), in relation to gender (Hart, 1981) or sexual identity (Leitman, 1995; Moon, 1994). While this is important it may be difficult (Garnets et al., 1991, 1997). In relation to culture it has been noted that 'non-minority counsellor trainees are more likely to be influenced by stereotypes than are minority counsellor trainees' (Atkinson et al., 1989:15). If this is the case with sexual identity, we must ensure that heterosexual therapists in particular are able to accurately empathise with the experiences of lesbian and gay clients, including the experience of desire for someone of the same sex (Odets, 1995).

These considerations are related to a theme in the literature of the need for the therapist to be open about, and comfortable with, their own sexual identity (Garnets et al, 1991, 1997; Hayes and Gelso, 1993; Liddle, 1996; McWhirter and Mattison, 1985). This parallels the importance that is placed on the therapist's level of comfort with their ethnic identity when engaged in cross-cultural work (Atkinson et al., 1989;

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American Psychological Association, 1981; Palmer and Laungani, 1999). In the lesbian and gay affirmative psychotherapy literature, there are also suggestions that the therapist should be knowledgeable about lesbian and gay sexualities (Isay, 1989; Liddle, 1996; McWhirter and Mattison, 1985; Milton and Coyle, 1998; Ratigan, 1995; Rochlin, 1985) and about the stresses associated with being lesbian and gay in discriminatory contexts (Annesley and Coyle, 1998; Coyle, 1993a; DiPlacido, 1998; Greene, 1994; McCann and Fessinger, 1996; Rotheram-Borus et al., 1994).

In parallel with the literature on feminist and cross-cultural therapy, the lesbian and gay affirmative psychotherapy literature also considers the importance of therapists thinking more widely than just the individual and the therapeutic process. Consideration should be given to the social and political contexts within which sexuality is allowed or disallowed (Denman and de Vries, 1998; Greene, 1994; Malley and Tasker, 1999; Milton, 1994; Ratigan, 1995; Tasker and McCann, 1999; Walters and Simoni, 1993). A contextual focus is thought important as it assists therapists in being able to assess whether problems are primarily related to personal dynamics or anti-lesbian and gay prejudice (Annesley and Coyle, 1995; Gonsiorek, 1985; Young, 1995). For example, will therapists conceptualise a client's experience of depression in terms of their favourite therapeutic formulation, e.g. psychoanalytic views of childhood trauma or existential theorising about the impact of death anxiety? Or will they be able to consider it as a manifestation of the social silencing of a lesbian and gay identity? Such questions may have parallels with the experience of minoritized racial identities. This differentiation is important in clinical formulation, treatment planning and the selection of a focus in therapy (Tasker and McCann, 1999).

2.10 Relevance of the literature to this study

As this review of the literature has shown, the psychotherapy literature remains unclear on many issues associated with working therapeutically with lesbians and gay men. The opinions vary from pathologising and disparaging to affirmative with an array of positions in between. There is also a literature that ignores the experiences of lesbians and gay men. Thus, while the term ‘lesbian and gay affirmative psychotherapy’ (or variants thereof) abound in the literature, a lack of consensus leaves important questions unanswered, e.g. Is lesbian and gay affirmative psychotherapy a model or a set of principles? How do existing models relate to the notion of being lesbian and gay affirmative? How does the term assist clinicians in thinking about the different problems that clients will present with? What role does the sexual identity of the therapist play?

There are many other questions that the literature does not address adequately and maybe cannot be answered yet. While a number of definitions may be used, a clear consensus as to what lesbian and gay affirmative therapy is remains lacking. The development of such a view will assist further research into the wider field. It is at this point that we must turn to the research itself.

3 Summary and Aims of the Study

Due to the lack of a clear consensus as to the nature of lesbian and gay affirmative psychotherapy literature, this study is necessary and may strengthen the field in a number of ways. Firstly, the literature relating to affirmative psychotherapy with lesbian and gay clients is frequently opinion-based and has yet to be theorised by way of research. This study addresses this gap by using a grounded theory method and attempting to generate theory - a coherent account of lesbian and gay affirmative

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therapy based in the accounts of those who have experienced it. Secondly, as illustrated in the previous section, the client's view of psychotherapy is often absent from the existing literature and this is also addressed in this study. Thirdly, the study may serve as a way to develop a framework detailing the nature of and the processes in lesbian and gay affirmative therapy and how these processes are related to good practice in general. These outcomes may also result in useful guidelines for those working in the field of lesbian and gay affirmative psychotherapy and it may open up areas for further research. Important questions for future research might include the role of the presenting problem in affirmative approaches to therapy, the role of the therapist's personal qualities (age, race, gender, sexual identity, etc) and comparative studies of lesbian and gay affirmative psychotherapy and its relationship to established models of therapy.

4. Methodology**4.1 Epistemological issues**

Two important contemporary views of knowledge are, firstly, an “‘experimental’, ‘hypothetico-deductive’ or ‘positivist’” stance and, secondly, a “‘naturalistic’, ‘contextual’ or ‘interpretive’” (Henwood and Pidgeon, 1992:98) stance. These are also often termed ‘essentialist’ and ‘constructionist’ stances. Briefly, an essentialist stance assumes that essential, true entities exist and it is ‘the task of objective scientific methods to *discover* those truths in an effort to justify prior theory’ (Henwood and Pidgeon, 1992:98). A constructionist stance assumes that there is very little that is a true, unchanging entity and that our perception and ability to invoke meaning is crucial to understanding experience, reality and identity.

In addition to these, a ‘critical realist’ (Pilgrim and Rogers, 1997) position is worthy of consideration as such a position acknowledges the material reality of objects in the world, but attends to the fact that our perception and experiences of these phenomena cannot be objective experiences. Objects are always experienced through individually and socially mediated processes (Pilgrim and Rogers, 1997). This position recognises that the accounts provided by the participants are mediated by their own and the researcher’s interpretations. However they have some relation to the actuality of the events they describe. By taking this stance, the research is ‘phenomenologically inspired research’ (Kruger, 1979:155) and is ‘concerned with the individual’s particular account of reality, rather than an objective reality itself’ (Smith, 1995:122).

As qualitative methodologies often tackle personal and social issues, the data used are frequently accounts provided by those involved in the phenomenon. This engagement

with the experience of the participants might be seen to have a political dimension (Burman, 1997). Thus the content and the method are sometimes seen as political. However, the degree to which the qualitative research process is political is no greater than with any form of psychological research. One difference is that the interpretive aspect is recognised in many qualitative methodologies (including the one used in this study) and made as transparent as possible. Qualitative methodologies also allow for attention to be paid to aspects of the political that are not easily translated into numeric, quantitative symbols. Indeed, “politically committed research is part of a long tradition in critical social psychology, from the studies of male unemployment on a community in the 1930s ... to research on fascist ideology and the National Front in the 1970s” (Griffin, 1995: 120).

Qualitative research methods have sometimes been seen as precursors to ‘proper’ quantitative research. This impression remains amongst the critics of qualitative research and is evident in assertions that qualitative research (especially in its constructionist forms) are not scientific (Dickins, 1999) and might better be housed in academic arts departments than in psychology departments (Morgan, 1998). However, the more recent prevalence of useful research in a range of psychological science projects has highlighted its legitimacy by providing insight into a range of psychological tasks and processes. Studies have been undertaken that explore a number of therapeutically relevant phenomena, e.g. staff perspectives at work (Clegg et al., 1996), counsellors’ construal of success (Frontman and Kunkel, 1994), reflectivity of supervisors (Neufeldt et al., 1996), clients’ experiences of therapy (Rennie, 1992) and events in supervision that are perceived as ‘good’ (Worthern and McNeill, 1996).

4.2 Speaking position

The speaking position of the researcher and the adoption of qualitative methodologies have been focuses of concern regarding their possible threat to 'objectivity' (Morgan, 1998). Where the researcher is an insider to the research sample (as in this study), particular accusations of bias and blindness to the issues/data have been made and this has led to evaluations of qualitative projects that are unfair (Ussher, 1996). This is unfair as bias and blindness are not particular to qualitative research - all research needs to be mindful of the effect of the researcher's own views (Salmon, 1996).

In addition to the concerns noted, there may also be advantages when research is undertaken in an area to which the researcher is committed. The commitment adds to an empathic appreciation of the complexities in the field by capitalising on the knowledge that the 'insider' may have, e.g. language, shared meanings and access to participants. On a more pragmatic basis, as the work is meaningful, motivation for the project may be more easily maintained throughout any difficult periods of the research process.

Precedents exist where the distinction between the researcher and the 'Other' has been dissolved and has led to a rigorous and insightful research enterprise. In fact, the dissolving of the artificial distinction between researcher and researched has enhanced the legitimacy of the study (Bewley 1993; Burman, 1994; Davies et al., 1993). It is therefore important to consider my own position in relation to this study, in more detail than has been outlined in the introduction to this thesis.

Professionally, I completed a survey of British psychologists on their work with lesbians and gay men in psychotherapy (Milton, 1998; Milton and Coyle, 1998). I have

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considered models of coming out and their usefulness for therapeutic practice (Milton, 1996), and have considered my own practice in this area (Milton, 1997). I have also been involved in the establishment of a British Psychological Society Lesbian and Gay Psychology Section (Kitzinger et al., 1998). These have all influenced my awareness of some of the issues and literature related to lesbian and gay psychology. This study has also been influenced by the fact that I have experience of working with lesbians and gay men in therapy, both in the past and currently. This is outlined in chapter four of this thesis and I have also contributed two case studies to the professional literature (Milton, 1996, 1997). There are also personal factors that bear on this research. As an 'Out' gay man, i.e. someone who identifies both privately and publicly as gay, I have an interest in seeing this field develop ethically and effectively.

As well as declaring one's position/s, it is important to consider how these might possibly influence the research questions, information gathered and interpretations made of the data. For example, as an out gay man, I have access to the social discourses of many lesbians and gay men in London. This may have assisted in the recruitment of participants and my 'insider' status may have been a conduit through which trust was seen as legitimate to give. My own position and experiences, as therapist, researcher and gay man in London will all influence the interpretations I am able to bring to the data.

The researcher's own position may also limit the research process. In some respects I am close to both sets of participants - being a gay man in therapy and being a practitioner who aims to be lesbian and gay affirmative - I risk making assumptions about my practice/experience and the relevance that this has to the experiences of the participants. In order to minimise this risk, I have ensured that the research was

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overseen at all stages by supervisors who had investments in the study. These investments both overlapped with my own in some respects (which rendered them appropriate as supervisors), yet differed in other respects, which allowed them to identify unacknowledged assumptions or ‘blind spots’.

5. Method

5.1 Participants

The state of the literature created a dilemma for this research in that the study needed to focus predominantly on the experiences of lesbians and gay men in order to relate the eventual findings to the available psychological literature. However, in doing so it appeared to replicate the silencing of bisexualities and other sexual identities. An alternative strategy would have been to include bisexuals in the study. However, this would have led to assumptions about the bisexual experience being the same as that of lesbian and gay clients unless I extended the scope of the study. As this was not feasible it was decided not to include the experience of bisexual clients, as the experiences of bisexual people should not be expected to mimic lesbian and gay experiences (Guidry, 1999). Indeed it is thought that bisexuality is ‘different from either homosexuality or heterosexuality in subtle ways’ (Garnets and Kimmel, 1993:112).

As it was important to gain access to detailed accounts of lesbian and gay affirmative therapy from both clients and therapists it was important to undertake interviews with two sets of respondents. Therefore there needed to be two sets of eligibility criteria for this research:

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1. Participants who were to provide the 'client's account' met the following criteria:
be a self-defined lesbian or gay man who had experienced psychotherapy for at least three months. Psychotherapy was defined as individual or group meetings with an appropriately qualified therapist. This was defined as being registered with the United Kingdom Council for Psychotherapy (UKCP), accredited by the British Association for Counselling (BAC) or chartered by the British Psychological Society (BPS) Divisions of Clinical Psychology (DCP) and/or Counselling Psychology (DCoP). Therapy was to have focused on the client and their difficulties. The client did not have to have experienced therapy with a therapist who termed himself or herself a lesbian and gay affirmative practitioner; the client was to be the one who determined that their experience had been affirmative. Psychotherapy was also negatively defined, i.e. not being akin to overt guidance, medical consultation or educational tutelage. During this experience the clients needed to have felt that matters related to their sexuality were attended to in a sensitive and productive manner. It was important to limit the participants to those that had been in therapy for a particular period to ensure that the clients were each talking about psychotherapy rather than any of the activities mentioned above. By using three months as a minimum period the research was able to focus on psychotherapy as practised either in its longer term or briefer modalities.
2. Participants who were to provide the 'therapist' accounts met the following criteria: Therapists needed to be accredited by at least one of the professional bodies, i.e. BAC, the BPS DCP and/or DCoP and the UKCP. Therapists needed to work from a position they felt was lesbian and gay affirmative. This position was not defined in any greater detail for at least two reasons. Firstly, as this area is

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poorly researched, there is no consensus as to a clear definition of what is lesbian and gay affirmative. Secondly, if I had imposed a meaning, I would have been pre-empting the findings of the research rather than exploring the meanings of those who have experienced a phenomenon they felt was lesbian and gay affirmative.

Having professional accreditation as a criterion meant that I could expect the participants to be knowledgeable about psychotherapy and also it meant that I would be confident that the participants had access to information about professional settings and practices.

In order that the research be feasible, both sets of participants needed to live or work in close proximity to London or Guildford – this made the interviewing possible. Where people were eligible, and keen to participate from afar (n=4), I was able to amend the interview schedule and send it to participants for written completion (see appendix A). This is a strategy that has been used successfully in other qualitative research that relied primarily upon interviews but needed to include geographically diverse participants (Rafalin, 1998). The self-completed form of the interview schedule collected demographic data and responses to a revamped set of open-ended questions in a questionnaire format based on the original open-ended questions from the interview schedule.

Calls for participants were placed where qualified psychological and psychotherapeutic practitioners would see them, as would clients who had experienced lesbian or gay affirmative psychotherapy. Client notices were placed in such services as psychology outpatient departments, student counselling services and therapeutic agency newsletters. Participants also heard about the study through word of mouth. Work and

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professional colleagues were informed of the study and asked to draw people's attention to the notices. It was through this route that Natalie (a colleague of a colleague) and Tania (partner of a colleague) made themselves available to the study. To recruit therapists, notices were placed in psychotherapy training institutes as well as in professional journals of the UKCP, BPS, BPS DCP and DCoP and the BAC.

The notices briefly outlined the project and invited people to make contact at the University of Surrey (see appendices B and C). This strategy was decided upon for several reasons. As long as this approach worked, it allowed for participants to select themselves into the project rather than being selected due to any bias on the part of research needs. However, one limitation that was initially overlooked however was that a substantial time delay arose as many of the professional journals are published infrequently - one notice was published almost a year after it had been sent. Difficulties were also experienced with attempts to place notices in training institutes with one psychoanalytic institute returning the notice to me saying that they could not possibly place it on their notice board.

In line with grounded theory the original aim was to supplement the initial sample through theoretical sampling – a procedure that aims to sample new cases as the research progresses. The new cases are ones that may offer new perspectives on the research topic in order to develop conceptually rich, dense and grounded accounts (Pidgeon, 1996), particularly those that have 'disconfirming potential' (Henwood and Pidgeon, 1992: 107).

Unfortunately, it was not possible to undertake theoretical sampling due to the limited time available. The further sampling could have been done through new notices or

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through snowballing procedures. However, it did prove feasible to supplement the sample with four self-completion questionnaires from areas outside of London and Guildford. This allowed the geographical and ethnic dimensions of the sample to be widened.

If time had allowed, snowballing may have been practical as in the initial sampling the therapist Sacha passed on information about the study to a number of places and this resulted in the client Ewen getting in touch with me. A similar process occurred whereby the client Kyle put me in touch with his therapist Jon, and a lesbian therapist Niamh was able to put me in contact with a gay male therapist Ross. This was not an active recruitment strategy at the time, but rather an attempt to increase the number of places where the original call for participants could be viewed.

Once contact was made with the potential participant, a brief conversation occurred outlining the research and its rationale. This also enabled an idea to be developed as to whether the experience that the participant was describing would be relevant to this study, i.e. whether the participant would meet the recruitment criteria. This was important as some people, in an effort to be helpful, did make contact to offer their experiences of what they felt were *not* affirmative therapies, but were in fact pathologising therapies. Once it had been clarified that the experience would be useful for the project, appointments were made to interview the participants. Demographic data were collected during the interviews, as was each participant's consent. This was formally obtained on a proforma that was signed before the interview got under way (See appendices D and E).

5.2 Ethics, power and potential harm to participants

Ethical issues are present in any form of research as it is “difficult to conduct any investigation which does not involve a degree of power differential between the researcher and the researched” (Griffin, 1995: 119). Consent and discretion were therefore very important. While this is of course true of all research, it is particularly important for the recruitment of those who may experience themselves as socially marginalised or vulnerable (Lee, 1993). The City University Department of Psychology granted ethical approval after the submission of an Ethical Approval protocol (See appendix F). The research was exempt from further University ethics procedures as the research was deemed to have minimal risk attached to it and the potential for benefit.

The issue of consent was also addressed by informing interviewees of their right to turn the tape recorder off or terminate the interview should they feel the need to at any point throughout the interview. Confidentiality was assisted by using a number of respondents rather than a small sample of identifiable participants, by drawing on the whole pool of experience rather than telling the account of one particular client or therapist and by taking a number of steps to keep transcripts separate from identifying details. Anonymity in the report is assisted by the fact that participants are not identified but pseudonyms are used with an indication of the participant’s speaking position as ‘client’ or ‘therapist’. Participants were allocated names from a list developed prior to the interview. None of these names coincide with names of any of those who actually participated, and places of work have been anonymised as well. Therefore, terms such as ‘Hospital’, ‘Mental Health Services’, or ‘Counselling Service’ are used instead of their formal title.

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In addition to the fact that the research was deemed to have minimal risk attached to it, a range of benefits may emerge from the research for clients, trainees, practitioners and trainers. There may also have been therapeutic and other benefits associated with the interview experience (Coyle and Wright, 1996) such as an opportunity to retell a positive story. This was assessed in the short term by asking the participants to comment on the experience of taking part in the research.

5.3 Grounded theory procedures

A frequently used qualitative approach in the social sciences, grounded theory was chosen as the method for this study as it would allow the research to explore the nature of lesbian and gay affirmative psychotherapy rather than relying on a priori assumptions of the phenomenon.

Grounded theory was first described in the sociology literature (Glaser and Strauss, 1967) and the term is used to refer to both theory that is clearly grounded in research data (Pidgeon et al., 1991) and also to particular procedures that have been developed to generate these theories (Glaser and Strauss, 1967; Henwood and Pidgeon, 1992; O'Callaghan, 1996; Pidgeon et al., 1991; Strauss and Corbin, 1994).

In epistemological terms, grounded theory approaches can vary between traditional realist (Strauss and Corbin, 1994) to constructivist (Henwood, 1996) and critical realist. Grounded theory is able to address a gap that is often identified between academic research and clinical practice. This gap can result in academic ignorance about the reality of clinical practice; research phobic clinicians; and the possible development of literature that is difficult to apply (Clemental-Jones and Malan, 1988; McLeod, 1994; Roth and Fonagy, 1997). Grounded theory offers strategies with which

to engage in this relationship, which is important for psychologists as scientist-practitioners and for all therapists working in the current ethos of evidence-based practice in the US and UK (Parry and Richardson, 1996).

There is an emphasis in grounded theory on theory development (Strauss and Corbin, 1994) or theory generation (Pidgeon and Henwood, 1992) with the aim being to produce theory that is conceptually dense and robust. The processes that characterise the flow of research are outlined in Figure 1 below. The figure highlights the fact that data collection, data storage and coding are not linear steps in a research study but rather aspects of the process that influence each other and may occur at various times throughout the research.

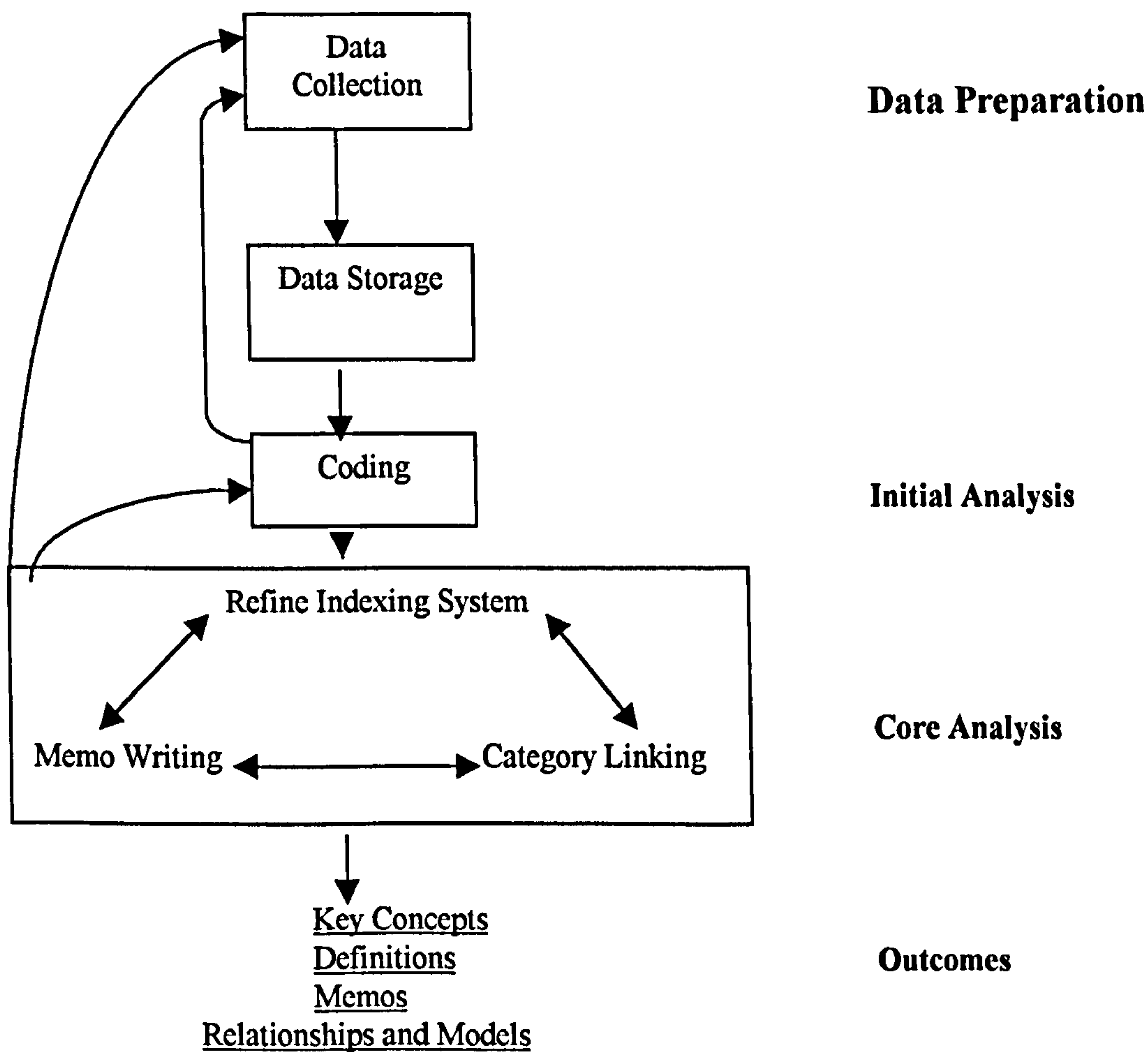


Fig 1: Steps in Grounded Theory Analysis (Pidgeon and Henwood, 1996: 88)

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Figure 1 also highlights how the process can occur again and again, as new data is required after an exploration of that obtained previously and must be subject to the analytic procedures.

In order to keep both the research process and the theory grounded in the data, rather than being overly drawn from other theorising, the method is one that requires the researcher to simultaneously collect data and undertake analysis. There is a great deal of interaction between the researcher and the participants; the research process and the phenomenon under investigation; and the researcher and the data.

Due to its focus on theory generation, the researcher must aim to be sensitive to theoretical possibilities. Theoretical sensitivity may be related to the degree to which the researcher can recognise what is important in the data and provide meaning to it, while ensuring that the meanings attributed are warranted by the data. Strauss and Corbin (1990) outlined areas that have an impact on theoretical sensitivity. They suggest that these include the literature, professional experience, personal experience and the research process itself.

While the literature review is often delayed when undertaking grounded theory, it is important to be aware of how the data relate to established theory (Glaser and Strauss, 1967). While this may be difficult for the researcher, it is important in order to ensure that a limit is put on the degree to which pre-existing formal theory structures the research process. In this study specific difficulties were noted. One difficulty was the awareness I already had of the limitations of the therapeutic literature in general and psychoanalysis in particular - in relation to lesbian and gay clients. Thus, when interviewing participants and in analysing the data I attempted to develop an openness

to alternative interpretations of the data in order to allow the participants' own views to be articulated, views which might identify the strengths of these models as well as their shortcomings. In line with Glaser and Strauss (1967) and Pidgeon et al (1991) the researcher alone undertook coding. Regular consultations with a supervisor and discussions with other doctoral students and professional colleagues were useful in becoming aware of the possible impact of pre-existing information on the current research process.

Grounded theory is characterised by a process of 'constant comparison'. This requires the researcher to constantly immerse themselves in the data. This activity sensitises the researcher to similarities and differences in the data, and to competing meanings and alternative interpretations available in the narratives.

5.4 Pilot study

In this study the interview schedules were considered and developed in the summer of 1997; and they were put to the test by way of a pilot study. Pilot studies are important aspects of the research process as they may ensure that questionnaires, interview schedules or research instruments are proven effective in obtaining the material necessary for a rigorous and useful study. A study with poor data collection procedures might render the study useless or irrelevant.

The pilot study consisted of face to face interviews with six people who had answered the recruitment drive, identifying themselves either as lesbian and gay affirmative therapists (n=3), or clients who felt that their sexuality had been attended to in a sensitive and beneficial manner in therapy (n=3).

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The process of interviewing these clients and therapists was undertaken during June, July and August 1997. On meeting the participant I would reiterate the purpose of the interview, the nature of confidentiality procedures and obtain signed consent (appendix D). I would set up the recording equipment while the participants completed the demographic questionnaire (appendix A). The pilot study allowed me to become familiar with the two interview schedules (one for interviews with clients and one for interviews with therapists) (appendix G). The pilot study also allowed me to get feedback from those interviewed about the schedules and therefore increase the sensitivity I could bring to the interviewing process and the data.

These interviews were all carried out in the participants' homes or places of work; the convenience to the participant determined where the interview was to be undertaken and the interviews lasted between 70 minutes and almost two hours. The interviews were recorded and transcribed verbatim. Transcription was a lengthy process with one interview taking almost 12 hours to transcribe due to a lack of appropriate transcribing equipment in the early phase of the research.

While the content of the initial interview schedule appeared useful, the structure had minor flaws. These included the fact that the schedule was visually too condensed and this led to me losing my place frequently during the interview. I also found that several of the questions appeared to come at an odd time in the interview sequence. The printed structure had been organised in such a way that there was no space in which to write and this limited the effectiveness of the interview structure somewhat. It was important to have space in which to note down aspects of the participant's responses as some of the later questions required consideration of earlier answers. There was also some repetition of questions. The interview schedule was changed in light of this

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experience. This meant that the visual structure and the ordering of some of the questions were changed and blank spaces were included on the interview schedule.

Interviewees had very little to say on the structure of the interview generally, although there were two exceptions. One 'client' identified the fact that the interview structure was very important as he had felt that it had helped him to focus. One of the therapists interviewed noted that for those who could 'talk all day', the questions were quite general at first. As the methodology that I was planning to employ valued people's own accounts of their experience I did not see this as problematic, especially as the general questions were followed up with more specific questions aimed at clarifying the meanings of people's answers.

5.5 Interviewing

The other 26 participants were interviewed in the period between September 1997 and March 1998 throughout the Greater London area and Surrey. As with the pilot study, on meeting the participant I would reiterate the purpose of the interview, the nature of confidentiality procedures and obtain signed consent from the participants (appendix D). The recording equipment was set up while the participants completed the demographic questionnaire (appendix A). The interview schedules used in the main study are included in appendix H. These interviews were mainly carried out in the participants' homes or places of work. However, two participants found my own places of work, and two others found my home, to be more convenient locations. As with the pilot study, the convenience of the location to the participant determined where the interview was undertaken. The interviews generally lasted over an hour, but none lasted more than 90 minutes. The interviews were recorded and transcribed

verbatim. By this time the speed of transcription had increased due to the availability of transcribing machines and the increased speed of my own typing.

As the amended interview schedules did not differ from the initial pilot interviews in any substantial manner regarding content, the data are not analysed here. Instead the data from these have been analysed with the interviews that followed.

5.6 Analytic procedures

5.6.1 Transcription of the interviews.

After the interviews had been undertaken, they were transcribed. While this is a long and time-consuming process, it allowed a familiarity with the participants' accounts of lesbian and gay affirmative psychotherapy to be gained.

Figure 2 is an extract from a transcript. In the transcriptions, lines were numbered, pauses were indicated (but not the times thereof) and any material that might identify the participant (e.g. name, place of work, etc) was changed to pseudonyms ready for the task of coding.

160 M What do, ... So you know what approach she uses, what does that mean to you when you are in
161 there? I mean I know that you've used that term to describe to me what's going on, but when you're
162 in there how do you know she's a psychosynthesis therapist?
163 A: she never Bloody says what she feels like, ... Well, she's always reflecting back, .. or she used
164 to all the time, you know, if I said something about her, this is most probably not the answer you're
165 looking for, but if I said something about what I thought about her she would just turn it right
166 around, like always, like a machine, you know. I'd complain in the end, you know, that I felt I was
167 being 'techniqued'. And then I'd say something and she's say, well what, you know, why do you
168 think you feel that, You know or something like that and there was to some extent ... an element of
169 formula about some of the things she did [XXX XXX XXX] I felt,
170 M: And you feel that that goes along with that approach?

Fig 2: Example of a transcript (Adam, Client1, p 6, Lines 160-170)

The emboldened script represents the researcher; the rest of the text in figure 2 is the speech of the participant. Where the conversation was not clear on the tape, this is indicated this by a series of capital Xs in square brackets.

5.6.2 Coding of interviews.

Once the entire interview had been transcribed, the transcript was re-read several times in order to code the data. Coding occurred line by line in an effort to note aspects of the data that were of interest to the nature of lesbian and gay affirmative therapy and was assisted by asking the question:

“What categories, concepts or labels do I need in order to account for what is of importance to me in this paragraph?” (Pidgeon and Henwood, 1996: 92).

During this process consideration was given to what was of importance in each line or paragraph and these concepts were given a label. These labels are sometimes called ‘Meaning Units’ and encapsulate the central meaning of the concept¹. These labels took the form of words or phrases that summarised my interpretation of what was important in that particular section. The initial stages of the coding process generated labels of immediate interest, regardless of eventual relationship to other labels or the comprehensiveness of the overall labelling. The coding allowed a range of concepts to be identified and these covered a diverse range of topics, issues and processes.

It was during this process that it was very important to be open to theoretical possibilities (Strauss and Corbin, 1990).

5.6.3 Initial documentation of labels

As mentioned above, the coding led to the identification of a number of concepts and these were labelled and documented on 5-inch by 8-inch file cards (one concept per card) in an attempt to capture the essential quality of meaning. Extracts from the data

were used to illustrate the concepts.

These concepts act as a first step towards characterising the larger phenomenon (Pidgeon et al., 1991) being studied. At this point it was also possible to make a note of preliminary interpretations and possible relationships between the concepts identified. The documentation of labels and illustrations is not a purely ‘objective’ task, but involves an interpretation of the data and an attribution of meaning on the part of the researcher. An example of a concept card is given in figure 3 (Card 61(2)). On the card the letter ‘C’ indicates the voice of a client of lesbian and gay affirmative therapy. The number equates to the line of the transcript. Here the concept identified and the label used is that of ‘Withholding Information’. This process took a lot of time and the research resulted in 440 concept cards for use in the analysis.

Card number		Label	Brief note of phenomenon
Pseudonym	61 (2)	Withholding Information.	
	C15:22	He didn't tell me anything about the silence, the technique, he didn't tell me	
	Tim	that it was only 50 minutes instead of 60, we never discussed payment.	
Interview	C9:16	There were certain things I didn't want my counsellor to know,	
	Sam		
	C1:163	She never bloody says what she feels like	
	Adam	Location in the transcript	

Fig 3: Example of a concept card.

5.6.4 *Grouping of concepts:*

As the process progressed, it became obvious that the different labels often related to others in specific ways. A period of time was therefore required in order to explore the possible relationships between the concepts and to group the related concepts together.

¹ The literature uses different terms to refer to the same idea. Therefore the specific meanings of ‘labels’, ‘concepts’ etc for this study are explained in the text.

In line with Glaser and Strauss (1967) and Pidgeon et al. (1991) the researcher alone undertook the grouping. The grouping together would indicate a relationship between (at least) two different concepts and represented a more abstract or more complex concept called a category. Grouping was also useful, as there were times when two different sets of labels were found to address the same phenomenon. This process of grouping occurred throughout the study and is the result of constant comparison. After several cycles of thinking and grouping, some of these labels came to be regarded as ‘fully saturated’ concepts. A concept was deemed fully saturated when participants’ accounts could add nothing further to the meaning already captured. The aim was thus ‘not to record on a particular card all of the instances of the recurrence of the idea or event in question’ (Pidgeon et al., 1991: 162) but to focus on the *range of meanings* inherent in the account and the theme.

5.6.5 Further recording of examples:

Pidgeon et al. suggest that ‘for the indexing to be of any use, the coded concepts must be checked against further data and related to each other’ (1991: 164). Therefore, the comparative process was followed repeatedly to confirm the relationship between the concepts and the establishment of categories. Visual methods were also used (flow diagrams and the beginnings of process models) to relate the concepts and categories together. It should be noted that phenomenological research does not *require* the development of process models but rather a rich descriptive account of a phenomenon (Kruger, 1979). However, grounded theory is a method that assists the researcher in attending to dynamic and fluid aspects of the participants’ accounts and arriving at a coherent theory. This was evident in the data and therefore allowed the research to attend to lesbian and gay affirmative psychotherapy as a fluid phenomenon.

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Relationships between concepts and categories were sometimes identified on the basis of the way in which the original labels related to each other. Some similar concepts and categories would refer to different views of the same phenomenon (e.g. the therapist and the client discussed different experiences of therapist disclosure). Alternatively, relationships were noted when participants had described an action and its aim. Implications of expressed causality and association would also identify relationship between concepts.

At times, this comparative process meant that concepts would come to be seen as better conceptualised separately, rather than categorised together. For example, this occurred when illustrations from a later transcript were added to a vague theme from one of the initial transcripts. The greater detail highlighted that while the original theme may have been related to the later illustration, it was not identical in meaning. It was in cases like this that a label and its illustrations could be split into two separate and new concepts. By developing deep understandings of concepts and the relationships between them, the researcher is able to identify gaps in the analysis. This might occur when the researcher realises that different participants have seen the same theme in different lights or have suggested that particular aspects of the phenomena being studied have specific qualities and/or processes.

Primitive conceptualisations (or early attempts to capture the meaning of certain labels) were elaborated and related to other conceptualisations in an effort to develop clearer and more meaningful theoretical categories and definitions of what might become a grounded theory of lesbian and gay affirmative psychotherapy. Thus, an illustration might initially reflect a vague theme that can be used as a label for a concept. After further data confirms (or challenges) the relationship between the label and the

phenomenon it is possible to check whether initial interpretations were warranted. Where they are warranted, categories that have relevance to the theory can be developed with a clearer definition. Definitions can then be developed and written as memos regarding the important aspects of the phenomena under study and this can facilitate theorising. Definitions were written as a way to “make the analysis more explicit by summarising why all the entries have been included under the same label” (Pidgeon and Henwood, 1996: 97). Thus, constant comparison of cards, labels and the original text assists in keeping the process grounded in the data.

5.6.6 Memo-writing:

Figure 4 is an example of a memo written during this study. Memos are useful, as they are a way to record tentative hypotheses or definitions. These memos focus on the possible meaning of labels and categories and relationships between them, as well as highlighting notes of potential links to existing theories, concepts or other relevant literature.

My own views and understandings of what I was witnessing in the data, explicit relationships mentioned in the data and the accompanying reading informed the memos. The memos also allowed consideration of aspects of the research process and the effects of these on the data obtained or on my interpretations. These memos allowed for initial thoughts to be captured, elaborated and considered at length both during the data analysis stage and also at the points when attempts were made to develop a coherent account of the relationships between the various concepts and categories, i.e. at the point of theory generation. The memos also allowed for the developing theory to be included in the process of constant comparison.

Memo Re: Knowledge of Issues

There are links between the themes 15) Knowledge of Issues, 22) Non pathologising, 39) Therapists' qualities and a whole range of other themes. The participants don't seem to be talking just about factual knowledge, but maybe it's about by taking a different stance to the same phenomena we can be accepting and provide therapeutic conditions. What are the therapists' qualities? Acceptance has been mentioned, as has flexibility in discerning the meaning of a phenomenon. i.e. openness to diversity. I wonder if it's not the knowledge per se, but that knowledge, or the stance to knowledge may be the conduit through which knowledge informs the process. I wonder if it's the stance to knowledge that allows the value/meaning of an issue/phenomenon to be known. So maybe, Knowledge of issues is actually about not-knowing for a bit.

Fig 4: An example of a memo.

5.6.7 Models and diagrams:

Models and diagrams were developed with a view to describing and exploring possible relationships in a clear and visual manner. The diagrams were influenced by a number of factors that could include explicit reference to these relationships in the data, or they could be more tentative exploratory hypotheses, based on the comparison between labels and the ever-growing field of data.

5.6.8 The adoption of a reflective stance

In the context of this study a reflective stance attends to the experiences of the researcher and the way in which experiences, thoughts and pre-existing beliefs may have impacted on any aspect of the research process. A reflective stance throughout the research process helps the researcher consider these possibilities thoroughly and particularly when the report was being written. Reflectivity was helped by the use of a journal (Cooper and Stevenson, 1998; Henwood and Pidgeon, 1992), supervisory discussions and constant attention to the actual data offered by participants and the use of quotations in the report. See appendix I for an example from the journal.

Supervisory discussions were particularly helpful. One of my supervisors drew my attention to the fact that one of my examples did not warrant the explanation I had

given it. I had written that a point of view expressed by a 'client' suggested something about a link between therapeutic model and the therapist. The supervisor highlighted that the example read in such a way that the opposite came across. This discrepancy allowed a return to the transcript to clarify the meaning in the data and express the meaning more clearly.

5.7 Issues for evaluation

The version of grounded theory used in this study recognises the inevitable role of subjectivity in any analysis, with the outcome being a result of an interaction between participants' accounts and the researcher's interpretive framework (Henwood and Pidgeon, 1992). The qualitative approaches to science have made efforts to attend to these issues while trying to develop rigorous and systematic approaches to knowledge generation (Elliot et al., 1999). The declaration of the researcher's own speaking position is one way of being accountable because it acknowledges the specific subjectivity affecting the research and allows consideration to be given to the impact this might have on the analysis. Alternative criteria for evaluating research are also necessary. As yet, qualitative researchers have not reached consensus on criteria for assessing scientific rigour (Burman, 1997; Elliot et al., 1999), although the following criteria each go some way towards addressing these difficulties:

5.7.1 Internal coherence and persuasiveness (Potter and Wetherell, 1987; Smith 1996).

Those who read the report (but who are not part of the research process) are in a position to assess internal coherence and persuasiveness. The assessment of internal coherence is possible when readers can read the study with a critical eye, asking

whether or not the study ‘hangs together’ (Stiles, 1993). This was evaluated by having a number of readers look at drafts of the report. These included complete outsiders (e.g. non-psychologist friends), supervisors and participants. Feedback from people at conferences where these results were presented, (i.e. the Society for Existential Analysis, Institute of Family Therapy, British Association of Marital and Sex Therapy) was also useful in highlighting areas that were unclear or limited the persuasiveness of the argument. This allowed further consideration to be given to various aspects of the analysis and presentation in order to improve how well the study hangs together.

The assessment of persuasiveness will be made by considering the degree to which the report offers a warranted and understandable explanation of the phenomenon and whether rival interpretations are addressed (Stiles, 1993). This is made possible by presenting illustrations of the themes in the form of quotations from the data. As outlined above, supervision also allowed for another critical eye to scrutinise the work and question the thinking and conclusions.

5.7.2 ‘Trustworthiness’ and accountability in relation to participants’ experiences.

Stiles (1993) suggests that reliability in research refers to the trustworthiness of observation/data and validity refers to the trustworthiness of interpretations/conclusions. ‘Closeness of fit’ is thus important between the initial descriptions of phenomena and the degree to which the ‘final products of analysis should faithfully reflect the social reality of those who have been observed’ (Pidgeon et al., 1991: 356). McLeod suggests that ‘trustworthiness consists of four components: credibility, transferability, dependability and confirmability’ (1994: 97).

In this study, trustworthiness and accountability are addressed by interpretations being backed up by reference to quotations from the participants. This is extended by rendering the analytic process as transparent as possible and thereby allowing readers to assess the trustworthiness of interpretations, i.e. whether the results keep close to the data and whether the theory that emerges can be integrated at diverse levels of abstraction. This means that the findings of this study should be considered for the degree to which they are useful at the level of individual therapists or clients, but also at a macro level of applicability where similar contexts and samples apply.

5.7.3 Validity

In much research validity is taken to mean that ‘the measure measures what it is supposed to measure’ (Barker et al., 1995: 66). However, when the research is not attempting to measure a phenomenon it is still important to assess whether the interpretations are valid (Woods, 1998) and if there is evidence for the conclusions drawn. Interpretations therefore need to be internally consistent, useful, robust, generalisable or fruitful (Stiles, 1993).

Validation can be undertaken by others and through an examination of internal coherence. External validation could be undertaken by way of someone who had not participated in the study or the participants. Validation with either of these groups is not without difficulty. I was aware that validation by an ‘objective’ outsider might mean that they and I came to an agreement about the interpretations while still being wrong about the participants’ experience. There is a difference of power between the researcher and the researched and it is difficult to ascertain if the participants agree with the findings or acquiesce to the interpretations put forward (Coyle, 1996). Thus it was important to attempt both types of validation.

External validation was carried out using friends and supervisors as described above. Respondent validation was undertaken in this study by providing information of findings to participants and asking for feedback. I did not receive a lot of feedback on this study. Out of the 32 participants, only two offered feedback (one therapist and one client). Many did not respond and a couple appear to have moved away and not left a forwarding address. The concerns raised by one of the participants were not directed at the study but rather at how the conclusions might be acted upon and these views have been considered in the overview. The feedback from the other participant addressed several issues that are also addressed in the overview as well as the literature review. This highlights the difficulties inherent in respondent validation.

5.7.4 Reliability

Reliability is another concept used to assess scientific rigour and, in much research, reliability ‘refers to the degree of reproducibility of the measurement’ (Barker et al., 1995:61). Qualitative methods recognise that replicability must acknowledge the role of subjectivity and attempt to work with it in an open and transparent manner. Thus, in qualitative research, reliability refers to the degree to which, when research is replicated with *similar* participants in *similar* contexts, the findings would be *similar* (Lincoln and Guba, 1985). Woods described this as ‘procedural trustworthiness’ (1998:28). Thus, when outlining the method used, care has been taken to include aspects of the researcher’s subjectivity so that this can be considered should others replicate this study. This would allow hypotheses to be developed about any different findings that might occur.

5.7.5 Generalisation

Generalisation is another important yet problematic concept for research and is

particularly noted in the concerns regarding the gap between formal academic research and its applicability in the clinic (Roth and Fonagy, 1997). While recognising that objective generalisation is not possible, it is important that this gap be considered. Therefore, the findings of this study are not meant to be applied to all participants in lesbian and gay affirmative psychotherapy, or even all participants in this type of therapy in the London and Surrey areas - a more realistic aim would be to evaluate the degree to which the findings are transferable to similar populations or contexts from where they were first developed. Thus where all the constituent factors of the theory are present, then one might expect the processes to be transferable although not identical to other situations/participants. Indeed to expect isomorphism between different sets of participants and different theoretical and professional frameworks is questionable.

5.8 Reporting the results

It is not standard practice within grounded theory to 'count' instances of a particular phenomenon (Barrington, 1998) as there are no pre-defined criteria for determining the extent to which themes must recur before they are deemed to be of sufficient significance to merit citation (Krueger, 1994). As advocated by Krueger (1994) adjectival quantitative phrases are used instead. Findings are therefore presented in terms of impressions or as hypotheses rather than as indisputable 'fact'.

In quotations, square brackets indicate the omission of material and three dots indicate a short pause. Pseudonyms indicate the sources of quotations and participants are identified either as 'client' or 'therapist'. Material added for clarification appears within square brackets. In the diagrams, arrows indicate direction of movement and lines indicate association. By direction of movement I am referring to where the data

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suggests causal or intentional aspects of the process. Thus where, for example, an emotion is felt by the client towards the actions of the therapist, the arrow will point to the client from the therapist (to indicate the impact of the action on the client). Where associations are discussed (lines with no directional indicator), they are based on participants' views that the factors being considered are related in some fashion. Unbroken lines indicate that the data link the factors in a clear manner while dotted lines indicate weaker relationships or a lack of certainty regarding the nature of the relationship.

6. Analysis of Demographic Data

The demographic data are given before interpretations of the data and discussions of the findings are presented. These interpretations and discussions are presented alongside the model and themes in one analysis section as this allows for the meanings and data to be discussed in a related manner, rather than forcing an artificial split between them. An explanation of a number of models (at both a micro level (figures 5-12) and a macro level model (figure 13)) function to elaborate different components of an overall theory of lesbian and gay affirmative psychotherapy. The grounded theory consists of several different elements – conceptual categories and their properties and then “hypotheses or generalised relations among the categories and their properties” (Glaser and Strauss, 1967; 35). The micro-models aim to illustrate categories and the processes that occur in specific aspects of lesbian and gay affirmative psychotherapy. The macro-model is more abstract and aims to predict and explain a wider range of processes, including relationships between the smaller models.

6.1 Demographic Information

Eighteen (56.3%) participants discussed experiences as clients and 14 (43.8%) discussed experiences as therapists. Data that characterise the sample are presented in this section. This data is presented in the form of tables and/or descriptive text.

Some of the important factors to recognise are highlighted in table form. Table 1 outlines the gender and sexual identity of the participants.

Sexual identity	Female clients	Male clients	Female therapist	Male therapist	Total
Lesbian/gay	4 (12.5%)	14 (43.8%)	2 (6.3%)	9 (28.1%)	29 (90.6%)
Heterosexual	0	0	3 (9.4%)	0	3 (9.4%)
Total	4 (12.5%)	14 (43.8%)	5 (15.7%)	9 (28.1%)	32 (100%)

Table 1: Gender and sexual identity of participants.

Of special interest to a study of lesbian and gay affirmative psychotherapy is the sexual identity of the participants. In this study over 90% of the participants identified as lesbian or gay.

Ethnicity	Male Therapist	Female Therapist	Male Client	Female Client
Indian	0	0	1 (5.5%)	0
Irish	1 (3.1%)	0	0	0
Slav-Polish	0	0	0	1 (5.5%)
White	8 (25%)	4 (12.5%)	13 (72.2%)	3 (16.7%)
White Jewish	0	1 (7.1%)	0	0
Total		14 (100%)		18 (100%)

Table 2: Ethnicity of participants (Self defined).

Table 2 illustrates that while sample represents diverse ethnic identities, the majority of the sample identified as ‘white’.

6.1.1 Age

The mean age was 37 years for clients and 43 years for therapists (Range = Clients 24–58 years, SD =8.6. Therapists 28– 64 years; SD = 11.9).

Table 3 outlines the educational level of the sample, the majority of whom have postgraduate education.

Education	Clients	Therapists
Up to O Levels	4 (22.2%)	0
Degree	4 (22.2%)	1 (7.1%)
Postgraduate degree	9 (50%)	13 (92.9%)

Table 3: Participants’ highest educational qualifications.

Table 4 highlights that the majority who provided client accounts could be classified as professional in terms of their occupational status.

Code # *	Title	# and % of Male clients	# and % of female clients
0/1	Professional, technical and related workers	11 (61.1)	4 (22.2)
2	Administrative and Managerial workers	1 (5.6)	0
3	Clerical and related workers	1 (5.6)	0
4	Sales workers	0	0
5	Service workers	1 (5.6)	0

Table 4: Clients’ occupations. (*International Labour Office, 1990)

Table 5 addresses the range of therapeutic professionals who provided data. The

therapists were accredited across the full range of therapeutic organisations in the UK currently, except the British Confederation of Psychotherapists (BCP). This conservative, psychoanalytic body is not represented and this may be due to several factors. One, being the conservative stance taken to homosexuality by prominent members of this organisation. A second may have been related to the fact that as I am not a member of the BCP I was not au fait with the networks in this organisation and thus may not have targeted the more influential people effectively.

Accrediting Bodies	Number/Percentage
British Association for Counselling	1 (5.9)
British Psychological Society: Division of Clinical Psychology	3 (17.7)
British Psychological Society: Division of Counselling Psychology	3 (17.7)
United Kingdom Council for Psychotherapy	6 (35.3)
Other	4 (23.5)

Table 5: Professional accreditation of ‘therapist’ participants.

Much of the literature suggests training is a central issue in helping therapists develop their competence with lesbian and gay clients. It was therefore important to get a diversity of training experiences within the sample. Several therapists were accredited by more than one professional body and therefore in this section n=17.

6.1.2 Length of accreditation.

The mean length of time since accreditation was 3.1 years. (Range = 6 months to 8 years, SD = 2.1). These figures may make it appear as if the respondents were not particularly experienced. However, this interpretation would be misleading as three of the accrediting bodies (BAC, UKCP and the BPS DCoP) have only developed accreditation procedures in the last five years.

Table 6 illustrates the range of theories that participants experienced as clients or drew upon in their work as therapists. The range is diverse and the largest number of clients (21.8%) reported experiencing a humanistic orientation and the largest percentage of therapists (15.2%) identified an integrative model as being informative.

Theoretical orientation	Therapist	Client
Cognitive-Behavioural	1 (2.2%)	3 (6.5%)
Existential-Phenomenological	1 (2.2%)	2 (4.4%)
Gestalt	1 (2.2%)	2 (2.2%)
Humanistic	3 (6.6%)	10 (21.8%)
Integrative	7 (15.2%)	1 (2.2%)
Jungian	0	1 (2.2%)
Neuro-Linguistic Programming	1 (2.2%)	0
Psychoanalytic	2 (4.4%)	4 (8.7%)
Psychosynthesis	1 (2.2%)	2 (4.4%)
Systemic	2 (4.4%)	0
Transactional Analysis	0	1 (2.2%)
Don't Know	0	1 (2.2%)

Table 6: Theoretical orientation of therapist/Theoretical orientation experienced by client.

As these categories are not mutually exclusive, several therapists and clients reported

experience with several models. Therefore in this section $n = 46$.

6.1.3 Settings.

Therapist participants were experienced in a range of settings that currently included: community mental health teams, drug rehabilitation projects, primary care (GP surgery), hospital bases, private practice, student counselling services and the voluntary sectors.

The majority of clients reported experiencing lesbian and gay affirmative psychotherapy in private practice settings ($n = 17$; 94.4%).

6.1.4 Other roles undertaken.

The therapists reported undertaking a range of tasks in addition to their therapeutic role. These included: consultancy, management, research, supervision and teaching.

6.1.5 Organisational status.

The therapist participants represented a range of experience and classified themselves across the spectrum of junior ($n = 1$) and senior ($n = 2$) therapist, assistant director ($n = 1$) and head of service ($n = 2$). A number also worked in a private capacity ($n = 5$).

6.1.6 Presenting problems.

Clients reported entering therapy with a wide range of problems. The problems mentioned are those that are characteristically presented to a range of therapeutic settings. Problems identified included: alcohol and sexual addiction, anxiety, panic and depression, bereavement, coming out and sexuality related issues, family and relationship problems, isolation and a general malaise. One person also suggested that

the commencement of their own therapeutic training was the factor that brought them into therapy.

Table 7 highlights the number of therapists who have experienced personal therapy themselves as this was identified as having been an important experience whereby skill in providing lesbian and gay affirmative therapy was developed. The therapists who did and did not have experience of therapy themselves was in line with training requirements for the different professional bodies.

Types of therapists	# and % of therapists with personal experience of therapy	# and % of therapists who have not experienced personal therapy
British Association for Counselling	1 (7.1)	0
BPS Division of Clinical Psychology	0	3 (21.4)
BPS Division of Counselling Psychology	3 (21.4)	0
United Kingdom Council for Psychotherapy	6 (42.8)	0
Other	4 (28.6)	0

Table 7: Therapists experience of personal therapy

At this point the findings of the study are introduced in both diagram and text. The grounded theorist has a choice over whether to present the findings as a “well codified set of propositions or in a running theoretical discussion using conceptual categories and their properties” (Glaser and Strauss, 1967: 31). In this case it is more useful to present the categories and properties in a running theoretical discussion as this “puts a high emphasis on *theory as process*; that is, theory as an ever-developing entity” (Glaser and Strauss, 1967: 32; italics in original). Thus, a number of individual processes are outlined and it is important that the reader refer to the diagrammatic

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representation alongside the written explanations. These processes are components of a larger theory and model and the results section ends by tying the study together in an overall model that theorises the nature of lesbian and gay affirmative psychotherapy.

7 Analysis of Interview Data

7.1 Processes

While an attempt is made to focus primarily on processes that are exclusive to lesbian and gay affirmative therapy, at times some aspects of generic good practice were invoked as crucial aspects of lesbian and gay affirmative therapy. Where this has occurred they are described in the analysis.

7.2 Choosing a therapist

In this study, both clients and therapists acknowledged that entering psychotherapy requires the client to make a number of choices and a number of examples were provided.

Personal reflections on being in therapy and being a clinician highlights some obvious choices that clients initially have to face – these include naming the difficulty as something amenable to psychotherapeutic help and decisions regarding the particular therapeutic agency to approach.

Sometimes participants felt that a choice of therapeutic orientation was important to clients, as were other factors such as the sexual identity of the therapist. In light of these choices, participants said that it would be very important that clients were provided with a choice as to whom they would see for psychotherapy. This is the starting point for figure 5 and is supported by participants when they noted the

importance of the therapist or therapeutic service respecting the client’s rationale for choosing a therapist.

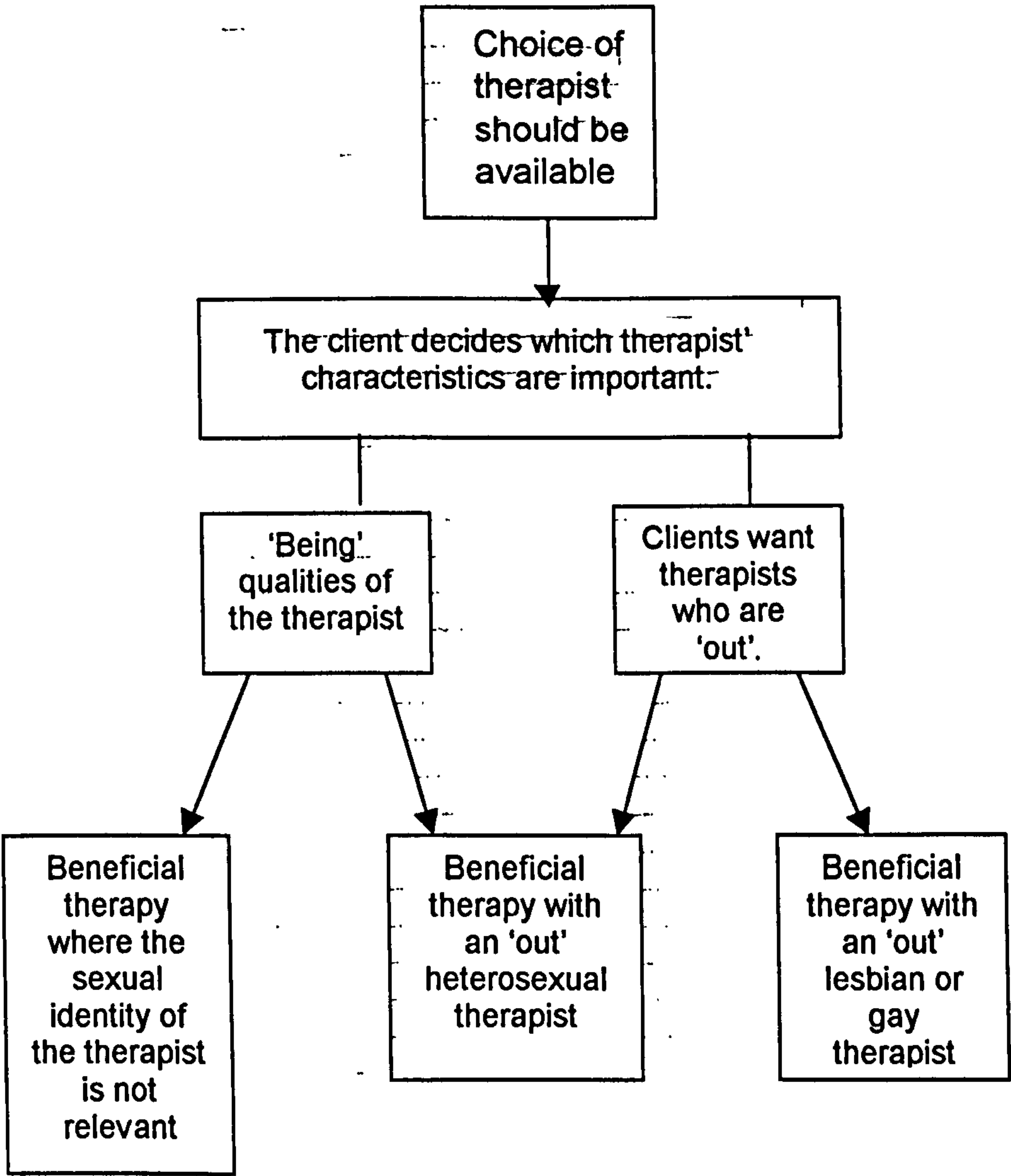


Fig 5: Processes involved in choosing a therapist.

Chris (client) said “if [clients] feel that what’s important to them is to work with somebody gay then that’s important”. Jennifer (therapist) said that clients “should always have the choice [...] so they could choose to see a gay or lesbian therapist if they wanted to, that should be an option for them”.

Participants supported the argument for the client’s choice of therapist by suggesting that when a choice is possible a sense of control is promoted in the client. This was

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seen as useful. Nadia (client) said *“It’s important to have the choice, and for [clients] to be in control”*. Choice and control appear to be linked to a sense of safety in the therapy and the ability to choose a therapist will allow the client a way of eliminating perceived (and real) gaps between themselves and the therapist.

Some clients did not elaborate on the choices they made, other than to say, for example: *“I am very selective”* (Curt). Sam, however, described a strategy he had used when seeking a therapist. Regarding the gender of the therapist, he said, *“I made an appointment with a male therapist and an appointment with a female therapist, thought I’d try them both, see how I feel, see which I like”*.

Such choices can sometimes be experienced as difficult. Ewen remembered *“speaking to my partner about it and saying ‘Which one shall I choose? How do you know which person to choose?’”* This is of particular relevance as clients often come to therapy at a point where they are vulnerable or unsure of themselves in a number of ways.

This experience of facing choices gives rise to the fact that different clients will experience different aspects of the therapist as important. This can be seen in figure 5, where the participants described specific dimensions as relevant to the choice of therapist. They suggested that individual clients could experience particular therapist characteristics as potentially positive or potentially negative.

The qualities that received a lot of attention from participants can be grouped into two areas and these are represented in figure 5 as the ‘Being qualities of the therapist’ and the statement that ‘Clients want therapists who are out’.

To focus on the ‘Being qualities’ of the therapist first, this was quite a broad concept that could include such factors as gender and theoretical model. A range of other

attributes could also be important to individual clients. Chris chose his therapist as *“[he] is very into the voice and how trauma affects the voice [] because I am [] training to be an opera singer”*. Thus a meaningful choice was made on the basis of a shared interest.

Other participants suggested that *“personal attributes and qualities are more important than [the] sexual orientation of the therapist”* (Ullie, client). Speaking as a heterosexual woman, Sacha (therapist) noted that:

“the lesbian and gay clients that I see come to me because they don’t mind, it’s not relevant to them, they just want to feel that they can work effectively with the person, and the sexual orientation isn’t an issue, because we get that out of the way at the beginning, it’s on the table and we discuss it”.

Figure 5 also represents another area of concern voiced by participants when considering their choice of a therapist. Participants suggested that it was important that clients should have a therapist who is out, i.e. open about their sexuality.

Participants reported that while some clients might seek a lesbian or gay therapist, other clients might inadvertently engage with a lesbian or gay therapist through being ‘allocated’ a therapist. This is particularly relevant to Health Service departments as opposed to private practice settings. Regardless of this, participants felt that the therapist must be able to be open about their sexual identity. Zoe (client) illustrates this point when she said:

“I certainly think if the therapist is gay or lesbian they had better be reasonably obvious about it, I mean not necessarily like having a rainbow flag flying, but I certainly think they wouldn’t have any business being closeted at all. I think that

would be dreadful, because that's immediately saying it's not right".

Participants provided examples where clients actively sought a therapist with a particular sexual identity, as when Hannah (therapist) said *"for the people I see privately [] they wanted a lesbian therapist"*. Hannah went on to elaborate on this.

She said:

"I don't know why, but [lesbian clients] said [] that for them they feel it is important, especially in the drug rehab, I think it is quite important because nobody else is lesbian, and so for lesbian, gay and bisexual people coming into the project there is some kind of connection".

Thus, as figure 5 illustrates, the therapist's sexual orientation and the other qualities of the therapist may have specific meanings for individual clients. For different clients, the implication is that lesbian and gay affirmative therapy can be provided as long as clients are able to feel that they can choose with whom to engage for psychotherapy. As figure 5 demonstrates, the implication is that lesbian and gay affirmative therapists may identify as lesbian, gay or bisexual or as heterosexual as long as they are at ease with their own sexuality and able to engage with the client around the issues they bring. It is also important for therapists to be able to relate to clients on a range of other issues and therefore view sexuality as just one aspect of the therapeutic relationship.

As the matching of the client and therapist with regard to sexual identity was discussed at length by participants we will turn to the particular processes thought to relate to specific sexual identities.

7.3 The role of the therapist's sexual identity

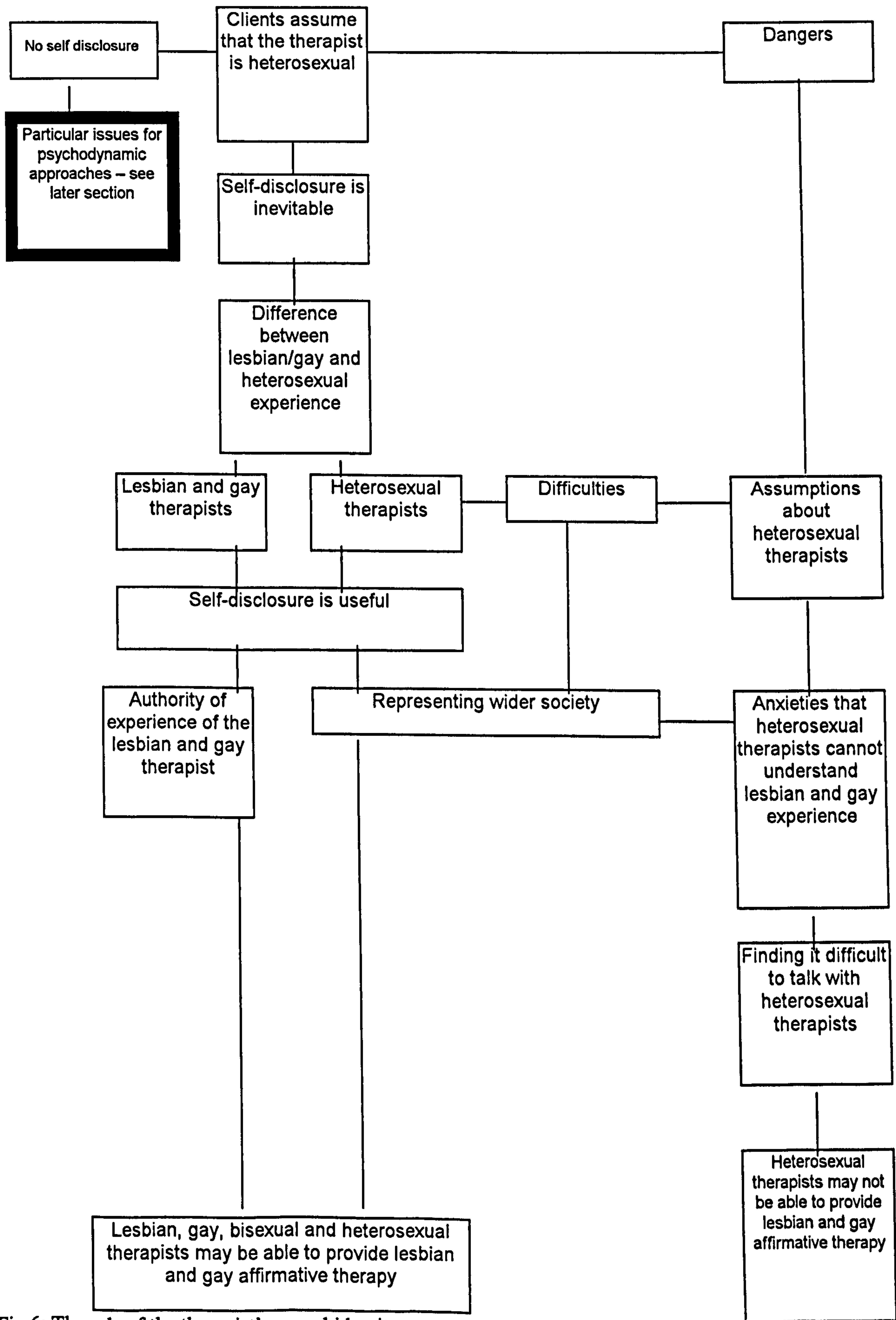


Fig 6: The role of the therapist's sexual identity.

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As suggested in the previous section, participants viewed the sexual identity of the therapist as potentially playing a number of roles in the processes that clients experience when entering therapy. This is also the case when therapy is under way. In holding this view, the participants supported much of the current writing on the different meanings of sexual identity (Spinelli, 1996, 1997), the significance that sexual identity might have for a client (Alleyne, 1998) and issues of matching therapist and client (Hitchings, 1994, 1997; Kaufman et al., 1997; Liddle, 1996). Sexual identity was seen by the participants as a factor that would influence the degree to which the therapist can engage with the experiences and material of lesbian and gay clients.

A number of views were offered by participants and these include:

- lesbian and gay affirmative therapy can *only* be provided by lesbians and gay men;
- the therapist's sexuality is not a particular feature of lesbian and gay affirmative therapy;
- while heterosexual therapists may be able to provide lesbian and gay affirmative therapy, this will be more difficult than it would be for therapists who are themselves lesbian and gay.

Figure 6 outlines a number of processes that relate to the therapist's sexual identity and their ability to provide lesbian and gay affirmative psychotherapy. As noted at the top of figure 6, the participants felt that unless a clear statement had been made to the contrary, they would generally assume the therapist to be heterosexual. Indeed Kyle (client) stated *"when I first started seeing [my therapist] I didn't know if he was straight or gay, and a lot of the time I did assume he was straight"*. However, in this case the therapist was gay. Where a statement is made that the therapist is not heterosexual it can be made by the therapist in person, by way of advertising or word of

mouth.

Figure 6 shows how, regardless of the sexual identity of the therapist, participants felt that self-disclosure was an important aspect of therapy to which they would respond whether the therapist did disclose about themselves or not. Figure 6 shows that where the therapist limits self-disclosure or is unwilling to disclose at all, a number of issues arise and a number of these were most closely identified with the psychodynamic models. For example, participants felt that clients would find it very difficult to engage with a completely non-disclosing therapist. Patrick (client) *“found the lack of self disclosure in my psychoanalytic psychotherapy painful and very difficult at times”*. And, while recognising the value of the hypothesised ‘blank screen’, one psychoanalytic psychotherapist noted that such a lack of disclosure might be problematic in therapy as non-disclosure can lead the therapist and the client to see the client as responsible for the therapeutic relationship alone. He said:

“there’s always the dangers in psychodynamic [therapy] of a defensiveness creeping in [it’s as if, because] I don’t have to disclose [] to you, let’s work entirely with your projections and fantasies. [] Everything belongs to the client and it doesn’t. Everything doesn’t belong with the client” (Tom).

This was seen as difficult for the practice of lesbian and gay affirmative therapy, and is something that is discussed later in section 7.6.

As indicated in figure 6, a number of participants were of the opinion that some degree of self-disclosure on the part of the therapist was inevitable. Tom (therapist) illustrated this when he said that he inevitably discloses *“my age, I disclose my appearance, my accent. I disclose a host of things about me that people can project onto”*. Nadia

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(client) agreed saying that *“it would have been pretty unlikely that we would have come a long way down this line without [her therapist] self-disclosing somewhere”*.

So far reference has been made to disclosure independent of particular sexual identities. However, as illustrated in figure 6 participants considered differences between lesbian/gay and heterosexual experience, suggesting that different issues and therapeutic processes may exist for those of different sexual identities. Natalie (therapist) attempted to outline what some of these differences might be. She suggested:

“different expectations in a relationship, different role models and things people aspire to [] perhaps different norms – [] actually a gay man being promiscuous in a relationship is different to a straight man being promiscuous in a relationship in terms of [] the frequency of it and the meaning it has in that person’s social circle and the meaning it might have to their commitment to the relationship”.

Adam (client) discussed some of the same issues. He said:

“I am not sure that the world is quite the same for a gay couple as it is for a straight couple ... polygamy in straight relationships may be more problematic than in gay relationships”.

As with the majority of the research into lesbian and gay psychology, the differences between lesbians/gay men and heterosexual people (or the experiences that are available to each) are central to the literature (Coyle, 1993b; D’Augelli, 1994; DiPlacido, 1998; Rose 1994). Niamh (therapist) provided a developmental example. Niamh felt that *“lesbians and gay men lost their adolescence, because very often, they had to make a choice in adolescence that is a particularly adult choice”*. Jack

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(therapist) felt that the denial of difference is unwarranted and dangerous as *“the research shows [] there are sub-cultural differences”*. Jack was also at pains to indicate the stance taken to the differences should be accepting and respectful. He said *“It should be seen as ... alternative and valid and [] different but equal, ... not different but superior, or different but inferior”*.

The difference between lesbian/gay and heterosexual experience was not just recognised in general terms but it was also considered in relation to specific sexual identities of therapists and what this would mean with different clients. Jennifer (therapist) said *‘there must be ways in which there’s a gap between the understanding of the straight [therapist] and the gay client’*.

In addition to the inevitability of self-disclosure, participants felt that disclosure on the part of the therapist is also desirable. Zoe (client) said:

“you don’t just want all this self-reflective crap, you actually want somebody to say ‘I do understand, I have been there and this is what I do. Maybe it won’t work for you, but I know other people that have done this’”.

Not only did participants desire some disclosure but felt that it was useful. Nadia remembered:

“instances where [] the quality of the rapport was improved because of something [the therapist] disclosed. I think because of what I knew about her, I felt that much more able to go into that subject”.

Clients suggested that disclosure could enhance the therapeutic relationship. Ross (therapist) felt disclosure was also useful in itself. He saw it as *“a way of offering new ideas to clients with a restricted range of thoughts”*.

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Participants suggested that lesbian and gay male therapists have more accurate awareness of their clients' experiences. They also suggested that by being 'Out' the lesbian or gay therapist might embody a challenge to those who hold pathologising stereotypes and thereby provide hope to the client that the negative view can be overcome i.e.

"As a therapist you are in a powerful position, and you can be a lesbian, which is a not good thing, [] possibly there's a way to make it a [] slightly gooder thing" (Niamh, therapist).

In this way the fact that the therapist is lesbian or gay plays a central role in providing the therapist with an authority that is not available to the heterosexual therapist.

So far, we have followed figure 6 through its 'central arm' – the one related to disclosure and sexual identity and the advantages for lesbian and gay therapists. There is another arm (on the right hand side of figure 6) that relates to the meaning of heterosexuality for lesbian and gay clients. If we return briefly to the initial assumption that many clients make, i.e. that their therapist is heterosexual, we should then consider some of the assumptions that are associated with this.

Participants noted that assumptions would often include an anxiety that therapy with a heterosexual therapist might not be safe. Jennifer (therapist) said that *"the fact of being straight can set up barriers, whatever my attitude. I may have areas that I am not aware of, even though I might try"*. This was also picked up by clients, e.g. Tania (client) felt that *"some heterosexual people [] would make judgements"*. These assumptions about heterosexual therapists can therefore lead to specific difficulties for heterosexual therapists in their therapeutic efforts with lesbians and gay men.

This section of figure 6 continues as the assumptions about heterosexual therapists are related to the question of whether heterosexual therapists can actually understand lesbian and gay experience. As a heterosexual therapist, Natalie wondered to what degree she was able to be lesbian and gay affirmative. She said:

“I’ve always felt slightly inadequate for being a straight woman [] like I don’t have the credentials or the cred or the [] in-depth knowledge of the scene”.

Niamh (therapist) also appeared sceptical about heterosexual therapists’ ability to meet this challenge. She said:

“I think it’s quite difficult if you are a heterosexual therapist frankly, ... I think you probably need to be wracked with angst, a great deal of the time in terms of being self regarding [] but it’s possible, but I think it’s hard”.

One of the reasons that Niamh felt it was hard for heterosexual therapists to be lesbian and gay affirmative therapists is that *“it’s terribly hard for them not to get caught in the trap of being overly nice, you know, is it easy to take risks?”* In recognising therapy as risky Niamh noted that risk exists in challenging lesbian and gay experience as this can sometimes be perceived as homophobic:

“If you’re a heterosexual gay affirmative therapist ... at some level you’re going to feel good about yourself, [], and is that a hard thing to risk? ... feeling bad about yourself? You know if someone said, ‘I think that’s a grossly homophobic remark frankly’ ... how certain are you going to feel that it’s not? Maybe it is”.

In this section a parallel exists with concerns that have been expressed regarding the

ease with which therapists from dominant (white, middle class heterosexual) backgrounds are able to represent (Wilkinson and Kitzinger, 1996) or provide effective therapeutic relationships to clients from minority groups (Laungani, 1999; Leitman, 1995; Vontress, 1971).

Some of the difficulties attributed to heterosexual therapists may be related to unwarranted assumptions about heterosexual therapists. Kyle suggested that *“if [the therapist] was straight, I’d be assuming that he was automatically against me”*. Like Tania, Adam agreed as he felt that he carried an assumption that *“if it was with a straight person, [] I would most probably be judged”*. Mark (client) agreed and said *“I didn’t believe that a straight person would be able to understand my experience of my sexuality and accept it, and really understand what is happening for me”*. Therefore participants recognised that they were making assumptions and generalisations.

However, it is important not to suggest that views such as these are purely an aspect of the client’s anxiety or a projection of such psychological constructs as ‘a punitive super-ego’. Participants were clear that many heterosexual people struggle to understand lesbian and gay sexuality. Oliver (client) remembered how two previous therapists *“clearly did not understand and it was as though I had to explain everything and check out ‘do you know what I mean’?”* A result of such an experience can be that the client pathologises himself or herself: *“Are my problems so bad that my counsellor can’t understand? – I must really be screwed up”* (Oliver).

Thus, as can be seen in figure 6, participants suggested that some lesbian and gay clients might find it difficult to entertain a therapeutic relationship with heterosexual therapists. Indeed reflecting on his own experience, Mark (client) explained that he had

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“felt too vulnerable or too threatened to be able to work successfully”. Ewen (client) agreed as he felt that *“some gay men may feel very uncomfortable talking to a heterosexual therapist”*.

These difficulties might make it difficult for lesbian and gay clients to trust their heterosexual therapists and this would limit the therapeutic possibilities available in the client–therapist pairing. In this regard, therapists were articulate about the reservations they held (and noted that it might be a controversial view). One therapist felt that he had *“set the cat among the pigeons when I [argued] that only gay men and lesbians should be therapists for gay men and lesbians”* (Brad). This is the end point of the right hand side of figure 6.

It must be recognised though, that there is a great complexity in this. The central section of figure 6 highlights that while there might be anxieties about heterosexual therapists, a number of participants (both clients and therapists) argued that it is not necessary for the therapist to be lesbian or gay in order to provide lesbian and gay affirmative therapy. Chris (client) said *“I would say he wouldn’t have to be gay”* and Ben (therapist) said, *“it is possible to be a gay affirmative therapist without being gay”*. Participants elaborated on this theme and reflected on their own experiences to support this. In fact, participants suggested particular therapeutic benefits might be available with a lesbian and gay affirmative therapist who was heterosexual. The particular benefits are seen to relate to the fact that by disclosing aspects of themselves, the heterosexual therapist can represent the ‘outside’ world. Indeed Adam said *“to have a straight person who is on my side, it could actually help with my relationship with the world out there”*. This was echoed when Ullie (client) stated *“it gives hope that the qualities can happen in society with other people”*.

However while participants did suggest this, there was also some discussion about particular areas that heterosexual therapists would need to explore before being able to provide such a therapy. Alec (client) felt that it was important that:

“the therapist has spent some time exploring their sexuality and [is] non-judgemental and accepting (truly) then they should be OK whether they are gay or straight”.

Figure 6 therefore illustrates that the therapist’s sexuality may affect a number of factors in lesbian and gay affirmative psychotherapy, and that participants felt that it is not purely a case of identifying lesbian and gay affirmative psychotherapists on the basis of their sexual identity. Other factors are also important. At this point we will turn our attention to the role of one of those other factors, i.e. knowledge and theory.

7.4 Knowledge and theory

Other factors that were seen as important by participants are the role of the knowledge that the therapist has available to them and the role of therapeutic theory. In order to distinguish between the two types of knowledge, the awareness of lesbian/gay experience will be referred to by the term ‘knowledge’ and ‘theory’ will be used when discussing formal professional knowledge. The relationship between these and the process of lesbian and gay affirmative therapy is outlined below.

7.5 Knowledge of lesbian and gay experience

In figure 7, the series of three overlaid boxes indicate that the participants felt that the person of the therapist, their personal characteristics and a non-pathologising stance to lesbians and gay men were seen as being closely related to and dependant upon each other.

Figure 7 has two sides to it. The left-hand side considers knowledge of the individual client, the way in which the client would identify themselves and the impact of this on the relationship.

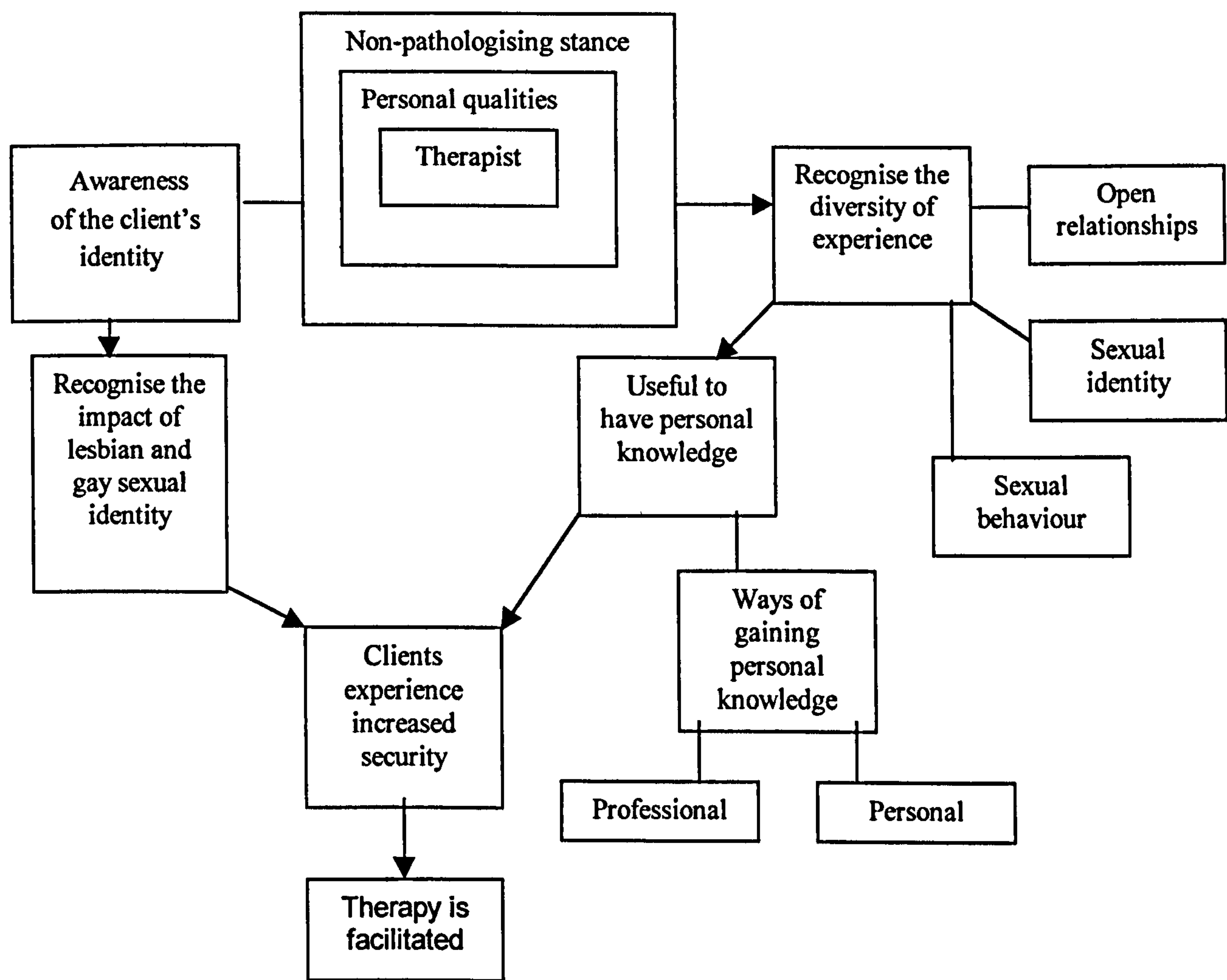


Fig 7: Processes regarding the place of knowledge in lesbian and gay affirmative psychotherapy.

The right-hand side considers knowledge in relation to the diversity of experiences that lesbians and gay men may have. Figure 7 is almost circular in that the left and right hand sides are bridged by the participants' suggestion that where this knowledge is available to the therapist and is used, the client will experience increased security.

Ben (therapist) noted the importance of knowing about the client's sexual identity early on in therapy, so much so that *"almost all the time I would know the sexual orientation ... I always thought that was an important part"*. This stance was also

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important to Ewen (client) who felt it was particularly important that the therapist have *“a good understanding of problems that could face lesbians and gay men”* and in particular he mentioned *“problems that people can have at work [] because of homophobia”*. In this statement Ewen is making a point that links the two boxes on the left-hand side of the figure. This knowledge assists the therapist in recognising the impact of sexuality on the experiences available to the client. Ewen also felt that knowledge of the effects of homophobia was important and felt that anti-lesbian and gay prejudice stemmed from *“family, religious beliefs, ... different cultural attitudes to homosexuality”*. Tony (therapist) echoed this when he said that he felt that the *“understanding of internalised homophobia”* is crucial to lesbian and gay affirmative therapy. The implication of this is that it is important for therapists to have a sense that these issues affect the client and the therapy.

The right hand side of figure 7 illustrates a range of experience that the therapist needs to be aware of if they are to provide lesbian and gay affirmative psychotherapy. As has been mentioned in the previous sections, the participants recognised that meaning is diverse. Sacha (therapist) not only felt it important to recognise this diversity but she would:

“make [it] explicit that [] there is huge diversity in a particular group, like among gay men or lesbian women, there's enormous diversity, [] that there is no single lifestyle or pattern of relationship”.

Jack (therapist) supported this when he cautioned that:

“just because you think you've got it all sorted out because you are openly gay, your parents know you're gay and you're living in Earls Court [] you have to

be aware [] that [] you [can't] just [assume to] understand [] a rural gay experience, or a black gay experience"

This caution was felt to be important, as many of the issues mentioned are central to lesbian and gay experience, yet at the same time do not make up the entire life of lesbians and gay men, nor are they the only topics that will be brought to therapy. Figure 7 provides examples of diversity and the topics that the participants felt the therapist should know about, and these included sexual behaviour; lesbian and gay relationships including the variety of potential relationship structures and the experiences of a marginalized sexual identity.

As illustrated in figure 7 participants felt that open relationships are a particular area that may have different meanings and were discussed in relation to gay men in particular. Some participants experienced their therapists as seeing their open relationships through heterosexual frameworks and felt that this was problematic.

Adam (client) has:

"an open relationship and I think I got a vibe that her feeling was that our relationship was insubstantial. That it was weak, that it needed to be propped up by affairs outside of the relationship [] and then rightly or wrongly I had the feeling it had something to do with a ... heterosexual's eye view of what an ideal relationship should be".

Another section of figure 7 associated with the importance of recognising diversity related to how clients valued attention being paid to the experiences of lesbian or gay identity. This was related to a sense of safety in therapy. Greg (client) said *"I wanted to talk about what it was like to be gay, I wanted it to be safe about being gay, to*

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express it". Zoe (client) also noted that at times this is central to therapy. She said *"it was the one and only issue I was struggling with, 'Was I bisexual?', 'Was I lesbian?', 'Had I just fallen in love with one person and it was a one off?'*" Thus, the topic of 'coming out' is particularly relevant and is part of the content of many therapeutic encounters with lesbians and gay men. Many clients explained that therapy was one of the first places they had voiced the possibility of a lesbian or gay identity and this was of benefit to them. Grant said *"I admitted for the very first time to any strangers my sexual orientation, ... I must say it was very positive"*.

The final aspect of diversity that is featured in this process (and illustrated in figure 7) is that of sexual behaviour. This was often a topic that clients wanted to explore in therapy. Same-sex sexual behaviour is often a taboo subject in Western societies and lesbian and gay clients may therefore need to consider their sexual experiences in a safe space. Curt (client) said *"I wanted to look at [] sexual compulsion"*, while Greg (client) *"wanted to talk about [] what it felt like to make love to a man"*. Greg was clear with his therapist that *"this will involve the actual, practical, physical acts"*. Again such conversations are often denied lesbians and gay men in our society. When talking *"about really intimate acts, it's very difficult"* (Greg) and it clients felt that it is therefore important that the therapist is not ignorant of or insensitive to the client's experience, as this will create even greater difficulties. It seems to me that it is important that therapists should be well informed about lesbian and gay sexual behaviour, particularly sexual practices that are not often considered as part and parcel of heterosexual relationships. For example, Dean (therapist) felt it was important to have information about *"having sex in cottages or public places or back room bars [] fisting and all the other sexual activities"*.

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Participants felt that where the therapist is able to engage with sexual material, it can be very affirming, increasing the therapeutic rapport and allowing issues to be considered in appropriate detail. Patrick (client) described a time where this was possible. He said:

"I revealed to [my therapist] that I'd [] rimmed [licked a partner around the anus] [] and he got concerned. [] He said 'There's all sorts of bugs and stuff around there, have you thought you might be exposed to hepatitis or something like that?'. He wasn't communicating any revulsion to the prospect of rimming but he was concerned [] was I aware of some of the dangers of this, which I thought was very sweet of him".

Patrick experienced this intervention as allowing him to consider his relationships further, rather than closing down on them.

Figure 7 illustrates the importance that participants accorded to the therapist's knowledge of diversity being based in experience of some kind rather than being gained through intellectual/academic methods alone. For example Liam, a counselling psychologist suggested that:

"any therapist will need to have explored their own sexuality, probably important for any gay therapist to have explored their heterosexuality and probably for any heterosexual therapist to have found at least a small part of themselves that might loosely be described as gay"

Another way of understanding the role of 'personal knowledge' is that it means "my knowledge of developmental models, gay subculture and gay experiences" (Jack, therapist).

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The participants felt that knowledge of lesbian and gay experiences are central to the provision of lesbian and gay affirmative therapy. Adam felt that his therapist had been able to do this and speculated that this was related to the fact that she *“had a brother who was gay and maybe ... that by a process of osmosis she kind of [knew]”*. Sam (client) felt that it had been useful that his therapist was able to use her own experience to *“draw upon a lot of things that are relevant to me and also to life in general”*.

In a sense the participants are talking about the therapeutic value of being known by the other person. Ross (therapist) felt that *“it’s not about thinking it’s about knowing at some level, as much as one does know anything that belongs to another person”*.

As is illustrated by figure 7, this personal knowing is useful as it may facilitate the therapeutic process by creating a sense of safety. Participants suggested that when therapists know *“what I’m talking about ... they could legitimately and securely talk to me about the various aspects of their day to day lives”* (Ben, therapist). Personal knowledge may lead to an increased experience of security for the client and it is this that may link the factors on either side of figure 7.

Another issue that the participants considered was the ways in which therapists could gain the personal knowledge that they had suggested is so important. Jack (therapist) suggested that lesbian and gay sexuality should be a topic discussed in theoretical courses. He said it would be important *“to cover it, in like, lifespan development, [] all the way through [] not just to have it as an addendum or a special interest”*. It was also suggested that the course should accurately relate the taught material to the diverse experiences of lesbians and gay men rather than at an abstract level of theory. A client, Mark, suggested that *“it’s important to have an anchor in theory, but then again you have a difficulty of rigidity and negativity for some population groups”*.

Jack (therapist) felt theoretical difficulties *“could be changed by asking different questions ... by not taking a pathological stance”* for instance. Natalie, a clinical psychologist felt that this issue was wider than individual trainers or courses in that:

“there should be a professional stance to bring it up [] courses should be teaching this stuff [] I don’t think it’s necessary to have a gay or lesbian lecturer in order for it to come up”.

This viewpoint highlights one of the difficulties frequently noted by lesbian and gay therapists in training, i.e., that they are often led to feel that they should ‘carry’ the gay issue for the group (Coyle et al., 1998, 1999).

In addition to what the therapist needs to know about lesbian and gay possibilities, participants felt that theory is also important and paid particular attention to the advantages and conceptual difficulties therapists face in relation to their theoretical orientation. It is to this area that our attention now turns.

7.6 Theoretical knowledge

Figure 8 represents the role that theoretical knowledge is thought to have in the practice of lesbian and gay affirmative psychotherapy and illustrates the range of theories discussed by both therapists and clients. The diagram indicates the approaches that participants felt were able to be lesbian and gay affirmative in unbroken lines, and those that participants felt were more problematic in broken lines.

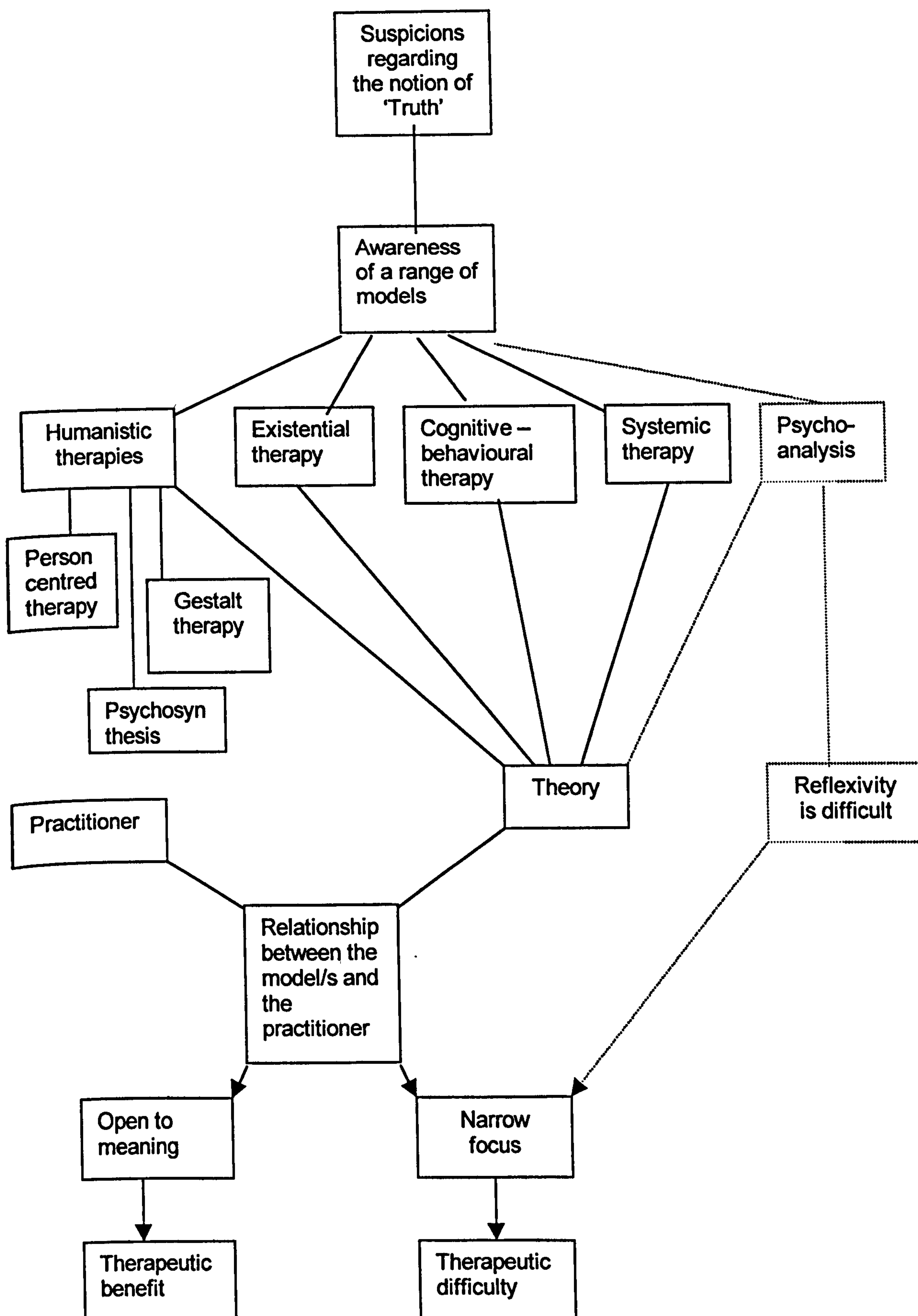


Fig 8: The role of theoretical knowledge in the provision of lesbian and gay affirmative psychotherapy.

The starting point at the top of figure 8 highlights a view that the participants took to

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a range of theories in order to assist a lesbian and gay affirmative stance and this view is akin to a suspicion regarding notions of truth (Billington et al., 1998; Burr, 1995).

Ross, a psychotherapist felt that he *“would certainly challenge the notion of truth”* and Sacha, a counselling psychologist felt that her background was important as she *“came from a very politically aware background, much questioning, not accepting official versions of the truth”*. This stance was critical, reflective and flexible and Brad (therapist) felt that lesbian and gay affirmative therapists must be *“open to questioning the theory. They aren’t dogmatic and highly opinionated [] it is an open-minded examining of theory”*. There was wide-ranging support by participants for the importance of moving from a stance of ‘theory as truth’ to theory as:

“frameworks and that’s really it ... [] they are quite useful in that respect, but to read into them a way of working as being the only way of working is quite dangerous really”. (Hannah, therapist).

Theory is often the phenomenon around which trainings are established and this received attention from participants when they suggested that current trainings are inadequate or inappropriate in relation to psychotherapy with lesbians and gay men. This theme is also evident in the literature regarding training (Crouan, 1996; Samuels, 1993b; Wheeler and Izzard, 1997).

Participants suggested that to have an awareness of a range of theoretical models rather than to be limited to one view is one way of being hesitant about notions of truth. It was *“something about [being] aware of other models of working and constantly building on that”* (Ross, therapist).

Both clients and therapists considered a number of psychotherapeutic theories that are illustrated in figure 8.

7.6.1 Humanistic models.

Humanistic therapies were considered by both therapists and clients and overall were seen to be useful models to work with when providing lesbian and gay affirmative therapy. This seemed to be because the participants felt that these models clearly aimed to be non-pathologising. Reflecting on his own experiences in therapy, Oliver (client) felt that *“humanistic and transactional analysis influenced therapists have seemed to be more affirmative”*.

Liam (Integrative and Humanistic therapist) suggested that humanistic models might be able to achieve this as they *“don’t hold an illness/sickness view of homosexuality [] that flows from the orientation”*. Not only do humanistic models *not* view lesbian and gay sexuality as pathological, but the particular qualities and principles of the orientation were thought to assist in challenging such a view. Humanistic therapy *“has a very strong anti-discrimination value embedded in its core philosophy, [] it’s absolutely crystal clear and so there’s a real commitment there”* (Sacha, Integrative therapist).

While pointing to the value of the humanistic stance when working with lesbians and gay men, some therapists did feel that it was problematic in the wider context. Tom (psychoanalytic psychotherapist) felt that when he was practising *“person-centred counselling, [it] wasn’t adequate to what I was doing”*. Chris (client) agreed when he said that *“just by using [] Rogers’ [] requirements you can support somebody in their homosexuality, but I would also say that that might not be enough”*. Thus,

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participants were not generally finding fault with the humanistic approach's capacity to be lesbian and gay affirmative, but rather were pointing to the model's perceived limitations in grasping the complexities of the range of human difficulties that can be brought to therapy.

Mark (client) also mentioned similar values to those expressed above: *"the humanistic [] are models that will respect the individuals for who they are"*, and in doing so he alluded to the fact that there are a number of therapies that would be included under the umbrella term of humanistic. Jack (Cognitive-behavioural therapist) agreed with Mark's view of these approaches to therapy when he said:

"Rogerian, Humanist, Existential lend itself very much to a gay affirmative stance ... ideas of kind of fulfilling your human potential, ... being a whole person and getting back to active listening, ... a fertile ground for gay affirmative practice".

7.6.2 Particular humanistic models

As mentioned above, the term 'humanistic' is used to include a range of therapeutic orientations, including models such as the person-centred approach (Mearns and Thorne, 1988; Rogers, 1951), Transactional Analysis (Stewart, 1989), Psychosynthesis (Assagioli, 1975; Whitmore, 1991) and Gestalt therapy (Clarkson, 1989). These are included in figure 8 with straight lines indicating their association to the humanistic therapies in general.

7.6.3 Transactional analysis

One slight exception to the general view of humanistic therapies as lesbian and gay

affirmative was Brad's (Integrative/Existential-phenomenological therapist) statement that he felt that the founder of Transactional Analysis "*Eric Berne is a bit homophobic really*". As this was not elaborated upon, this study cannot place Transactional Analysis on figure 8 with any certainty.

7.6.4 Gestalt therapy

Participants felt that Gestalt therapy could be viewed as respectful of lesbian and gay sexuality as it allows flexibility and recognises the value of difference. Mark (client) suggested that:

"one of the values of Gestalt is that the beauty is in the eye of the beholder, everyone works individually, it's a way of working, it doesn't have a firm theory of development".

Mark also felt that "*Gestalt is very positive to people who are different [] [it] would respect people who are in minorities and who view things differently*". Tony (Gestalt therapist) agreed and felt that "*Gestalt is phenomenological and field theory based, thus only values the client's experience*".

7.6.5 Existential-phenomenological therapy

Participants also discussed existential-phenomenological psychotherapy. Tony (Gestalt therapist) felt that "*any existential-phenomenological therapy should be gay affirmative*". On being asked to describe how a therapeutic model might assist the therapist's attempts to be lesbian and gay affirmative Brad (Integrative/Existential-phenomenological therapist) referred to phenomenological psychotherapy. He said that:

“the whole idea of phenomenology and dialogic relationship is very useful. That the purpose of the therapist is to enter into the phenomenological world of the client and by doing that, and by struggling [] to understand the client, that in itself is extremely curative”.

The issue of existential-phenomenological therapy as a lesbian and gay affirmative therapy is further considered in this thesis in chapter four and in Milton (2000).

7.6.6 Cognitive therapy

Cognitive therapy is also an important model of psychological therapy identified in figure 8 and several therapists were able to consider the stance it took to lesbian and gay affirmative therapy. Like Humanistic models it was generally seen to be non-pathologising and Jack (Cognitive-behavioural therapist) felt that:

“it assists because it has a pretty much a value neutral, pragmatic rather than a dogmatic stance ... and because it doesn’t have much to say about early developmental processes”.

This statement echoes the value that was identified in relation to Gestalt therapy i.e. the value of being free from limiting developmental theories. While thinking of cognitive-behavioural therapy (CBT) Liam (Integrative and Humanistic therapist) echoed the point made earlier about all therapies (and included in figure 8 as a link between theory and practitioner), that there is a clear relationship between the model and the way a practitioner uses it. He felt that *“a CBT model wouldn’t be underpinned by some particular value system necessarily, but the people could be”.*

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Thus CBT was seen as being able to assist practitioners in being lesbian and gay affirmative, yet like other models in figure 8, participants also suggested that the value of the model might be undermined by the individual practitioner. Thus regardless of the degree to which any model is lesbian and gay affirmative, the relationship exists between the practitioner's values and the affirmative possibilities of the therapy. It was suggested that where the practitioner held damaging views of lesbian and gay sexuality, lesbian and gay affirmative cognitive therapy could be hindered. This was illustrated when Jack (Cognitive-behavioural therapist) said:

"clumsily done, [CBT] can [ignore] environmental influences, ... individualise what's going on, blame the stress on the ... individual's belief structure" .

In addition to this, Sacha (Integrative therapist) felt that CBT had been used in non-affirmative ways with lesbian and gay clients in the past and recalled that as with society, in cognitive-behavioural therapy *"the predominant view [20 years ago] was that homosexuality was a deviation"*. However, she felt that recent dominant social views and values had affected cognitive therapy for the better and said that *"It's [CBT has] changed since then"*.

7.6.7 Systemic therapy

Participants felt that systemic therapy was particularly useful because of the attention that this paradigm pays to the context of the client, family and therapist and the relationships between all these different positions. Other advantages were felt to include the formal attention to the speaking positions of the participants and the impact that these might have on the therapeutic relationship and therapeutic possibilities. Participants also felt that the systemic models also consider how therapists might

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challenge the blaming of an individual. Niamh (Systemic therapist) felt that:

“a systemic orientation is good as it deals with context [] it’s very useful in assuming that the circumstances of your external world and the circumstances of your internal world are not in fact separate, discrete entities, ... that they [] inevitably [] affect each other and are affected by each other”.

When thinking about actual systemic clinical methods, Ross (Systemic therapist) suggested that:

“the narrative people might [] elicit from the client an image of homosexuality and use that as a basis to fight against so they might externalise homophobia as something concrete that lives out there and attacks them”.

Again a flexibility of thought, both about the individual and their context is seen as valuable.

Therapists also addressed ways that the systemic orientation might be limiting. In this regard Liam (Integrative and Humanistic therapist) focused on the systems model’s tendency to challenge individual pathology by reformulating the problem as a family issue being held by one member. He wondered whether this might allow the model to pathologise homosexuality *“to think of homosexuality as one [family member] holding it for the rest of the family, and if we intervene in a particular way it’ll dissolve”*. Niamh, herself a systemic therapist, felt that:

“some kinds of systemic family therapy can be very prescriptive in terms of [] ideas about [] family in the largest sense [] and the worst thing about systems family therapy is that it always says that all people in the system are equally

responsible for maintaining the system, and that isn't necessarily true at all".

Limitations such as these are noted in some of the systemic literature. It has been suggested that some systemic formulations of the family have been limited by prevailing heterosexist social discourses (Bor et al., 1996; Malley and Tasker, 1999).

7.6.8 Psychoanalysis

In this study, the consideration of psychoanalysis was characterised by greater caution on the part of the participants and this is illustrated by broken lines in figure 8. Participants voiced a great deal of concern about the manner in which psychoanalytic theory was seen to pathologise or ignore lesbian and gay sexuality. Jack (Cognitive-behavioural therapist) suggested that:

"psychoanalysis ... has quite a homophobic history, and that's still very evident in what's going on ... teaching ... so I think that there are gay affirmative practitioners that ... they've still got a long way to go and you can have a bad experience".

Mark (client) also took an historical view when he noted that:

"traditional psychoanalytic theory is very homophobic and anti-gay and people coming from that traditional theoretical training are going to be harder to work with if not impossible".

Tom, a psychoanalytic insider, noted the inadequacy as it manifests itself in psychoanalytic training. He said *"they [the trainers] didn't really talk about it [lesbian and gay sexuality]"*.

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Sacha (Integrative therapist) addressed another impact that the pathologising stance has had when she noted that:

“gay and lesbian people [] have been, and I think still [are] actively excluded from training because it [lesbian and gay sexuality] is regarded as a deviation or perversion”.

This was echoed by Jon (Psychoanalytic therapist) who wrote that his:

“first training analysis had to be abandoned after 18 months (three times a week). It became apparent that the therapist wasn’t going to ‘pass’ a trainee who was a practising gay man. Only a ‘cure’ to heterosexuality would have passed me”.

Jon’s experience was very recent and supports previous research into the denial of psychoanalytic training to lesbians and gay men (Ellis, 1994) based on theories of homosexuality as pathology.

The participants in this study also addressed some of the factors that may maintain such a stance and these are also included in figure 8. Ross (Systemic therapist) felt that *“psychoanalysis as a model has not got the flexibility within it”* and Niamh (Systemic therapist) felt that it was a question of psychoanalysis being resistant to reflection on itself. She said *“it didn’t take to being questioned”*. Psychoanalytic insiders such as Lewes (1995) have also noted this recently.

Moving away from individual models of psychotherapy, a critical stance to theory was advocated by some participants as this was thought to provide therapists with a useful tool. Participants felt that this was important because in some instances, as was noted

above, *“probably the model itself is neutral, but the people probably aren’t”* (Liam, Integrative and Humanistic therapist). Yet, for other models it was suggested that *“if a model is definitely homophobic it’s hard for it not to influence therapists because it has a lot of authority behind it”* (Jennifer, Psychosynthesis therapist). As well as acknowledging the relationship between the model and the practitioner, Jennifer extends the principle to the relationship between the model and the institution, acknowledging the authority that can maintain this prejudiced view. These views move us to the lower section of figure 8.

The lower section of figure 8 considers the relationship between theory (as discussed above) and the practitioner. This relationship was thought important by participants as it affected the degree to which flexibility was possible for the therapist and flexibility was felt to add to the chances of a sensitive and empathic engagement with the client. It is evident that an ability to be open to meaning was seen in terms of *“thinking from lots of different perspectives”* (Natalie, Integrative therapist) or thinking of the different meanings in sexual imagery. Dean (Neuro-Linguistic Programming therapist) reflected on his own therapist and said:

“Suppose I said to her that my dream was about being screwed by five guys in a disused warehouse ... and if she said ‘Oh that’s interesting, just a sec, why a disused warehouse? What does it actually mean? [] that would have been fine”.

It may be that this is an example of being open to the range of meanings in any client narrative. In this case it appears that the participant is identifying how important it is for therapists not to overemphasise sexual behaviour, something that has been noted in

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the literature (Garnets et al., 1991; Milton, 1998; Milton and Coyle, 1998). It may be that interventions that are open to diverse meanings could be seen to *"make it easier for the client ... to talk about their sexuality"* (Ewen, client) and *"obviously it is widening my choice"* (Mark, client).

Figure 8 also alerts us that when the relationship between the practitioner and the model is too rigid thinking about the individual client may suffer and this may result in therapeutic difficulties. When thinking about this rigidity, Ben (therapist) said that there are *"problems inherent in any model that you just apply without thinking about other factors outside the person"*.

These difficulties were seen to affect clients in a range of ways. One way was that clients could receive a view of themselves framed as *"perversion or immature sexual developments, and things going wrong"*.(Jack, therapist). Hannah (Integrative therapist) identified another difficulty that resulted in the premature termination of therapy. She talked of her own therapist asking whether she had ever *"considered herself a pugnacious little boy"* and described how this had provided her with an experience of being in a double bind in therapy. She said, *"whether I do or whether I don't, I'm not about to prove or disprove your theory and I just left the session and thought 'I'm not having any more of this'"*. Alternatively Oliver (client) identified that one experience of therapy had left him feeling *"like a curiosity, a case study, I felt that he attributed all my problems to my sexuality"*.

Thus, participants felt it was important to reflect critically on theory in its entirety - its content, the stance it takes to lesbian and gay experience and development, and the implications it has for practice.

As noted above, psychoanalysis received a lot of attention. One particular aspect of psychoanalytic thought was addressed frequently by participants, both as an aspect of theory and of practice across models. This was the phenomenon termed ‘countertransference’.

7.7 Countertransference

One of the terms used within the psychoanalytic literature is countertransference and it has several meanings. Smith tells us that “Freud equated countertransference with the way analysts’ blind spots, complexes and inner resistance hamper their effective psychoanalytic functioning” (1991:47). Thus it is seen as an aspect of the therapist that affects their therapeutic endeavours.

Participants from a range of orientations attended to this issue frequently, sometimes invoking psychoanalytic discourse directly and at other times talking about the feelings, thoughts and values that the therapist experiences in relation to their lesbian and gay clients and how this affects the possible meanings and practices available to them. Participants thought that countertransference issues underlie many of the processes in lesbian and gay affirmative psychotherapy. It is seen as a central facilitating link between the model of lesbian and gay affirmative psychotherapy and the ability to respond to the client and their needs. The effect of this on the therapeutic process is now considered.

7.8 Countertransference processes

As has been seen above, participants felt that the experiences, thoughts and emotional responses of the therapist to lesbian and gay clients are central to a full engagement with lesbian and gay clients. This is one of those factors that participants discussed as

central, but not unique, to lesbian and gay affirmative psychotherapy. However, the frequency with which participants discussed it suggests that it is of prime importance to this study and it is therefore elaborated in detail.

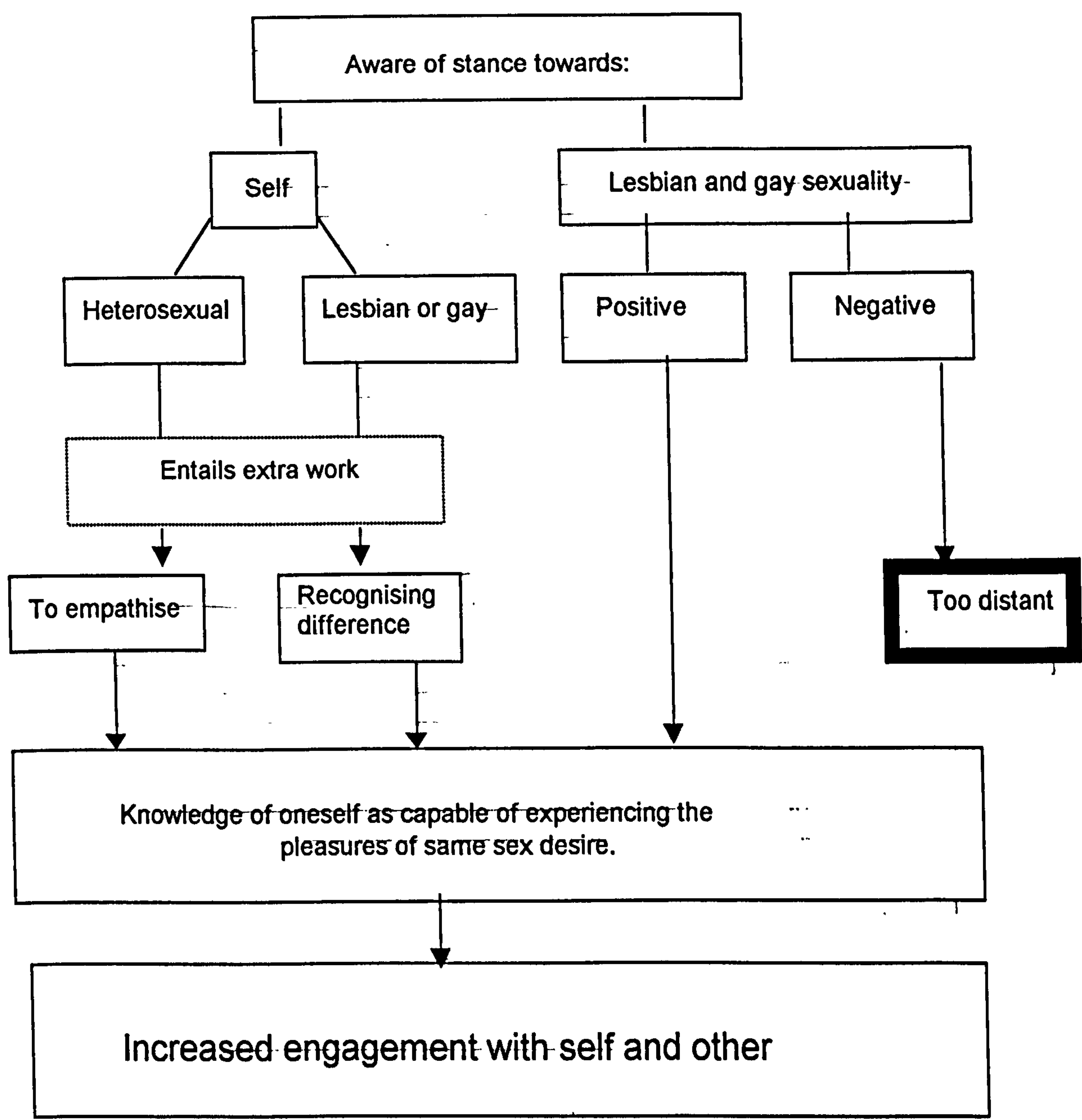


Fig 9: Countertransference processes.

As illustrated in figure 9, participants in this study indicated that an awareness of the therapist's stance was important. Many participants attempted to demonstrate an awareness of this in two central domains, firstly in relation to themselves and then in

relation to lesbian and gay sexuality in general. In this way these processes are related to those outlined above as 'theory' and 'knowledge'.

The participants explored this stance in emotional terms, describing some of the feelings experienced. In relation to her heterosexuality Natalie talked of a sense of inadequacy and said:

"I've always felt slightly inadequate for being a straight woman [] like I don't have the credentials or the cred or the [] in-depth knowledge of the scene".

Speaking as a gay man, Ben (therapist) talked of fear saying: *"it's terrifying to be dealing with gay men's issues straight and full on, particularly in the context of HIV"*.

Here the experiences of a heterosexual woman and gay man highlight the central role of the therapist's sexuality and how working with lesbians and gay men can have an emotional impact on the therapist.

In this study the therapists noted that the feelings of the therapist often provided clues to the extra work that needed to be undertaken in order to respond effectively to their lesbian and gay clients. As indicated in figure 9, the participants identified areas that would entail extra work for therapists who identify as lesbian or gay and for those who identify as heterosexual.

Figure 9 first addresses the work the heterosexual therapist may need to undertake to engage fully with the emotional aspects of lesbian and gay clients' experience. As described earlier Niamh (therapist) felt that it would be difficult for heterosexual therapists to overcome counter-transferential anxieties about lesbian and gay sexuality.

While not denying that it would be possible she felt that it would require a great deal of effort. She said: *"I think it's quite difficult if you're a heterosexual therapist frankly, ... I think you probably need to be wracked with angst a great deal of the time"*.

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Alternatively, participants suggested that when clients need to discuss explicit sexual material, this may be difficult for heterosexual therapists due to a lack of awareness (as outlined above). Participants also suggested that gender might have an influence in the emotionality of the response. Brad (therapist) said that he had fewer:

“concerns about lesbians working with heterosexual women. Many heterosexual women I know seem to truly understand that a woman could love another woman. I think heterosexual men and women have more difficulty with cock sucking and fucking among men”.

As illustrated in figure 9, and in this example, it is suggested that the heterosexual therapist may need to work particularly hard to be able to empathise with the gay client's experience. The extra effort or thought may also require particular supervision or personal therapy (see Milton, 1998).

Figure 9 shows that the participants suggested that some counter-transference issues might affect lesbian and gay therapists more acutely than heterosexual therapists. For example, by being more informed about different social mores there may be a:

“danger of a gay therapist and a gay client colluding in a folie à deux, where both accept certain aspects of the gay lifestyle as OK, when the fact is they're not, e.g. [] promiscuous [] sex and the gay therapist accepts this as perfectly fine, whereas a heterosexual therapist might say 'what's going on here'?”
(Brad, therapist).

Alternatively, as Tony (therapist) put it, there is a danger for the therapist of *“colluding with sub-cultural issues [] that might be unhealthy”.*

One way of viewing the last two illustrations is that the participants were not suggesting that these activities are inevitably unhealthy but rather that they were noting how important it is to recognise that any behaviour may be healthy or unhealthy depending on the context and the individual's motivation. Tom (psychotherapist) identified this when discussing sado-masochism. He said:

"Of course it's OK, if he's enjoying that, [it's if] he's trying to tell you that he's not sure whether he does or not [] or maybe he does enjoy it but maybe it still leaves him feeling bad or whatever [] it's how to challenge the behaviour without the identity".

Alternatively, Zoe (client) felt that lesbian and gay therapists might *"have higher expectations"* of their lesbian and gay clients.

Thus, participants suggested that the lesbian or gay therapist might need to pay particular attention to the differences that exist between themselves and lesbians and gay men as a whole. In this way they may avoid over-identification with clients and be able to attend to the individuality and specific meaning of the client. The risk is a function of the individual therapist's unconscious processes and as such is a function of the countertransference.

So far, the explanation of figure 9 has addressed how difficult the feelings of the therapist can be and how these can affect the therapeutic process in a problematic manner. This was not a unanimous view as many participants had faith that:

"you could [] have explored yourself in your own therapy whilst becoming a therapist, issues around your feelings around ... sexually towards men and women and differences and explored your own sexuality" (Kyle, client).

Whether attained through therapy or through other experiences, participants suggested that therapists work effectively with lesbians and gay men when the stance taken towards lesbian and gay sexuality - emotional, intellectual and behavioural – is positive and this, one might imagine, would need to be at both conscious and unconscious levels. Chris (client) felt that *“absolutely a respect for homosexuality”* is necessary. Sacha (therapist) felt that the therapist should *“value the client, [] to make explicit that their way of life is valid for them”*. Niamh (therapist) said that *“I genuinely believe that [] being a lesbian or gay man is an entirely positive choice”*.

Negative counter-transferences were seen by the participants to be based on fears (again conscious or unconscious) that the therapist has. It was suggested that fear might be central to the adoption of a defensive and pathologising stance to lesbian and gay sexuality. It was suggested that this dynamic might also be involved in the refusal to disclose the therapist’s sexual identity. Greg’s (client) initial experience in therapy was difficult because *“[the therapist] was just too frightened”*. This is problematic as *“they [therapist’s fears] will reinforce their [the client’s] own fears, their own concerns or their own negative view of themselves”* (Dean, therapist). When the therapist is insecure and:

“fearful, then they start being defensive and start attacking and pathologising [] and the person who internally goes ‘UUGGHH’ when you say ‘I’m a lesbian’ or when you [] talk about sex and sexuality, [] there’s this freezing up kind of fear reaction” (Nadia, client).

As indicated by the square in figure 9 that is emboldened, if this situation occurs, participants felt that psychotherapy would not be possible and would be likely to end. Brad (therapist) was not convinced that therapists (heterosexual therapists in

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particular) would be able to overcome difficult reactions to lesbian and gay experiences. He described having had conversations with *“pretty sophisticated psychotherapists who are a bit disturbed by it [lesbian and gay sexuality]”*. He felt that:

“if one of [their] children were gay [they] wouldn’t have any problems with it, but what if [they] had three children, and all of them were gay? That’s the challenge”.

It is also important that the therapist is able to withstand what the client finds overwhelming. Greg (client) felt that the therapist needed to be able:

“to recognise [sexual] desire and not be terrified by it and scared out of their pants, and run away, or to be stuck in some kind of [] ‘professional model’ of being that protects them from it”.

Both clients and therapists took the notion of a positive stance to lesbian and gay sexuality further by moving from a value that should be held by the therapist to a position where the therapist is able to identify with same sex desires. This means that it is advantageous for the therapist *“to know the possibility of themselves being attracted to somebody of the same sex, even if they’ve never acted on it”* (Nadia, client).

A similarity between the actual experience of the client and at least the imagined experience of the therapist was thought important as it may allow for an increased degree of engagement between the therapist and the client. This is necessary before the encounter can be experienced as open, trusting, warm and genuine.

Where the therapists’ values and emotional capabilities are able to engage positively with lesbian and gay sexuality, Jennifer (therapist) felt that:

“there’s more likelihood that people are on the same wavelength, [] so they [clients] won’t need to explain so much. More of an instant empathy perhaps and the trust that the person [therapist] isn’t going to judge your sexuality”.

This might allow clients to even:

“talk negatively about your sexuality, and about your sexual partner, because you know the person [therapist] wouldn’t be making assumptions [like] ‘Oh right, it’s true what I thought about gay people all the time’ (Jennifer, therapist).

When reflecting on clinical practice, I recognise that the ability to talk negatively about one’s experience is often an aspect of developing ideas and a sense of oneself. Thus, where this is too risky the client will be denied important exploratory conversations and thinking. When not encumbered by negative views of lesbian and gay sexuality the participants felt that the therapist has “*a sharper eye for subtle homophobia operating [] than maybe some of my colleagues*” (Liam, therapist). In this respect participants were suggesting that a therapist who is able to perceive negativity and then consider and challenge the role of this anti-lesbian and gay prejudice would provide useful therapeutic experiences for their clients.

At this point, the findings in relation to the outcomes of these processes are explored.

7.9 Outcomes

Participants’ accounts of lesbian and gay affirmative psychotherapy address the issue of outcome as an important consideration for both clients and therapists. Therefore, this section outlines how the process of lesbian and gay affirmative therapy is related to a number of outcomes that were considered particularly important for lesbian and gay

clients. These include a reduction in symptoms, the development of better relationships with themselves and with others and the development of more positive views of lesbian and gay sexuality.

7.10 Reduced symptoms

The participants identified lesbian and gay affirmative psychotherapy as a process that resulted in reduced symptomatology and begins with sensitivity to the myriad reasons that bring clients into psychotherapy.

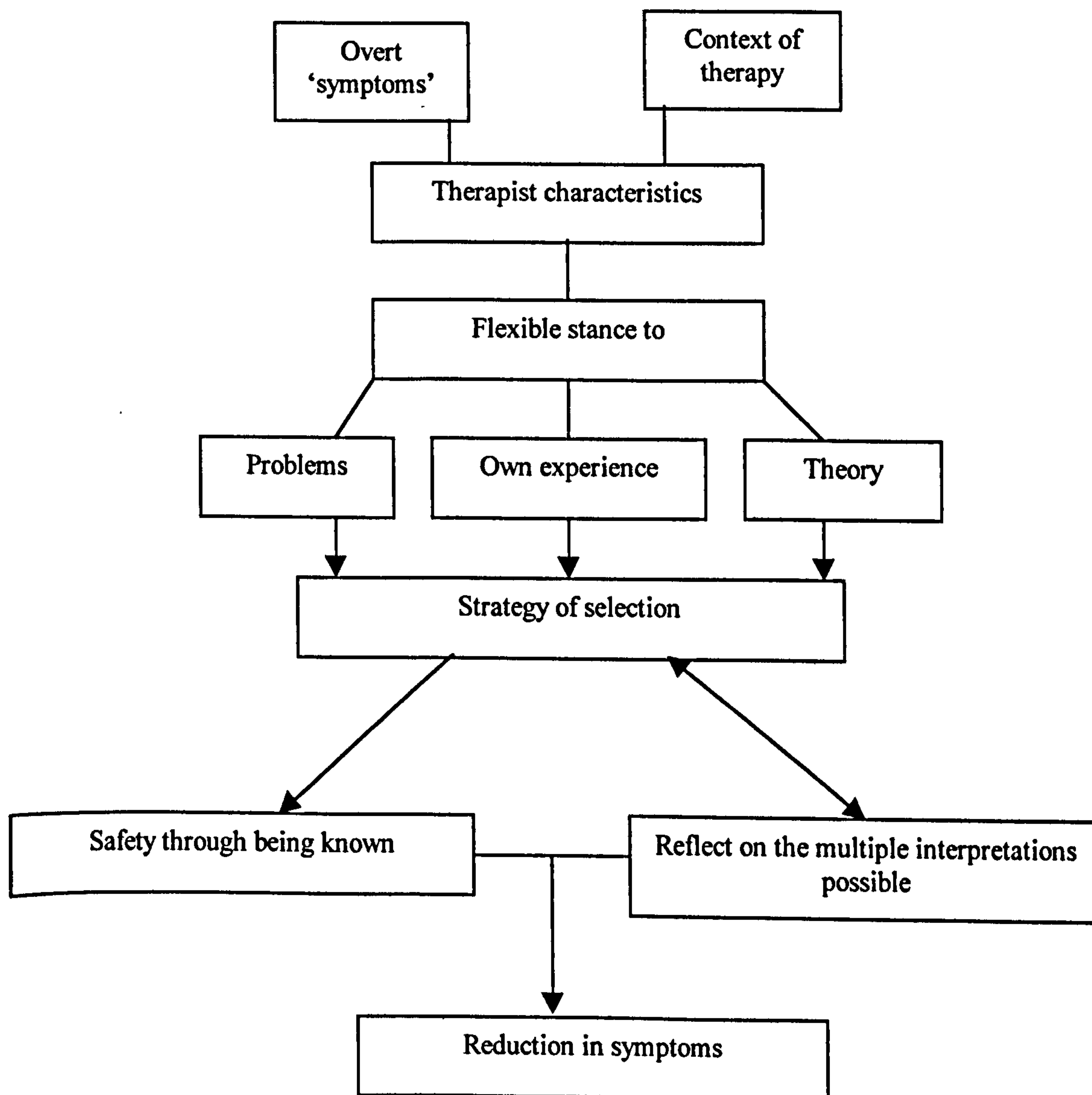


Fig 10: Processes involved in the reduction of symptoms.

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Frequently, as indicated in figure 10, there are identified concerns that the client wants to 'work on'; these are sometimes termed 'symptoms'. At times the symptoms that bring lesbian and gay clients into therapy are overtly related to sexuality and at other times not. This can be seen by some of the difficulties that took the research participants into their therapy experiences. Ullie mentioned "*Chronic anxiety, recurring depression, panic feelings and social phobia – alcohol abuse and sex addiction*". These are all difficulties that are the "bread and butter" work of many psychotherapists, psychologists and counsellors - particularly in public sector settings, such as the British NHS. Another client, Alec, described difficulties common to clients of therapists working in educational settings: "*I was not able to concentrate on my studies properly. [I was] feeling unfocused and chaos*". Thus lesbian and gay affirmative therapists are required to assist clients with the gamut of psychological and emotional difficulties that clients bring to therapy and not just issues that are clearly related to sexual identity. This obviously requires the lesbian and gay affirmative therapist to be able to identify and conceptualise a wide range of clinical difficulties.

Figure 10 also indicates that the context of therapy was seen as important to lesbian and gay affirmative therapy. Participants felt that some contexts facilitate attention to lesbian and gay sexuality, difficulties related to sexuality in general and other psychological difficulties. It was also noted that the context could affect the client's access to therapy and the therapist's clinical practice.

The issue of access to therapy was highlighted when Ben (therapist) noted that "*I come across very few lesbians [] probably because of HIV work*", thus linking setting and client group directly. The setting was also seen to influence practice directly. When thinking about therapy generally, Sacha (therapist) reflected that "*if I am working with*

an EAP [employee assistance programme] referral, there are certain parameters that I have to work within". Ross also considered how the context affects lesbian and gay affirmative practice. He noted that:

"there's something about the setting [child psychiatry] that assumes heterosexuality, colludes with family assumptions about heterosexuality and so doesn't ask the right sort of questions".

Figure 10 indicates that the client's overt symptoms and the context of therapy relate to the characteristics of the therapist. Rather than describe these again, it will suffice to recognise that these have been explored in the section outlining processes in the choice of therapist (section 7.2). In that section the therapist's characteristics were seen as important both in facilitating a relationship with the client and allowing the therapist access to the relevant information needed for working with lesbians and gay men.

The initial three factors (symptoms, therapeutic context and therapist qualities) were felt to bode well for beneficial outcomes in therapy when the therapist is able to be *open to* the possibility of discussing all aspects of the client's life, even if the client does not immediately make links between the various aspects. This would mean taking a flexible stance to therapeutic theory and the client's problems (in this regard this model is related to the processes presented in figure 8). The participants stressed that this flexible stance would be characterised by its non-pathologising manner. In addition it would not view sexuality as the *cause* of the difficulties. Hannah (therapist) described the organisation she worked in, where the clients often have overt therapeutic goals that are related to drug use. As a lesbian and gay affirmative therapist Hannah would complement her knowledge about drugs and drug related behaviours

with the possibility that:

“they [clients] could explore their sexuality, ... [] it would be for them to be able to explore their sexuality as and when they would feel that they would want to do that, for them to bring HIV and drugs, and coming out and wanting to explore that”.

While not necessarily drawing on all the available information, the therapist should be flexible and have:

“a good understanding of problems that could face lesbians and gay men [whether they be] because of ... family, religious beliefs, different cultural attitudes to homosexuality [or the] problems that people can have at work [] because of homophobia” (Ewen, client).

Mark (client) also addressed this by noting that the lesbian and gay affirmative therapist waits to see if particular dimensions are important as *“it depends on where the particular client is and what particular areas they want to look at”*.

With regard to outcomes and theory, clients reported positive experiences when therapists linked the different aspects of the client's experience without necessarily assuming everything is related to sexuality in a causal fashion. Kyle (client) said:

She'll [my therapist will] actually say, ... whatever, but it won't be related to my sexuality, it'll be related to other things, ... other relationships that may have happened in my past”.

This flexibility is seen as important as it was seen as facilitating a collaborative working alliance and an increased ability to be empathic. Craig (client) noted that in comparison

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to his Freudian therapist, his Jungian analyst was much more flexible and he experienced him as *“much more interactive with me and I find that much more helpful”*. Ben (therapist) felt that a flexible stance to theory and his own experience of being a gay man would allow him to *“know what I am talking about ... they [clients] could legitimately and securely talk to me about the various aspects of their day to day lives”*.

Participants also felt it important that therapists show flexibility in more general and practical ways. Sacha felt that as a therapist one helpful aspect of her practice was *“the fact that I am willing to work to 10 o’clock at night”* and Sam felt that his therapist *“also passed the criteria that I could have it [therapy] once every fortnight”*. For Sam, it had been important that his therapist would see him fortnightly rather than insist on weekly sessions.

Another view of flexibility that was seen to be important in assisting clients in therapy was the use of a strategy of selection when it came to the level of theory and technique. The psychoanalytic psychotherapist, Tom, illustrated this when he said, *“I realised that I didn’t accept many of the theories around homosexuality, that I didn’t accept theories around perversion”*. Tom felt he was able to separate these theories from the way that he would relate to clients. This flexibility was also discussed in relation to self-disclosure earlier in this study.

Flexibility and a strategy of selection were seen to be related to positive experiences of what might be termed ‘safety through being known’. Clients recognised this and thought it was important. Indeed, Adam (client) supported this when he talked of the opposite experience, the experience of not being known. Adam remembered an

experience of talking to a therapist about aspects of his sexual behaviour and realising that the therapist *"didn't know what a cock ring was"*. He felt unsafe at that point, suggesting that safety increases when the therapist knows of the phenomena the client presents. The wider the therapist's knowledge and thinking, the better able they might be to consider and understand the client's experience.

The ability to recognise the multiple meanings (theoretical, personal and clinical) of phenomena in therapy was also considered useful and important aspects of practice. Some participants felt that this was fostered by effort being made to reflect on practice in theoretical terms. In this regard, Tom felt that as a supervisor he would *"always ask people to give me some theoretical back up for what they are doing"*. Liam echoed this when he noted the *"importance of being able to understand what you are doing by reference to some theoretical model"*. Natalie expanded on this by suggesting that it was important that therapists did not think in singular models but were *"thinking from lots of different perspectives"*. Thus thinking in diverse ways and looking for alternative possible meanings that might be relevant for the client.

Clients also considered the issue of alternative interpretations. Adam said, *"if she makes a point and I think she's wide of the mark, ... she's very open"*. Chris valued that his therapist *"isn't very dogmatic in her approach"*. Thus it was not only therapists who voiced an appreciation for a strategy of selection in affirmative psychotherapy. However, as mentioned in the introduction to this chapter, this strategy requires consideration at a conceptual level as Lewes makes the point that "new ideas cannot simply be grafted onto a large theoretical structure: they must be integrated into that structure and made compatible with it" (1995: xiv). This issue is considered further toward the end of this chapter.

In summary then, figure 10 identifies a process where the client's difficulties are brought to both a therapist and a therapeutic context that is able to be flexible and knowledgeable about the difficulties, the client and therapeutic theory. This flexibility allows the therapist to use a strategy of selection, which may allow the clients' experience of themselves to be recognised and a sense of safety to be experienced. The client may then be better able to engage in the task of therapy, which is to consider the meanings of their beliefs, actions and experiences and to challenge rigidity of belief. When this is possible participants felt that symptoms can be reduced or eliminated. Clients talked about this as a positive aspect of therapy. Ewen (client) said, "*the depression has gone, that seems to have gone a great deal*" while Ullie (client) noted "*a reduction in panic feelings*". Ullie also talked of having achieved "*abstinence from alcohol, reduced feelings of anxiety and depression*".

The second outcome to be explored is the ability to improve relationships with self and others.

7.11 Improved relationships with self and others

The participants in this study felt that another important outcome of therapy is the capacity to develop good relationships with oneself and with others – both those in our intimate worlds and others more generally. A process of therapy that leads to this outcome is presented in figure 11.

The process begins with the client's recognition of the choices they have and the therapist being open to questioning rather than accepting of just one view. As indicated on the left of figure 11, participants felt that the therapist's questioning should be directed both at themselves and their knowledge. Jack (therapist) noted that therapists

who are themselves lesbian or gay are likely to have:

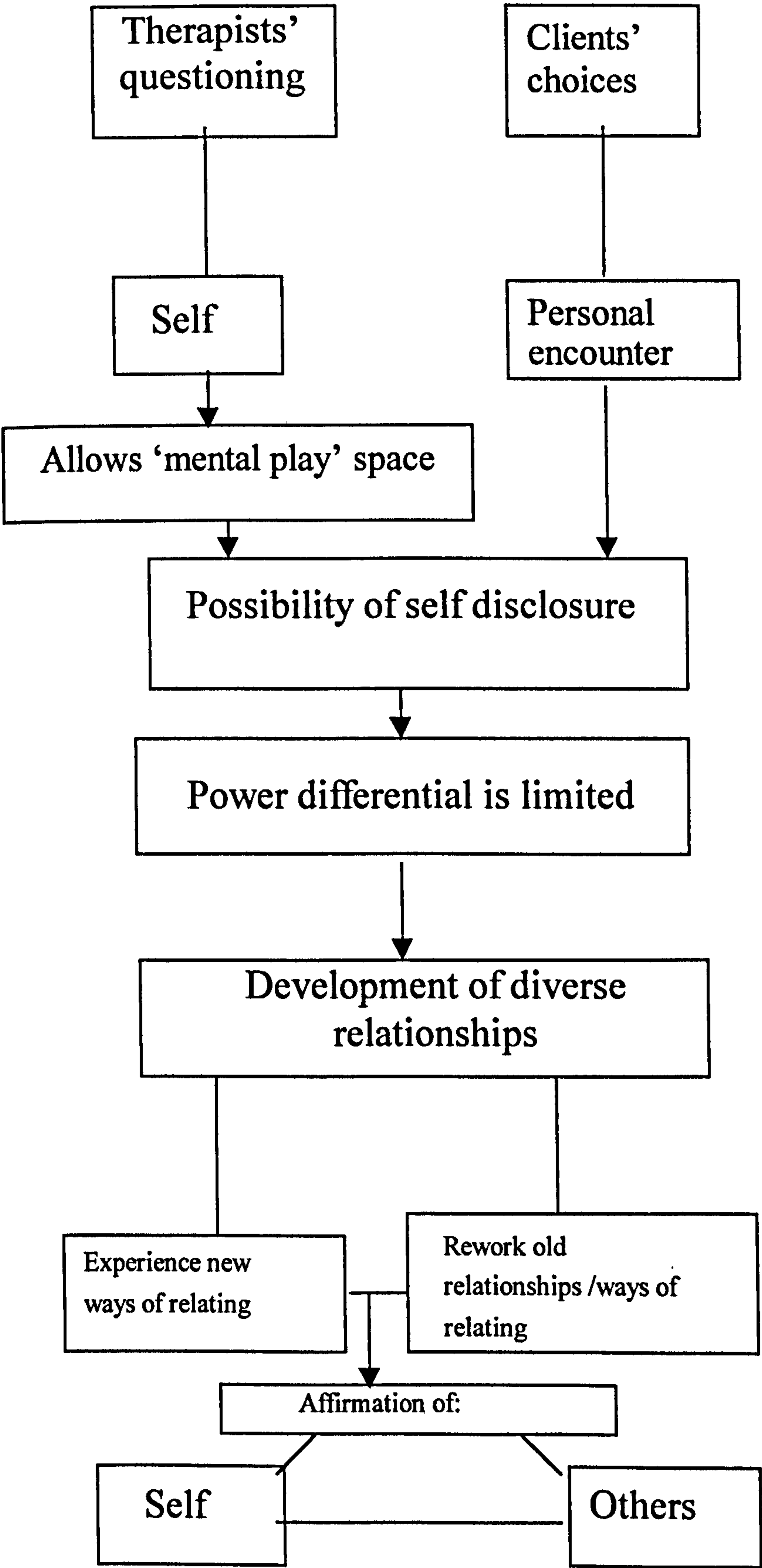


Fig 11: Processes that lead to improved relationships.

“gone through a process [whereby] they’ve dealt with their own sexuality, their own sexual identity, their own ... sexual formulation, they’ve thought about the issues and they’ve experienced the distress”.

While these values are embedded in much writing and generic professional training, Ross (therapist) felt such questioning is more than just a useful aspect of therapeutic practice, but is central to lesbian and gay affirmative psychotherapy. He said: *“scrutinising one’s belief systems and prejudices [] is the basis of gay affirmative psychotherapy”.*

Jennifer felt that this was particularly important in relation to the therapist’s views of lesbian and gay sexual identity. She said:

“the main thing is to work through one’s own homophobia [] if you are straight, and through your internalised homophobia if you are gay or lesbian”.

The questioning of themselves was thought to be important for therapists as it may be that this process allows therapists:

“to be as conscious as possible of the risks of stereotyping, prejudice and trying to deal with our own tendency to be prejudiced” (Sacha, therapist).

The questioning of oneself may eliminate aspects of anti-lesbian and gay prejudice or at least allow the therapist to become more aware of it. A process such as this was thought to enable the therapist to be open to the meanings that experiences have for the client and to provide the therapist with clarity of knowledge and possible hypotheses. Ross (therapist) said:

“based on my relationship to their material, their relationship to their questions, [] by formulating ideas, [] I check those out before working on the assumption that they are true”.

In essence then, a questioning stance was said to allow the therapist ‘mental play’ space to consider the therapeutic issues.

Figure 11 highlights the fact that clients also face a number of choices. For example, clients considered the gender of the therapist and Oliver noted that *“this is entirely a matter of personal preference”*. Not all clients felt the same way though. Some participants suggested that some characteristics of the therapist are very important to them and that gender may be one of the most important. Tania said *“I’m sure men are equally as good as therapists [] but it was important to me to have a female”*.

It is suggested that these characteristics increase the possibility of engagement. In fact, it was seen to be important that the therapeutic meeting be seen as a personal encounter for both of the participants. This is evident in some participants’ views that the therapists’ personal attributes are more important than whether the therapist is a member of any particular group (as detailed in figure 5).

Indeed, it seems that where therapy is conceived of as a technical process, the participants felt that the alliance between the therapist and client can be threatened. Adam remembered that he would *“get angry that she [his therapist] was ‘techniquing’ me and that she was a complete closed book”*.

The desire for therapy to be a personal encounter and the therapist’s ability to use their imaginative possibilities was thought to lead to the therapist considering self-disclosure in the therapy (as has been discussed previously) in order to allow different possibilities of self and of relating.

There is often a reluctance to consider therapist disclosure in the analytic therapies in particular. This may be due to theoretical formulations that suggest that the client may identify with the therapist if the client has information about the therapist. This identification may deny the difference that is required to foster a transference within which the therapist would work. However, Tom (psychoanalytic psychotherapist) argued differently, saying that *“what I’ve found is that there’s so many differences within [gay] identity that we can work with difference”* even with disclosure. From a different therapeutic perspective, Ross (therapist) outlined how he might ensure that disclosure was considered with clients. He said:

“I have had clients say that ‘You must know what I’m talking about here’ and I have [] said ‘I kinda know what you’re talking about from my own experience, but I’m not sure it’s exactly the same and I guess some of the questions that I am wondering about in relation to what you’re raising are something about the difference between your experience and my experience’”.

Self-disclosure may therefore be a method of opening up space for thought and experience.

On the part of the client, participants recognised that self-disclosure by the client *has* to occur - either spontaneously or by probing if information about the client’s sexuality is to be made available to the therapeutic process. Participants also recognised that disclosure can feel risky to both clients and therapists. Sam (client) said *“it is risky to tell anybody in a way [] risky for me to look at it”*, as disclosure has implications for self and other. Because of this risk, participants felt that it is important that therapists are thoughtful about when and how they encourage disclosure – or when they

themselves make personal disclosures.

As illustrated in the middle of figure 11, participants argued that disclosure might be particularly useful when working with lesbian and gay clients. As lesbians and gay men live in a world where others frequently respond to their sexuality with anxiety and antagonism, it was suggested that therapist self-disclosure is a way of potentially diminishing an unnecessary power differential between therapist and client. Thus Jennifer (therapist) said:

"I might be a little bit more self-disclosing because a gay client might need to know where I am coming from [] often they have an expectation of people being prejudiced, and they might ask about that – I suppose in order to lessen the power between us I would be a bit more self-disclosing".

Self-disclosure is thus one way that a client can experience the therapist as being safe to engage with. Jennifer noted that:

"one gay client I disclosed being Jewish to, turned out that she was Jewish, and that was a link between us, but that wasn't really to do with her being gay [] an understanding of what it is like to be slightly outside the mainstream".

As discussed previously, participants did not suggest simplistic rules about *always* or *never* disclosing – but rather the importance of being willing to *consider* disclosure and in this study, therapists described different strategies they employ prior to disclosure. One was to bring in *"a certain selected amount of personal material [] to benefit what is being talked about in that session"* (Hannah). Another is to ask the client what disclosure is required as when Ben described an intervention he made to a client. He said:

“there seems to be a whole aspect that you’re not talking to me about, that you find it difficult to talk about, what would help you [] what would you need to know about me?”

In this way, these therapists capitalise on the usefulness of disclosure, yet are tentative about it, being aware of possible contraindications.

Contraindications were mentioned as occasionally, there are times when it may not be useful to self-disclose and this was thought about in relation to the needs of the client. Liam gave an example of how he might decide that it is not important or therapeutic to self disclose. He gave an example related to disclosure of his sexual identity. He said with:

“clients who are very ambivalent about they may be gay, they may not be gay, and [where] they are doing some kind of struggle, and they don’t know about me for the moment, [] unless they ask I will leave that”.

Thus it was suggested that therapists might find it useful to consider the relevance of disclosure and where it was deemed useful, to disclose in a relevant and appropriate manner. The result may be that power is acknowledged, considered and worked with. While this is a complex dynamic to work with, this engagement may allow therapy to be experienced as a safe enough place to experience and develop new relationships.

The diversity of relationships may also require the issues of ‘difference’ to be explored between the therapist and client and analytic notions of projection were frequently invoked. Some clients felt it was possible to relate to the therapist as if they were the parent – and while they initially considered this in relation to the parent of the same gender they also considered it in relation to the other gender. Kyle (client) said *“I do project my father onto him, and obviously with a female I would be projecting my*

mother onto ... her". This can be useful for some clients but is not necessarily the easiest issue to deal with. Adam said:

"I have had ... four years of therapy with a woman ... which I think has been, in some ways, difficult, because I was probably in a relationship with my mother".

In this illustration Adam was describing the reworking of previous relationships. The term, 'the development of diverse relationships' may be more meaningful when we consider that the participants were at pains to point out other ways relationships could be reworked, e.g. participants noted that male therapists could be experienced as similar to the mother. In fact, this was discussed as an important aspect of the therapy. Kyle (client) talked of having a male therapist who could sometimes be experienced as he had experienced his father, but *"I have also projected my mother onto him"*.

Thus, it appears that where questioning allows 'mental play' space and different ways of relating to the therapist, the client is exposed to a range of interactional experiences and possibilities to make meaning of. While some might argue that all identities are socially constructed this is frequently not the lived experience of individuals. People experience many identities as essential and given. While the participants did not explain it in this way, we can consider what these possibilities might be for the client to entertain and work through. *Is* the therapist the mother? (i.e. where the lived experience is that the therapist is the same as the mother?). Is the therapist *like* the mother or *like* the father? (i.e. where the experience of being with the therapist is similar to being with either mother or father?). These interactional possibilities may also pose questions as to how people can be experienced across identities and thus provide an effective challenge to the notion of essentialist identities, e.g. male therapist experienced as mother?

Where the therapy allows the client to consider and experience diverse relationships with the therapist, they may also gain insight and skill in developing new ways of relating. Grant (client) remembered feeling anxious that his female therapist *"might be like a parent, like my mother, flinging her hands up and saying 'how dreadful'"*. However, this was not the experience at all, as his therapist's response to his sexuality *"help[ed] affirm me and value me as an individual"*.

Figure 11 illustrates how participants felt that after a client recognises that these relationships are possible within the therapy and develops a relationship as a lesbian or gay man with the therapist's acceptance and respect, the client may then be able to consider this aspect of themselves further. This was seen to allow for the affirmation of the client by the therapist and by the client himself or herself.

Ewen (client) noted that his therapy *"made me a lot more open within myself"*, and indeed this may be the point of therapy as Oliver (client) said that he had gone into therapy expecting *"to feel a greater sense of ease with myself"*. Ullie agreed when he told of a number of therapeutic gains: *"Increased self awareness and self understanding. An ability to confront conflicts and dilemmas in my life – and to make decisions"*. Therapists in particular, noted that therapy assists in the client's self-relationship. Jack (therapist) would expect or hope for his clients to experience *"greater self acceptance, a ... freeing up of shame or distress, around sexual identity."*

As well as the affirmation of self, the other section of figure 11 illustrates that improved relationships with others were an outcome of the process. This was manifest in a number of ways. Adam (client) noted that he could *"come out with a stronger and better relationship having had a blazing row with someone ... that's something I've got from therapy"*. Ewen (client) felt that he was more assertive. He said, *"I'm not*

quite so quick to hold back on speaking my mind now, which I think is a good thing”.

Jack (therapist) not only considered improved relationships with others, he acknowledged the importance of improved relationships to those one has yet to meet.

Jack would hope that his lesbian or gay client would gain *“a greater acceptance of other gay men or lesbian women ... more of a kind of awareness of diversity rather than using the stereotyped images”*. It is to this outcome we now turn.

7.12 More positive view of lesbian and gay sexuality

The final outcome that participants described was related to the development of more positive views of lesbian and gay sexuality and is illustrated by figure 12.

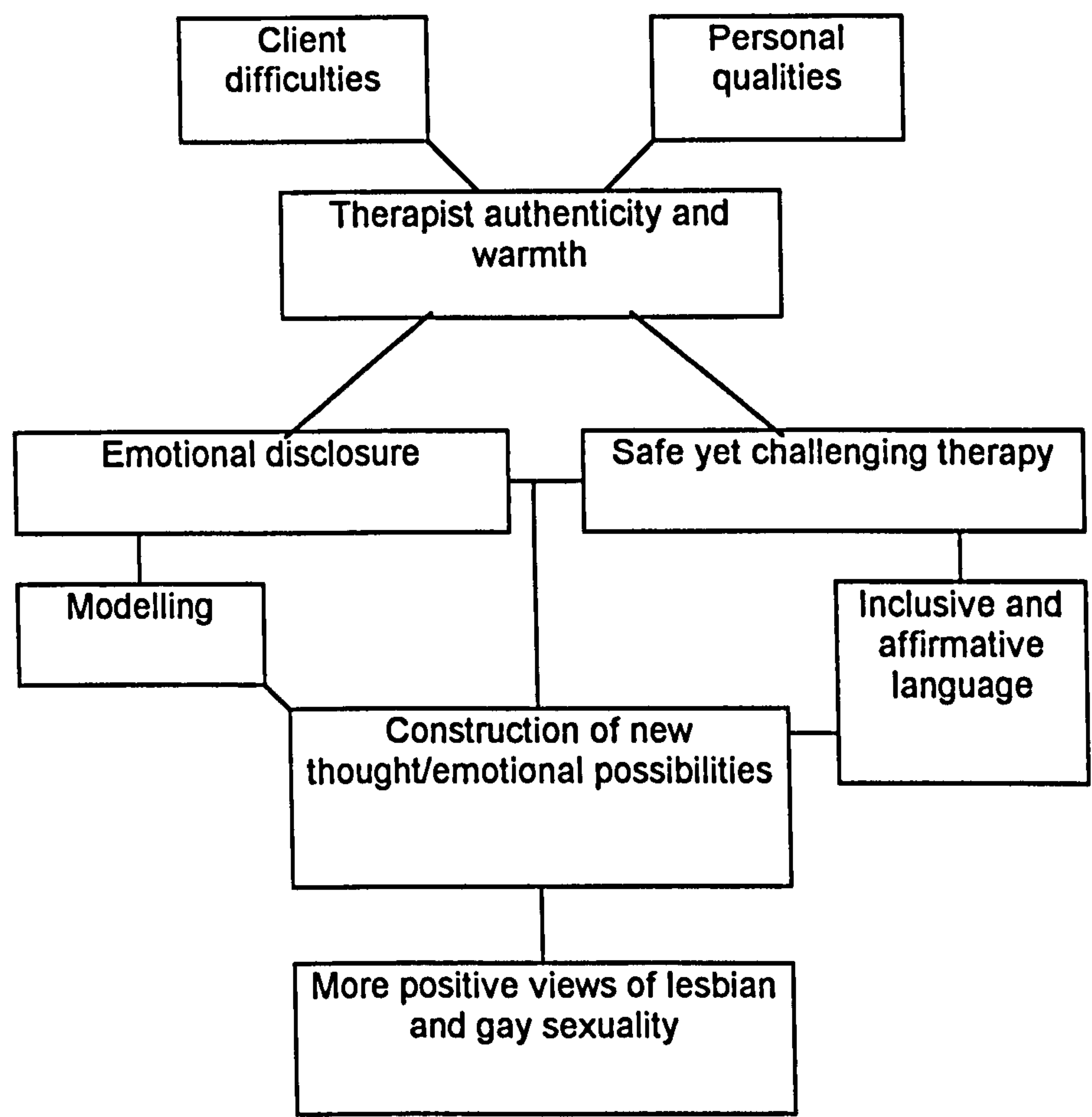


Fig 12: Processes involved in developing more positive views of lesbian and gay sexuality through the experience of affirmative therapy.

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As the participants related much of this process to issues that might generally be seen to be good practice, a dilemma existed as to whether it should be included in this report as a process related to lesbian and gay affirmative psychotherapy. In the end, it was decided to include it as the participants had noted that while good practice might be expected, with lesbians and gay clients it has not always been forthcoming. Therefore to assume that one can expect people to apply principles of good practice to lesbian and gay clients without elaboration may not be realistic.

Figure 12 illustrates that, as with many of the processes identified in this study, the clients' difficulties and therapists' characteristics are the crucial initial aspects that will influence the therapeutic process. What is particularly relevant in this section is the way in which these factors relate to each other in order to provide a therapeutic environment that is experienced as safe yet challenging. This is illustrated in figure 12 by the third section down.

Authenticity is a concept that was felt to be related to safety in therapy. As in Annesley and Coyle's (1995) research, participants felt that the ability to interact with lesbians and gay men in a warm and respectful way is not something that was taught on academic courses. Rather, it was seen as an aspect of the individual therapist crucial to a containing therapeutic environment. Tom (therapist) felt that *"the most important thing is being myself [] I am amazed at how challenging that is to people"*. Ross (therapist) agreed:

"If you aren't accepting, the therapy is going to be distorted, and you are going to be inauthentic in terms of working with gay and lesbian clients and their families".

Sacha (therapist) agreed and said, *"it's absolutely about being an authentic person"*.

It was not only therapists who addressed this aspect of the therapy. Mark (client) said *"I don't know where it comes from, either his experience, his personality or whatever, of really being able to be with me in my core"*. Another example is when Ewen (client) described his therapist as coming *"across as being a very warm person [] she would be quite easy to talk to"*.

Amongst these aspects the authenticity of the therapist is seen to be related to the degree of emotional disclosure that is possible. It is also seen to be a crucial factor that allows therapy to be experienced as a safe and challenging place. In turn, emotional disclosure is related to the safety and challenging nature of the therapy. Inter-relationships between these aspects are therefore evident. However, in order to describe the different aspects they will be addressed as if they are separate.

As previously mentioned, self-disclosure was seen both as a sign of the therapist's ability to relate to the client in an authentic manner and it was also seen to be related to making the therapy a safe and challenging experience. Jennifer (therapist) remembered that self-disclosure on her part led to a client saying *"'Oh, right, You've got an understanding of what it is like to be slightly outside the mainstream"*. This was influential in Jennifer's thinking and she felt that she would often be disclosing *"in order to lessen the power between us"*.

A number of participants considered other aspects of emotional disclosure. They noted that the considered *showing* of emotion could be a way in which the therapeutic relationship is nurtured. For example, Tom (psychoanalytic therapist) said that *"it's OK to cry sometimes"*. This is an example of the concept of 'giving back' emotion to the client in a manner that is safe but facilitates thinking. Patrick (a client) also

described occasions when a therapist not only felt emotion, but also found a way to express it. He said it was valuable that his therapist:

“was able to demonstrate annoyance with me, but annoyance that wasn’t crushing [i.e.] he could be congruent with me and it didn’t wreck me and it didn’t wreck the relationship”.

By the use of the term ‘demonstrate’, Patrick alerts us to the possibility that the therapist’s emotional availability may model possibilities for the client.

Moving to the right hand side of figure 12, participants noted that safety is important in therapy. Sometimes the difficulties a client brings to therapy are related to a lack of safety in their world after experiencing the results of living as a minority. Patrick (client) remembers coming to therapy *“feeling a [] bit of a freak because I was just such a randy bastard and sex was on my mind constantly”.*

It was also possible to consider the behaviours that participants felt were related to the development of safety in therapy. Greg felt that his therapist had been experienced as non-judgemental as he *“didn’t direct content on the whole and was generally non-judgemental”.* It is aspects of therapy such as these that were stressed by participants as being important to include in lesbian and gay affirmative psychotherapy, that are also seen generally to be aspects of good practice.

Returning to figure 12, participants felt that it was not only the safety of the therapy setting and relationship that was important, but also that it is important that therapy offers the client the chance to be challenged. Challenging was seen as more than a passive activity, e.g. not *“automatically or unintentionally imposing certain norms”* (Adam, client), but rather a more active stance which questioned the meanings associated with the client’s narrative. Tania (client) felt that her therapist had been able

to *“really push and to make you really explore your inner-most self”*. Zoe (client) linked this to lesbian and gay issues in particular when she said that *“people need a bit more of a push in being out”*. This ‘pushing’ can sometimes be difficult, as illustrated when Sam (client) described this experience as his therapist sticking *“the knife in a bit”*. Despite this discomfort, clients felt that this was important as *“she wasn’t just patting me on the head and saying ‘there, there never mind’, she actually pulled me up to confront the risk I’d taken”* (Sam). Nadia (client) agreed and described the challenging aspect of therapy as *“most useful”*.

It was not just clients who recognised the value of challenging in therapy. Ross (therapist) felt that it is important to challenge anti-lesbian and gay stereotypes. He said he would:

“challenge some of the assumptions they are making about gay and lesbian lifestyles, [] internalised homophobia in gay and lesbian clients as well”.

Hannah (therapist) described this ability to challenge as being related to a *“tendency to be quite naturally who I want to be ... fairly direct, not necessarily directive, quite open in some ways”*. This ability to challenge may have benefits in that it may facilitate a process that allows the client to recognise that views are open to rejection or development. In addition to this, participants suggested that the challenging therapist might act as a model for the clients to develop a stance that can challenge anti-lesbian and gay prejudice in other contexts.

Ross (therapist) talked of the manner in which he would challenge negative views of lesbian and gay sexuality. One way would be to *“normally very gently challenge assumptions that assume heterosexuality”* – whether these are his own, other members of the family therapy team or more importantly assumptions held by members of the

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family he was working with. Ross also gave specific examples of this in practice with adolescents. He said he:

“would never ask [] if they had a boyfriend or girlfriend, because it just rules out other possibilities. [I would ask] do they have a partner? Or do they have someone special they are seeing at the minute? I put it in a gender-neutral way”.

Thus challenging can be undertaken in a subtle way and Ross suggested that this allowed the client *“to understand that I was OK about the possibility that they might be gay or lesbian”*.

Another aspect of challenging was related to the exploration of the client's sexuality. In the context of this study we must consider how practices might challenge the prevailing negative views of lesbian and gay sexuality and identity. However, in addition to challenging sexuality and identity specifically, the process may also assist what is evident in some of the feminist and social constructionist literatures, and this is the need to challenge the idea that any identities are fixed and must be chosen once and for all (Alleyne, 1998; Burr, 1995; McNamee and Gergen, 1994). This approach was assisted by such questions as *“‘What is being gay like for you?’ or ‘How are you gay in this world?’ ‘In what worlds are you straight?’* (Liam, therapist).

The concepts discussed so far are related in such a way as to allow new thought/emotional possibilities to be developed. This in itself can be challenging with the challenge being an embodiment of new cognitive, emotional and behavioural possibilities within the therapeutic encounter.

Related to the creation of new meaning, were the participants' views that the therapist can model a different way of being and it was felt that one way of doing this was with

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the use of inclusive and affirmative language. Again, while modelling may be one of the more general aspects of therapeutic practice, it was seen as central to practising in a lesbian and gay affirmative manner (see also Annesley and Coyle, 1998). Tom (therapist) felt that:

“the most important thing I can do is to model something positive about being gay, that it is possible to be a gay man or a lesbian and be healthy and well and reasonably stable and secure”.

Zoe (client) felt that:

“she [my therapist] was a great role model, in that she [] had lots of qualities that I had been aspiring to, [] she was very [] aware of herself and her dealings with other people”.

However, the concept of modelling was not seen as unproblematic and participants did not suggest that the therapist should be the blueprint for the client's way of being. In fact Niamh (therapist) noted that *“I find the whole idea of role modelling completely dodgy. I think if you used your therapist as a role model you'd be dead in the water”.*

While challenging and modelling are both complex processes, with both facilitative and potentially restrictive possibilities, the participants argued that challenging and modelling allow consideration of the diversity of experience that exists within the identity of 'lesbian' or 'gay man'. This can allow confidence in the facing of, or developing a sense of one's uniqueness.

Participants suggested that there were ways that the therapist might create a focus that challenges sedimented viewpoints while allowing the therapy to remain safe, and this was through the use of inclusive and affirmative language. The use of such language

was seen as an effective way to challenge the notion that lesbian or gay identity is something foreign and allow the construction of new possibilities. Curt (client) felt *“affirmed with [] people when they sort of talk about ‘we’, not necessarily as in ‘we’ sexuality, but ‘we’ as in humanity”*.

Reflection on therapeutic practice suggests that it may be, that these actions invite the client to reconsider stereotypes and assumptions they hold about the nature of their own and other lesbian and gay identities. These may be views that are related to their individual difficulties or of societal stances to lesbian and gay sexual identities. This reconsideration may allow the construction of new possibilities.

The process outlined here (and illustrated in figure 12) completes a process where the client has experienced (both intellectually and interpersonally) a number of challenging factors and has been exposed to a number of competing views on sexual identity. By exploring the meanings of these views the client may be able to develop new meaningful and fulfilling understandings of themselves. Clients alluded to this in a number of ways. Kyle felt it led to *“a more positive attitude towards homosexuality”*. Oliver said *“I began to see my sexuality as an integral part of me, something to cherish and welcome – not to be ashamed or uncomfortable with”*. Ullie felt that it was a *“confirmation that being gay is good. Confirmation that being gay is natural and acceptable”*.

Therapists had also considered this. Brad (therapist) agreed with these views when he said that the therapist’s role is *“really to help all [] gay clients be more OK about being homosexual”*. Statements such as these are also related to the development of healthy self-esteem and diminished symptoms and therefore the three different outcomes that have been discussed may be linked through lesbian and gay affirmative

psychotherapy.

Up to this point, a number of findings have been presented that act as theories of particular processes. These theories identified a number of properties (or categories) that make up steps in the process and are evident, for instance, in the individual blocks that form the diagrams. These models are considered theory as they outline relations between these properties in a way that describes micro-processes within lesbian and gay affirmative psychotherapy.

The relationship between these models can now be considered and represented in an overall model (figure 13) which will act as theory at a higher conceptual level.

7.13 Lesbian and gay affirmative psychotherapy: A model

This section aims to build on the previous analysis by focussing on the mechanics of the overall picture of the findings. In doing so an overall model of the findings are presented and this contains a meta-theory of lesbian and gay affirmative therapy. Where processes previously elaborated are important the reader will be referred back to previous sections rather than repeat the information again.

The components have the status of a related component of the theory or possibly a bridge to eventual formal theory, i.e. “theory developed for a formal, or conceptual, area of [] inquiry” (Glaser and Strauss, 1967: 32). Even though, there has been an increase in the lesbian and gay affirmative therapy literature in recent years, *lesbian and gay affirmative therapy theory* is not yet well enough researched or defined to be seen as a formal theory.

Fig 13: Lesbian and Gay Affirmative Psychotherapy: A model

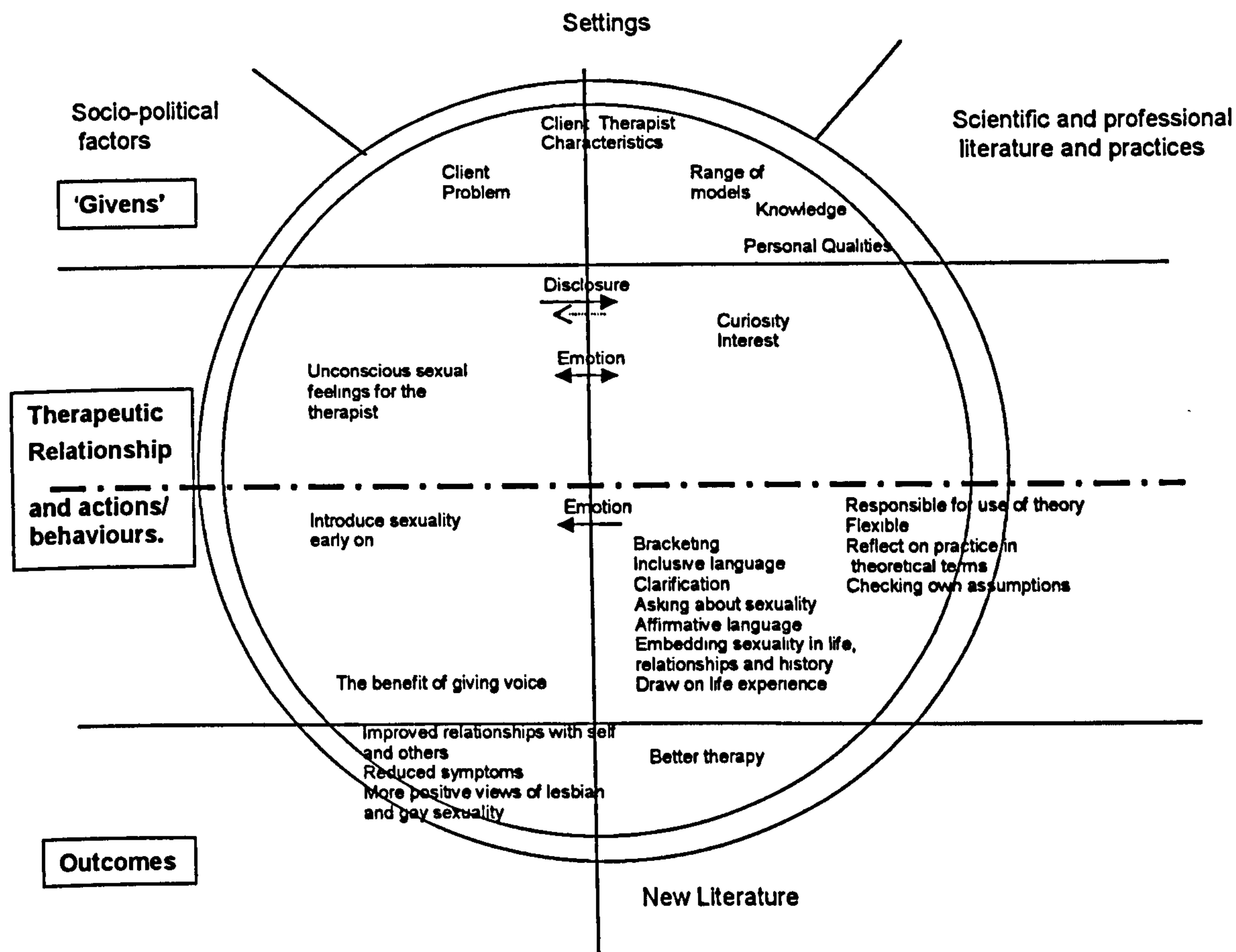


Figure 13 outlines a number of factors that participants identified as central to lesbian and gay affirmative psychotherapy practice. These factors are located both within the consulting room and in social and professional contexts. In figure 13, the factors located within the circle represent issues/factors within the therapeutic endeavour itself. The factors outside the circle relate to factors that influence but are located 'outside' of particular therapeutic encounters. In this model arrows indicate direction of movement and lines indicate association. These associations are discussed, based on participants' views that they are related in some fashion, but the data do not provide causal links. The dotted lines indicate weaker relationships or a lack of certainty regarding the nature of the relationship. The strength of these relationships reflects either the strength of the attribution in the data (e.g. participants suggested that some behaviour would impact on clients in a certain way) or the frequency with which the

link was made by participants.

Three foci run across figure 13. These are: the 'givens' of the consulting room, the type of relationship developed between therapist and client, (including the actions and behaviours undertaken in therapy) and the outcomes of therapy. The type of relationship and the actions taken are so closely linked that it is more accurate to conceive of them as different stances to the therapeutic relationship. Thus, the dotted lines highlight where participants suggested that the separation is permeable.

The vertical line that runs through figure 13 separates the factors into those that participants felt relate primarily to the client (on the left) and those that relate primarily to the therapist (on the right).

7.13.1 Given/contextual factors

It is evident from earlier sections that the participants felt that contextual factors are crucially important for the practitioner who aims to work in a lesbian and gay affirmative fashion. This view also mirrors a great deal of contemporary writing in psychotherapy (Cohn, 1989; Safran, 1990a, 1990b; Samuels, 1993a; Stolorow et al., 1994). The particular 'given' factors that were seen as important by the participants in this study can be located both within the therapeutic encounter and in the wider socio-political domain and were of particular relevance as they shape the possibility of the therapy being lesbian and gay affirmative.

Several contextual factors are elaborated here to complement earlier discussions.

Particular attention was given to such contextual factors as age, gender and sexual identity in the consulting room and participants suggested that it is important to understand the client as an individual in relation to these factors.

7.13.1a Gender

The participants in this study saw gender as a complex factor. To recap, for some, the gender of the therapist was thought to be irrelevant in therapy as when Jack (therapist) said *"It doesn't matter"*. For others it was a particularly important aspect. A client, Kyle said *"I think gender is a big one, for me anyway"*. Where gender is experienced as important, it is experienced as crucial to the manner in which a therapist is chosen and it influences the issues that can be worked on. This is because male therapists and female therapists were seen in different ways, which sometimes mirrored the ways each gender is seen in everyday social interactions (Alleyne, 1998; Burman et al., 1998; Frosh, 1994; Herek, 1993; Trevithick, 1998).

Participants identified the types of views they might hold regarding gender and it is possible to recognise the effects that this might have on the therapy. Grant (client) felt that men were *"sometimes a bit harder and ah, brittle, um and less allowing of human frailty perhaps"*. Alternatively male therapists were seen as being better able to withstand some of the material that the client might bring to therapy. In this regard Grant said *"I felt I could perhaps talk a bit more openly with a man, and uh, talk about my homosexuality more to a man, than I could to [a female therapist]"*.

Women therapists were seen in terms of stereotypically feminine qualities to some degree, as when Sam (client) noted that he had *"wanted some sort of mothering in a way, some supporting"* and felt that an absence of sexual tension was an aspect of this. He said *"I find it very easy to talk to women [] the lack of sexual threat [] and the*

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older sister bit'. Thus, current views and experiences of gender affected both the therapeutic relationship and the anticipation of acceptance or criticism of the client's sexual identity.

7.13.1b Race

Race was discussed by some of the participants and was seen as another issue that influences the client-therapist dyad and may be an area where a therapist's lack of competence is evident. When reflecting on a difficult therapeutic experience a client, Alec, felt that as an Indian gay man *"many of my personal issues revolved around the issue of fitting in with my family and relatives"*. He felt that the difficulties in therapy may have been complicated as *"there may have been specific cultural difficulties"* with his therapist. His therapist was not Indian.

Participants noted a parallel between the experience of race and lesbian or gay sexual identity. Like sexuality, participants felt it is important that race is not overemphasised or seen as the 'cause' of the client's difficulties. Jennifer (therapist) used a poem she had read to illustrate the parallel. She said it was *"written by a black woman to a white woman [] which says 'first of all never forget I am black. And second of all always forget I am black'"*.

Participants are therefore suggesting those contextual factors such as race and gender influence the understandings available to the therapist and the client.

7.13.1c Sexual identities

Sexual identities have been discussed earlier (section 7.3) and are mentioned here to note their role in lesbian and gay affirmative psychotherapy.

7.13.1d Impact of the setting

As discussed in section 7.10, the physical setting and the practices associated with the organisation often have an impact on the clients' initial experience of therapy. Some participants felt that the settings were sometimes able to encourage an open expression of sexuality issues. Zoe (client) noted how a student counselling service had managed this. She said that having sexuality issues on the therapy centre's intake form as *"something you could tick [] was quite nice and easy to do it that way"*. Other participants noted that the setting could limit the degree to which practitioners might work in a lesbian and gay affirmative manner by censoring an acceptance and open discussion of lesbian and gay experience. Ross (a therapist) noted:

"I would have been heavily censured by the organisation I was working in because [] I would have been seen as encouraging his [adolescent male's] homosexuality, which would not have been acceptable within that organisation".

Aspects of the setting were therefore felt to encourage or limit the degree to which the client and therapist can engage in lesbian or gay affirmative therapy.

7.13.1e Scientific and professional contexts

It is not just the setting that was seen to affect the practice of therapy. Participants also noted that the scientific and professional literature is an aspect 'external' to therapeutic relationships that is influential in developing practitioners and has an impact on the degree to which they are able to be lesbian and gay affirmative, hence its position in figure 13. Participants noted that this impact is due to the influence of the literature on training, supervision and particular models of practice.

Many participants suggested strongly that training was generally lacking in relation to lesbian and gay clients. Participants felt it is lacking in appropriate theory and skills and in that respect participants drew a parallel between therapeutic professions and social stances towards lesbian and gay sexuality.

When considering this lack, Dean felt that while *“sex has always been there [] it’s always been underground”*. This means it is difficult to talk openly about sexual issues. This view is supported by the need, some therapists have felt, to publish on lesbian and gay issues while using a pseudonym (Cunningham, 1993).

The participants noted that the professional literature is characterised either by an absence of or limited and stagnant views of lesbian and gay experience, development and therapeutic practice. Hannah, a counselling psychologist said:

“I don’t find that counselling provides much diversity in the knowledge that’s presented about lesbian and gay theory ... I find it quite boring actually. I find it quite tedious [] saying the same thing over and over again”.

Hannah continued by contrasting the psychological and sociological literatures on lesbian and gay experience. Whereas Hannah felt that the psychological literature had limited use, she felt that lesbian and gay affirmative practice could be strengthened by attention to the sociological literature. She felt that turning to sociological literature was useful as:

“looking at lesbian and gay sexuality from a sociological framework, [] provides me with a useful resource of information that I don’t find I can get in touch with via counselling books and courses, or counsellors [] It’s completely different, it’s like suddenly going from black and white to colour”.

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Jack (therapist) also detailed how little these issues had been addressed in his clinical psychology training when he noted that the total coverage of lesbian and gay issues occurred *“in part of the two or three days on HIV, there is [] an hour’s lecture on homosexuality”*. In this example, Jack also highlights the medicalised context within which lesbian and gay sexuality was presented in his training.

In these illustrations the importance of contextual knowledge is quite clear. It is seen as a factor that can facilitate lesbian and gay affirmative therapy by allowing the client to recognise that the therapist is aware of the issues and phenomena they bring to therapy.

7.13.1f Client and therapist characteristics.

Again these are issues that are clearly located in a model of lesbian and gay affirmative psychotherapy and were discussed at length in sections 7.2 and 7.8.

7.13.1g Theoretical models

Related to the ‘external’ aspect of scientific literature is the manner in which the therapist takes the literature into the consulting room. This can be problematic if it is incorporated into practice in the form of theory led practice. Participants viewed theoretical models as being of great importance. Rather than viewing any particular model as intrinsically useful to lesbian and gay affirmative practice, the participants felt that the stance taken to knowledge and theory is noteworthy, and this stance is the responsibility of the therapist. An earlier section (7.6) presented the data on theoretical models.

7.13.1h Knowledge

Knowledge was attended to in great detail in the data and was elaborated in earlier

sections of this chapter (sections 7.4, 7.5 and 7.6).

7.13.1i Personal qualities

The final aspect of the first section of figure 13 is that of the personal qualities of the therapist. The participants felt that the personal qualities of the therapist are central to the provision of lesbian and gay affirmative therapy. A number of strategies were identified as ways in which these qualities can be conveyed to, or experienced by the client. Overall the participants felt the qualities are those that are necessary in any human relationship and these are frequently mentioned in the literature, e.g. qualities such as warmth, authenticity, openness, a degree of objectivity and respect (see sections 7.2, 7.3 and 7.8).

To take the previous analysis further, some of the participants appeared to suggest that it is particularly important for the therapist to be willing to talk about sexuality and this is related to issues of transference and countertransference that were discussed earlier (section 7.8). Ewen was happy that his therapist *“was quite open and ready to talk about my sexuality”*. Tom (therapist) felt it was important to be *“open [to] talking about sex and sexuality, that itself kind of gives people permission and says these things are OK”*. Oliver (a client) valued *“that it was genuinely OK to talk about my sexuality”*.

This is at odds with much of lesbian and gay experience in heterosexual society where discussions of sex and same-sex sexual experiences in particular are often socially prohibited. Tom reflected on his practice and noted that in spite of that, talking about sex is not particularly difficult. He gave an example *“[the question] ‘when did you start to masturbate?’ [is] quite easy to ask and not difficult for [] people to answer”*.

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Therapists can convey personal qualities through the type of interventions they make. This is an important area that links the first two sections of the model together by facilitating the relationship between therapist and client. Chris felt that his therapist conveyed these qualities in a number of ways:

“by pointing out to me things I may not have picked up on, by being quite thorough in that, by giving me his [] opinion, [], by questioning my view of things, predominantly by questioning my view of things”.

Participants suggested that it is important that therapeutic interventions remain within an effective human relationship. Sacha (therapist) noted that *“it’s implied, you don’t put it across, it’s about who you are as a person, the life experience”*. Tom agreed and felt that *“the way you welcome somebody [] is absolutely paramount”*. These illustrations lead us to a consideration of the next section of figure 13, the therapeutic relationship.

7.13.2 Therapeutic relationship

As indicated by the lines that separate the first and second sections of figure 13, the therapeutic relationship is related to the ‘givens’ just discussed. The participants discussed the therapeutic relationship frequently and with enthusiasm. In doing this, the participants parallel some of the traditional and contemporary literature that views the relationship between the therapist and the client as central to the practice of psychotherapy (Clarkson, 1995; Gelso and Carter, 1985; Safran, 1990a, 1990b; Spinelli, 1994; Stolorow et al., 1994; Winnicott, 1977).

One area that was outlined in earlier sections was that of therapist disclosure. Disclosure is included in figure 13 with a solid arrow from the left to the right. This

indicates that it is crucial to therapy that the client is able to disclose material to the therapist. Disclosure is also drawn with a dotted line from the right to the left. This indicates that the participants had some ideas about therapist disclosure being useful to the client. However, the data did not indicate this relationship with the same degree of certainty.

7.13.2a Emotion

Another aspect that is important in lesbian and gay affirmative psychotherapy is the recognition of it as an emotional process. The locating of 'emotion' on the vertical line between the two sections indicates that the participants felt that both participants in the therapy would experience the process as emotional. Adam (client) illustrated the power of this emotion when he felt that he *"would almost go mad with the intensity of it [the emotion]"*. Zoe (client) referred to other feelings noting that *"it makes you feel very vulnerable at first"* and Tania addressed 'fear'. She said *"I was very frightened about going into therapy [] I was also very frightened about crying in therapy"*.

Therapists described how they experience their work in emotional ways. Ben noted that *"it's terrifying to be dealing with gay men's issues straight and full on"*. He also noted other emotions such as feeling *"pissed off [] at times"*. Tom felt that more than just experiencing emotion, it was also permissible to allow the client to have access to his feelings, e.g. he felt that *"it's OK to cry sometimes [] not in an overly dramatic way; I allow my feelings to inform me about what's happening"*.

More than just informing the therapist, participants noted that it is important that the therapist is able to give emotion back safely. By doing this, the client develop an awareness that the other has been affected. Adam (client) valued it when his therapist had said *"Oh, I really feel for you"* and he noted that *"she kind of emotes and has*

emotional experiences sometimes on a par”.

7.13.2b Interest and curiosity

An aspect that participants frequently mentioned as characterising the therapeutic relationship was that of the therapists’ interest and curiosity in the client. As this is generally considered an important aspect of good practice in therapy (Rogers, 1951), to mention it as relevant will suffice here.

7.13.2c Sexual feelings.

Several of the client participants suggested that clients desire to know about their therapists and indicated that this is likely have a role in establishing effective therapeutic relationships. These participants suggested that this desire might include sexual interest in the therapist. Greg talked of this at length, suggesting that *“there has to be some kind of sexual interest from the client towards the therapist [] you have to find your therapist physically attractive”*. Such attraction was not seen as dependent on the sexual identity of the therapist, as Greg’s Jungian analyst had been a heterosexual man. Adam recounted that, whether or not this needed to happen, it had also been an aspect of his therapy with a heterosexual woman. He put it that:

“the groin stuff came with it [] I did also feel very sexually attracted towards her, but it was much more, ... it wasn’t just like ‘phwoah, I fancy you’, it was ‘WOOMMPPHH’ Good grief”.

This may of course be particularly important when the work of the therapy is to consider the client’s experience of themselves as sexual beings. Greg felt that:

“contact [] has to be at a very sexual level, [] there’s the possibility of something to come, that you want, and if your therapist is good enough, then he

or she will be safe with that too, and will allow you to fulfil that initial desire and expand it. Not necessarily fulfil it in sexual terms, but change it [the sexual feelings], and let it [the sexual feelings] create what it wishes of itself within the relationship”.

While these feelings are seen as an important facilitating aspect of therapy, the accounts provided by the research participants also acknowledged that sexual feelings in therapy, or even the potential thereof, can create anxiety in the therapy – both for clients and for therapists. Some participants who spoke as male clients voiced particular concerns about entering therapy with gay male therapists because of this possibility. Ewen described how he had decided against seeing a gay male therapist: *“Obviously he was the same gender as me, and the same sexual orientation and it would almost be ... as if it would be too near the knuckle”*. Adam had experienced a similar process when he had decided to enter therapy. He said that if his therapist *“was a gay man he’d be throwing me off my transference as my dad’s not gay, .. as he’s straight”*. Ewen and Adam also illustrate the manner in which clients may consider their needs prior to engaging in therapy.

Participants also noted that sexual feelings are not always directly *experienced* between therapist and client but are discussed more generally. Patrick (client) described how, in order to ‘normalise’ his passionate sexual activity, his therapist had disclosed:

“having sex with his wife all weekend when they first met [] and it was a bit of an unthreatening fantasy, because if he had told me that he was gay himself and spent the entire weekend shagging his boyfriend [] when he first met him, that might have been a bit too, that might have freaked me out a bit”.

An interesting factor related to this is how gay male therapists described their supervisors as being anxious. A participant attributed this anxiety to sexualised views of gay men and an anxiety that the gay male therapist might act out sexually with his clients. Ben (therapist) noted the effect of this and said in his work setting he *“had to really fight for issues to do with my sexuality not becoming pathologised”*. He felt that he *“was being told by more experienced therapists ... that I [had] to look at myself quite carefully”*. One way in which this would manifest itself was that any mention of his sexuality would be *“seen as me working through my own issues”* rather than a straightforward recognition of the issues in the first place.

So far we have explored the first two sections of figure 13. These have acknowledged the relationship between the ‘given’ factors and some of the qualities of the therapeutic relationship. The inter-relationship of these two areas is often related to the explicit, observable behaviours that are viewed as beneficial skills in lesbian and gay affirmative psychotherapy. It is to these observable behaviours that we now turn our attention.

7.13.3 Action/Behaviours

The broken line in figure 13 that separates ‘Therapeutic Relationship’ and ‘Actions/Behaviours’ indicates that in many ways these actions remain aspects of the relationship. The fact that they are observable means that they can be separated and discussed. The earlier sections of this chapter have already outlined and explored a number of behaviours, such as self-disclosure. This section outlines other behaviours that participants suggested would be experienced as affirmative when incorporated into practice. They are often actions that may be undertaken in a variety of different ways and therefore allow the individual practitioner scope to consider how best to interact with each individual client and to integrate this into different theoretical models.

7.13.3a. Naming sexuality

Participants noted that lesbian and gay affirmative therapy is characterised by the early naming of the client's sexuality. This can be initially voiced, either by the client or by the therapist. Participants felt that clients will often ensure that sexuality is mentioned at an early stage. Ewen (client) *"raised it in one of the initial sessions"* and Greg (client) said he raised it *"right from the very beginning, the very first time I ever saw him, I said I needed to talk about it"*.

Participants also considered the manner in which the client informs the therapist of their sexuality. Ullie raised it *"in assessment. In terms of difficulties I was experiencing with my gay partner"*. Kyle also mentioned partners as the context wherein sexuality is often raised. He raises it:

"when I'm having problems with dealing with certain aspects of my sexuality, or there's been relationship issues, or there's been something around ... finding someone else attractive, or even him [my therapist] attractive".

He suggested he would begin the conversation *"with something like 'I met this really nice bloke over the weekend...'"*.

As mentioned therapists recognise that sexuality is important to the client. Some of the therapist participants felt that sexuality could generally be left to the client to raise. The therapist Tony, said *"I think it is up to the client to raise them [sexuality issues] and they always do [] I have no special, pre-arranged way of dealing with them [sexuality issues]"*. Other therapists had different views. Some felt that at times it might be important for therapists to search actively for information about sexual identity. Several therapists commented on this and Liam provided an example of how he might do this. He described asking a client: *"so tell me [], when you go to the gym,*

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do you notice that you find some of the people, the men or the women, interesting and sexually attractive?”. He felt that this allowed space for a variety of possible identities to be discussed. Jack agreed that he would also seek information on the client’s sexual identity. Not to do so would be a form of not attending to lesbian and gay sexuality and it might be that this could be seen as colluding with the silencing of lesbian and gay sexuality. Jack said *“you kind of see so much ‘gay neutral’ therapy, that I practice ... to actually try and kind of ... suggest it [] search for what the impact might be”*.

Participants also provided accounts of how sexuality was broached later on in a therapy that was already established. In these circumstances clients seemed to value the fact that the therapist, independently of the client, might link the sexuality to the material presented. Ewen valued his therapist as after hearing of his family’s reactions to himself and his married sibling, independently of him *“she would just sometimes say things along the lines of ‘Do you think your parents were disappointed about your sexual orientation?’”*

Greg, a client in long term analytic therapy, noted that the relationship was a collaborative one and that *“it’s open between the two of us, sometimes he will [] bring it up as much as I will”*. Sacha agreed and suggested that the role of the therapist is to *“make it explicit that [] their sexuality, like everything else is [] on the table for discussion”*.

Having stated the importance of voicing sexual identity, it is important to consider the function that this might play. In earlier sections we have seen how the voicing of sexual identity is an aspect of the therapy which allows the exploration of sexuality and the development of a range of possible meanings and identities.

7.13.3b. Inclusive and affirmative language

Language is particularly important as language both reflects and constructs experience (Billington et al., 1998; Heaton, 1997; Parker, 1998). While participants felt that it is difficult to describe what should be said, they noted that it is easier to recognise that the language used needs to be inclusive and affirmative. This was discussed earlier in section 7.3.

There are a number of other factors that participants felt were related to the process of lesbian and gay affirmative psychotherapy. Two examples of these are the need for therapists to reflect on their work in theoretical terms (see the section on knowledge and theory); and the ability to draw on the therapist's own life experiences (see section on disclosure).

7.13.4 Outcomes

The fourth section of figure 13 is where the processes related to outcome (see sections 7.10, 7.11 and 7.12) are located in the overall model. In the literature positive outcome has long been attributed to a range of factors such as therapeutic relationship (Beutler et al., 1986; Gelso and Carter, 1985) and factors such as the matching of ethnicity (Moodley and Dhingra, 1998) and sexual identity (Kaufman et al., 1997; Liddle, 1996). In line with this, some of the participants suggested that positive outcome in lesbian and gay affirmative therapy would be similar to positive outcomes in any good therapy. Ben (therapist) said *"I don't think there are any different outcomes"*. Despite this, we have seen that one outcome was identified as important for lesbian and gay clients in particular. This was the development of more positive views of lesbian and gay sexuality.

Two other aspects are included in this model but can only be briefly mentioned. Participants addressed these issues and suggested something quite interesting, yet the data only addresses these issues in limited detail. Therefore no strong, causal hypotheses can be developed at this point.

The first aspect is located with the 'therapist's' arena and this was thought to be that when therapists experience lesbian and gay affirmative therapy themselves they might be better able to provide lesbian and gay affirmative therapy to their clients. The second further implication is related to this, but is located outside of the actual practice of therapy. Two of the participants felt that a result of lesbian and gay affirmative therapy might be the development of an improved psychotherapeutic literature on the issues involved in working with lesbians and gay men.

The model represented by figure 13 therefore acts as a template for lesbian and gay affirmative psychotherapy. At this point we will turn to a brief reminder of the findings.

7.14 In Brief: The Main Findings.

- When the client has a choice in who their therapist is they feel more at ease with the therapist and this may play a part in establishing a good therapeutic alliance. Choice may be based on sexual identity, gender or other factors that have meaning for the client.
- Therapists need not necessarily identify as lesbian or gay in order to provide lesbian and gay affirmative therapy. What is of prime importance is that the therapist is knowledgeable about a diverse range of lesbian and gay experiences and able to relate to the client's particular experience, including knowledge about forms of relationship, the meaning of sexual identities in different contexts and sexual behaviours.

- Many psychotherapeutic theories may be amenable to lesbian and gay affirmative practice. The findings suggest that the practitioner's stance to theory is especially pertinent - the more able they are to be open to a variety of interpretations (in theory and the clients specific meanings) the more likely it is that they will offer therapeutic assistance to clients.
- Lesbian and gay affirmative practice is assisted by the therapist's ability to attend to their own responses to same sex sexuality (often termed 'countertransference' by participants) – both by recognising their difficulties and an ability to work on these issues. Reflective practice is central to lesbian and gay affirmative therapy.
- The findings suggest that a lesbian and gay affirmative therapy is important in working with many presenting problems, not just issues clearly related to sexual identity, and may result in a broad range of therapeutic gains. It assists therapists in reducing overt symptomatology, improving relationships with the self and with others and helping clients develop a more positive view of lesbian and gay sexuality.

8. Overview

This study presents useful local theory of lesbian and gay affirmative psychotherapy. Section 8 considers the strengths and limitations of the study and the resultant models as well as considering the relationship between the findings and the existing literature. The section concludes with recommendations drawn from the study.

8.1 Limitations of the study.

An interesting issue relates to the previous discussion of the role of the therapist's sexual identity and the impact that this might have on the therapy. Despite attempts to engage the full gamut of practitioners, the sample of therapists did not include any heterosexual male therapists (see table 1) who felt that their work is lesbian and gay affirmative.

This absence of heterosexual male therapists was not intentional. In the recruitment process calls for participants were placed where a range of therapists would see them. This was effective to some degree as a number of heterosexual women offered to participate in the research and their contribution has been very useful. Therefore the calls for participants were not poorly placed. At the current time, it is only possible to speculate about the meaning of the absence in relation to this study.

One possible explanation is that heterosexual male therapists either do not identify as lesbian and gay affirmative practitioners or they selected themselves out of this study for some reason. It may be that research by others can shed some light on this question. Research on male counsellors and gay and HIV infected clients (Hayes and Gelso, 1993) and Lewes' review of psychoanalytic stances to homosexuality noted the "remarkable ambivalence most people, especially men, feel for the very idea of homosexuality" (1995:1). This may provide some evidence that heterosexual men in particular find gay male sexuality difficult to engage with. It has also been suggested that an oppositional stance to gay male sexuality is functional - it both preserves the hetero-patriarchal position of heterosexual men in society and provides security to individual heterosexual men by providing clear examples of what masculine identity is deemed not to be (Herek, 1993; Ryan, 1999). If this is the case (and without empirical

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evidence, it is only possible to speculate) then it may not be surprising (although it is a matter of concern) that heterosexual male therapists did not volunteer their time to this study.

A second possibility is that lesbian and gay affirmative therapy may be conceptualised as being an overtly political activity - or at least politically aware. The presence of lesbian and gay male therapists and heterosexual female therapists may indicate that therapists who themselves experience oppression of some kind (for example, on the basis of sexual identity and/or gender) are open to more political formulations of therapy than those who are less likely to have experienced oppression. If this is the case then heterosexual male therapists may embody political dominance (at least in terms of sexual identity) and may be unable to relate to the experience of oppression – or to relate their own experiences of oppression to that of lesbians and gay men. Alternatively it may not be in their interests to relate to this experience as to do so may challenge the maintenance of hetero-patriarchal privilege (Herek, 1993; Ryan, 1999). This is an issue that Ward (1997) raises in relation to racial identity in therapeutic professions. The implications for cross cultural therapy are that where the therapist is unable to recognise or accept the reality of racism they may not be able to affirm the person experiencing oppression nor formulate the difficulties in a contextually sensitive manner.

To attend to the absence of heterosexual male therapists, snowballing had been considered as a way to facilitate theoretical sampling. This was difficult in two ways. The first difficulty was related to ethical considerations in contacting therapists after having heard about them from their clients, when these therapists were already likely to have heard about and declined to select themselves into the study. They would have

seen calls for participants from the original notices that were placed in the journals of all of the professional bodies.

The second difficulty was the pressure of time in that this research was undertaken for the purposes of an academic degree and thus there was pressure to complete the research by a certain deadline. As many of the clients' therapists had been consulted a number of years ago, it may have taken considerable time to track down the therapists. It was therefore decided not to engage in further recruitment at this time.

8.2. Strengths of the sample.

While the absence of heterosexual male therapists is a limitation of this study, it is not catastrophic, as this study is an initial expedition into investigating lesbian and gay affirmative therapy and the breadth of participants (see demographic data) provided very useful accounts. A wide range of therapists did participate and clients provided accounts of experiences with a range of therapists (including heterosexual male therapists). The sample led to a number of interesting findings being generated and the questions raised by this absence can be explored in further work. By highlighting this absence this study can guide theoretical sampling for future research on the same or related topics. The conclusions from this study are therefore open to development when this population is further investigated. In addition to this, the findings are useful in their own right. The findings are in the form of a rich local theory that accounts for a wide range of behaviours in the practice of psychotherapy.

8.3. Relationship to existing literature.

Much of the literature has argued that lesbian and gay affirmative therapy must attend to a number of dimensions (Annesley and Coyle, 1998; D'Augelli, 1994; Davies and

Neal, 1996; DiPlacido, 1998; Garnets et al., 1991; Greene, 1994; McFarlane, 1998; Milton, 1998). In this way this study supports some of the existing literature and provides clarity on which dimensions are important and how they influence the process of lesbian and gay affirmative psychotherapy. In particular the links that are evident with the cross cultural and feminist therapy literature are noteworthy. It maybe that consideration of these findings in relationship to these two bodies of knowledge may allow formal theory to be developed.

A number of findings are supported by the literature. These include:

- the use of inclusive and affirmative language (Odets, 1995; Ratigan, 1995; Rochlin, 1985; Tasker and McCann, 1999; Wolf, 1997),
- the need to view lesbian and gay sexuality as normal, natural and healthy as any other sexual identity (American Psychological Association, 1991; Bayer, 1981; Cohn, 1997; Cunningham, 1993; Davies, 1996a; du Plock, 1997; Hitchings, 1994; 1997; Spinelli, 1997),
- and the danger of imposing meanings onto a clients experience (Ellis, 1997; Cohn, 1997; du Plock, 1997; Malley and Tasker, 1999; Milton, 1998; Spinelli, 1997; Wolf, 1997).

As well as therapeutic practice, the literature addresses related phenomena such as training (Crouan, 1996; Samuels, 1993b; Wheeler and Izzard, 1997) and supervision (Hitchings, 1999; Milton and Ashley, 1998). Again the findings support and develop some of this literature. For example, the findings about intellectual knowledge highlight how important it is for trainings and supervisors to attend to the personal characteristics of the therapist, their values and attitudes – particular their attitudes to those who are constructed as different. Indeed, it has been argued that therapists have

a responsibility to extend accepting and affirmative behaviours beyond their professional lives into their personal lives (Atkinson and Hackett, 1997) – this has implications for methods of training.

The development and dissemination of useful models has an ethical dimension to it. Both the American Psychological Association and the British Psychological Society have codes of ethics that state that therapists should not work beyond their limits of competence (American Psychological Association, 1992; British Psychological Society, 1991). Thus, when faced with this situation the guidelines indicate that ‘psychologists obtain the training needed’ (American Psychological Association, 1992; 1601). This is problematic as much psychological training is based on research that did not attend to lesbian and gay experience or drew on samples that were not representative of non-clinical populations. This dilemma will be assisted by the dissemination and discussion of this study.

One major difference between this study and much of the existing literature is that the findings are able to offer a model of lesbian and gay affirmative therapy that is grounded in the experiences of both therapists and clients. Thus, the model is able to challenge and extend many of the opinion based views that have been used in therapeutic training and practice.

Due to the method taken, the results have links to the existing literature as well as being able to present a number of new insights into the nature of lesbian and gay affirmative therapy. These include; an exploration of the degree to which the therapist’s sexual identity may legitimately be a central issue in the development of a working alliance with lesbian and gay clients. The findings also consider the ways in

which consideration of sexual identity can assist therapy, e.g. by being a topic that is discussed early on in therapy.

On a different level, the model demonstrates the importance of being able to consider one's clients, their experiences and the therapeutic process from a number of conceptual levels. In this way the findings are not only useful to lesbian and gay affirmative psychotherapy, but also to the current interest in the integration of models of therapeutic practice (Bergin and Garfield, 1994; Clarkson, 1997; Samuels, 1997).

As well as highlighting the importance of this ability of think broadly and independently, the model provides insight as to how therapists use a strategy of selection and how this can facilitate broad conceptualisation. The findings suggest that a therapist who is able to draw on a range of knowledge (theoretical and personal) is more likely to be effective as a lesbian and gay affirmative therapist than one who positions themselves within one model only. It may be that by focusing on a number of models the therapist can critically examine their theoretical base and select what is useful to particular clients and renounce what is unhelpful. The strategy of selection is especially important for lesbian and gay affirmative therapists as it allows for alternative, non-stereotypical, pathologising meanings to be considered and generated and where relevant, privileged.

8.4. Recommendations.

As well as providing a local theory of lesbian and gay affirmative psychotherapy, the study allows a number of recommendations to be made with regard to research, training, personal development and professional standards.

8.4.1. Research

While this study has produced some useful findings, the difficulties that psychology and psychotherapy continue to have with understanding and relating to diverse sexual identities must not be ignored. One recommendation is therefore, that further research be undertaken in lesbian and gay psychology broadly. Some useful research studies might include:

- an exploration of psychologists and psychotherapists views on lesbian and gay sexuality and how they account for the views they hold.
- the impact of homophobia (overt and covert) on psychological symptomatology, formulation and therapeutic practice.
- the adaptation of existing models of practice in light of lesbian and gay affirmative training,
- the exploration of particular factors that facilitate the working alliance between lesbian and gay client and effective affirmative practitioners.

A variety of different research methods will be useful in exploring these issues further.

As participants indicated that useful literature and training had been difficult to access, another recommendation is that research not only be undertaken but be disseminated in easily available forms and made available to as wide a field of therapeutic practitioners as is possible. For journals this will mean the need to review their history of publication of lesbian and gay psychology topics, and it will also require the gatekeepers of psychological journals to be open to papers on diverse topics and the use of diverse methodologies.

8.4.2. Training.

Related to the question of research is that of training. While it was not the central question of the study, in common with other studies (Annesley and Coyle, 1995; Buhrke and Douce, 1991; Coyle et al., 1998; forthcoming; Crouan, 1996; Garnets et al., 1991; Moon, 1994) therapist participants identified limitations in the training that they had received regarding lesbian and gay issues in psychotherapy. The prevalence of this experience is difficult to assess thoroughly as so little research has been undertaken to establish the degree to which lesbian and gay issues are covered in therapeutic training (Iasanza, 1989). However, these concerns are mentioned in the literature (Atkinson and Hackett, 1997) and in relation to training in the wider area of multicultural competence (Palmer and Laungani, 1999).

This model goes some way towards providing substantive theory for discussion with those training to be therapists or for the continuing professional development of qualified practitioners. As the findings highlight the role of knowledge and context in the provision of lesbian and gay affirmative psychotherapy, the training of therapists would usefully include exposure to lesbian and gay topics throughout training – in generic academic modules (such as lifespan development) as well as in specialist modules, in clinical practice, supervision and in personal development groups.

It has been argued that training can also be assisted by:

‘(1) a faculty sensitive to diversity issues, (2) a curriculum that is designed to train counselors to work with special populations; and (3) students who are receptive to training in the area of non-ethnic minorities’ (Atkinson and Hackett, 1997; 374).

Thus lesbian and gay issues should be considered throughout training – at the levels of selection, staffing and teaching (Crouan, 1996; Samuels, 1993b). Different models are used in delivering this training (Atkinson and Hackett, 1997; Palmer and Laungani, 1999). Atkinson and Hackett (1997) suggest three models, the separate course approach, the concentration model or the interdisciplinary and integrated model. This study could usefully be used by trainers in any of these approaches.

8.4.3. Personal qualities.

In common with much of the literature (Annesley and Coyle, 1995; Crouan, 1996; Davies, 1996b; Hayes and Gelso, 1993; Kwawer, 1980; Leitman, 1995; Milton, 1998; Milton and Coyle, 1998; Ryan, 1998; Samuels, 1993a, 1993b) the findings of this study identify the personal characteristics of the therapist (and the way they influence countertransference processes), as being of particular importance in providing lesbian and gay affirmative psychotherapy. Thus, it has been argued that training should include ‘experiences designed to confront students with their own biases and to sensitise them to the discrimination experienced by minority populations’ (Atkinson and Hackett, 1997: 385; Rudolph, 1989a, 1989b).

British psychologists have taken a variety of stances to lesbians and gay men. For example, responses to the organisers of a recent BPS conference entitled ‘Gay and Lesbian Identities: Working with young people, their families and schools’ were reported as being abusive (Preece, 1999), as were recent and historical responses to the establishment of the BPS Section for Lesbian and Gay Psychology (Hamilton, 1995). Responses such as this in the professional domain raise questions as to the suitability of some professionals to be working with lesbian and gay clients and the lack

of response from the professional bodies is also important to consider. As the professional bodies have articulated policies about racist attitudes being inappropriate and unprofessional, the findings of this study suggest that we should recommend that attention to, and development of, appropriate attitudes towards lesbian and gay clients should also be at the forefront of personal and professional activity. Not to do so 'only serves to perpetuate the homophobia that is the primary source of oppression for gays' (Atkinson and Hackett, 1997; 362).

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CHAPTER 4

CLINICAL REPORT

Depression and the Uncertainty of Identity: An existential-phenomenological exploration in just twelve sessions.

Depression and the Uncertainty of Identity: An existential - phenomenological exploration in just twelve sessions'

Introduction

The literature of Counselling Psychology values a comprehensive approach to therapeutic work with clients (Woolfe and Dryden, 1996) and this is evident in this chapter. While this report is primarily concerned with a description of an encounter between Graham (my anonymised client) and myself, it also describes what might be termed time limited *existential* therapy. The model described is an existential-phenomenological approach to therapy outlined in Strasser and Strasser (1997) rather than existentialism as philosophical discourse. My own approach to time limited existential therapy is informed by other psychological considerations, such as behaviour, cognitive style, ability to develop and maintain relationships, a consideration of early experiences on development and the resultant psychodynamics.

As may be evident from chapter two and the research findings in chapter three, it is important for a counselling psychologist to take a critical stance to knowledge, particularly that of our own discipline. Without a critical reflectivity psychological knowledge can be rigid, reductionistic and prescriptive. (Parker et al, 1995; Pilgrim, 1997; Smail, 1995; Deurzen, 1993). This study highlights how an existential-phenomenological theory, with its constructionist epistemology and phenomenological approach to practice assists in my ability to critically reflect on practice.

Due to a constructionist epistemology, the existential therapeutic paradigm does not consider the person as an individual, but rather as *Dasein*. This term means Being-in-the-World, with the hyphens highlighting a central understanding of this approach. This

is that the person is embedded in the world and can only be understood as such. There *cannot* be an independent Dasein. The world comprises physical, social and intimate dimensions as well as the world of values. An existential paradigm addresses some of the difficulties inherent in many approaches based on the Natural Sciences (e.g. psychodynamic, humanistic and cognitive-behavioural models) which are based on the assumption that subject and object are separate.

Central to an existential understanding of human experience and distress is Meaning (Spinelli, 1996; Strasser and Strasser, 1997). *Dasein* takes an attitudinal stance towards an experience, and it is this stance, in its emotional, cognitive, behavioural and value dimensions, that shape the form that is experienced and observed. Psychological distress can be understood in a variety of ways. An existential-phenomenological view sees it as a consequence of the particular stance taken towards experiences. Distress is experienced when the stance taken is sedimented, where other possible options and interpretations are not available for consideration. ‘Sedimentation’ is a term meaning the way in which “human beings become stuck or fixed in certain beliefs and behaviour patterns that deposit themselves deep down in our belief systems” (Strasser and Strasser, 1997: 90).

Context

As I have described elsewhere (Milton et al., 1998), as a therapist I work primarily in the British National Health Service (NHS) where we face a huge demand for psychological services but limited resources. Such pressures influence my practice as much as my own values and beliefs or an existential therapeutic orientation. In fact, a factor in my practising a time limited approach to psychotherapy in the NHS is my

department's decision to impose a 'quota system' to try and meet the demand being placed on the service.

Goals of therapy

Goals are both an important aspect of psychotherapy and also a complex one. Where the goal is desired by the client or collaboratively outlined they may be a matrix around which the client and the therapist find meaning. In this way goals can be a useful aspect of many forms of therapy. However, clients often complain of therapists ignoring the experience of the client because of their own therapeutic agenda. An existential-phenomenological approach focuses on the client's way-of-being and it can therefore be conceptually useful in both focussed and open-ended therapies. A directive, goal centred approach to therapy (as some psychodynamic and cognitive-behavioural models advocate) is rejected as this jumps ahead of the client and while this can sometimes provide 'results', these are often transitory (Roth and Fonagy, 1997). Such a stance to the client may result in a lack of understanding or the taking of responsibility for another. Instead, there is much therapeutic gain in clarifying the stances that the client holds to allow different perspectives to be recognised and choices to be considered. Insight is an important aspect of therapy although insight does not lead inevitably or easily to change.

Therapists in public settings work with a range of people and these clients needs are diverse. It is therefore important that the therapist is able to enter into a variety of relationships, or types of encounter with the client (Spinelli, 1997). Resonance with research into the therapeutic relationship (Clarkson, 1995; Gelso and Carter, 1985) is thus evident. This research and an existential stance focus on the development of a

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relationship that is meaningful and based on a shared and negotiated understanding of the encounter. One aspect of the relationship is the attempt on the part of the therapist to deliberately tune into the world of the client, e.g. by ensuring that accurate descriptions are gained of the client's experience. Another aspect is an intersubjective one, where the therapist is recognised as *part of* the experience rather than a thinker *about* the experience. The therapist will need to move between these two modes throughout the therapy. Thus each different therapeutic encounter has the potential to be unique.

Assessment

Assessment is problematic due to the limitations of labels and a concern for the individual client rather than a universalised construction of people or presenting difficulties (Milton and Judd, 1999; Milton et al., 1998). However, regardless of the setting, most therapists engage in a process whereby some sort of judgement is made about whether *this* therapist and *this* client can work together. To decide on this, issues such as the presenting concerns of the client, the experience of the therapist, expectations of the role of each, and maybe such variables as race, gender and sexual and emotional identity are considered.

The structure of time limited existential therapy

As with other models of time limited psychotherapy (e.g. Mann, 1973), an existential approach to time limited work requires structures to be negotiated and held to.

The structure of time limited existential therapy is outlined diagrammatically below and it is a modular approach. Where clients return for further therapy, the initial meeting (of the next module) should be the assessment session for a further, distinct period of

therapy that culminates in review rather than a taken for granted continuance from where the previous experience ended.

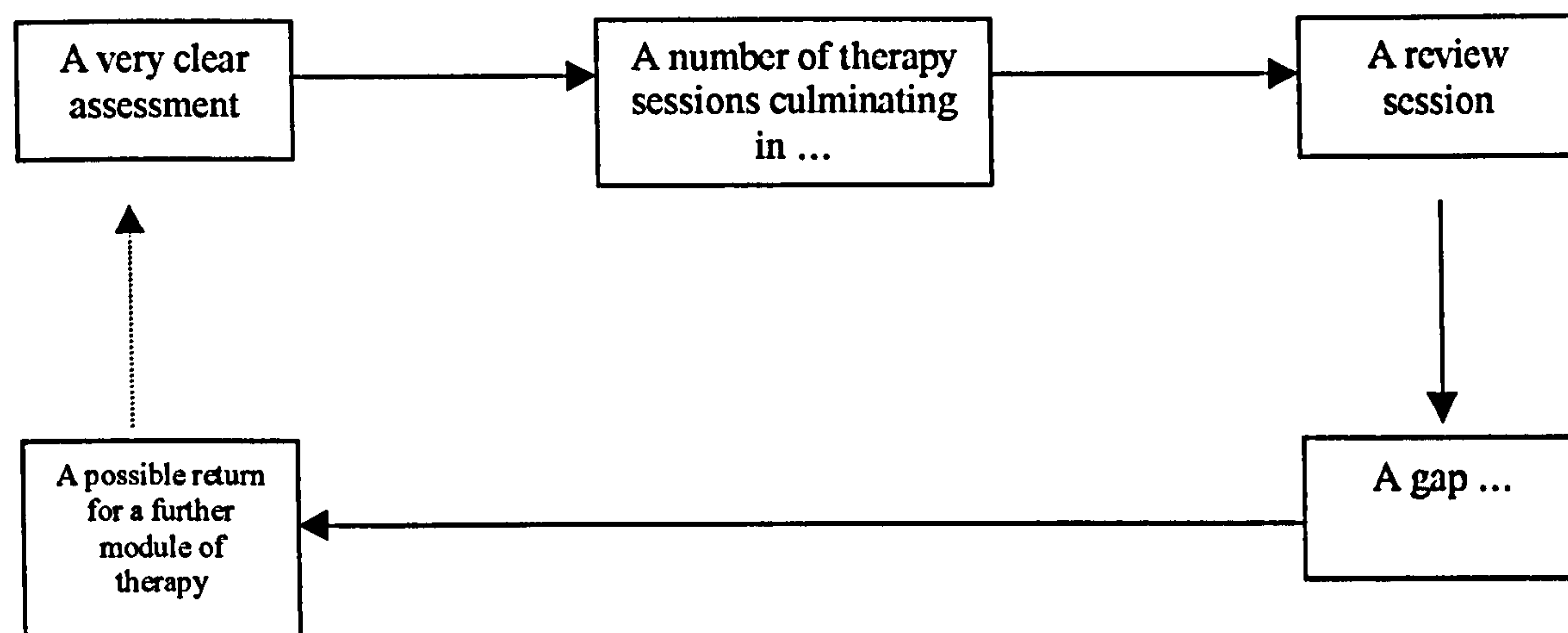


Fig 14: Time limited existential psychotherapy

Depression

Graham presented with difficulties he described as depression. Depression is thought to affect approximately 6% of the population and is “characterised by a high probability of relapse” (Roth and Fonagy, 1997:92).

Depression has been conceptualised differently by differing theoretical/research models. Diagnostic systems such as the Diagnostic and Statistical Manual (DSM) have created semi-definitive criteria for psychological difficulties. These systems function on a basis whereby a certain number of criteria have to be met before a diagnosis can be made. Not all of the criteria are evident in each experience of depression. Thus different experiences of depression may have little overlap in symptomatology. The DSM criteria for depression require only five of the possible nine criteria to be met before a diagnosis can be ‘confirmed’. For Graham, the following DSM criteria were evident:

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1. Depressed mood most of the day nearly everyday.
2. Insomnia nearly everyday
3. Psychomotor retardation nearly every day.
4. Fatigue,
5. Feelings of worthlessness.
6. Recurrent thoughts of death, [...] recurrent suicidal ideation without specific plans.

(DSM-IV, 1994)

Psychodynamic models have focussed on the role of “early loss, self esteem and everyday dependency” (Wilkinson and Campbell, 1997:227) in depression. The characteristic need for care, approval and affection is thought to stem from needs that were not satisfied in early childhood. Later losses re-stimulate this distress “and cause the person to regress to the original helpless, dependent state” (Wilkinson and Campbell, 1997:227).

A cognitive-behavioural formulation considers depression to be a reaction to a negative life event by those who either have a pre-existing “depressogenic attribution style” or pre-existing “negative schemata laid down in childhood” (Twaddle and Scott, 1991: 65).

An existential-phenomenological stance attends to the experience of depression as related to meaning and the client’s manner of being-in-time. “The depressed person has no future, or merely a bleak one, where nothing of value can occur” (Deurzen-Smith, 1997: 137). Unlike the cognitive and analytic models, the existential-phenomenological approach does not attribute history to clients, but focuses on experience in the present. This is because it recognises the selective use of memory to construct a past that confirms our identity in the present. Thus, depression isn’t an entity, but an intentional stance. This allows the

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therapist and client to develop other conceptual possibilities for the client rather than them inevitably being the victim of their past.

Regardless of orientation it is important to note that lesbians and gay men experience higher levels of depression than average (Coyle, 1993; DiPlacido, 1998). This is partly explained by the increased number of stresses experienced in the face of social and institutional responses to lesbian and gay sexuality (D'Augelli, 1998). Vulnerability is also increased due to the lack of social support many lesbians and gay men experience when first acknowledging their sexual identity (Coyle, 1998; Rivers, 1997).

The therapy

'Graham' is a gay man in his thirties. He has no siblings, is working part time and was referred by members of the Primary Health Care Team. His difficulties included intrusive thoughts about his gender identity and the type of intimate relationship he would like to have. It was noted that there was a degree of depression with biological symptoms and some 'self-destructive' behaviour such as self-cutting and suicidal ideation. The medical practitioner involved had treated Graham with anxiolytic medication.

The initial encounter

When I first met Graham I noticed a degree of nervousness and a lack of certainty about his reasons for attending. He was uncertain about what he hoped would come from our meeting. Where clients present like this, I often feel that cognitive therapy will not be the most appropriate therapy to embark upon. When the therapist pushes for a focus, they can often be experienced as unwilling to hear the client's story or unwilling to bear the experience. Despite his lack of clarity on this issue and after some difficulty in

starting, Graham settled into a description of himself that was both current and historical and was also descriptive of the debilitating emotions he experienced. This, plus the interest shown in the meaning of his experience and relationships suggested a good match between Graham's desire for therapy and an existential approach to therapy.

In the phenomenological method the 'rule of horizontalisation' (Spinelli, 1994) requires the therapist to be mindful of the need to clarify Meaning specific to the client rather than impose any prescribed, socially fashionable or theoretical meanings. In this way the phenomenological approach is different to the theory led stance of much cognitive and psychoanalytic practice. The rule of bracketing assists by aiding therapists' awareness of their own feelings and thoughts and the use that is made thereof.

Counter to the uncertainty Graham had felt, the process became quite 'certain' at points, focussing on questions relating to his experience of his world and his 'symptoms'. This illustrated the experience of paradox and contradiction in Dasein. At this point, my aim was to get as clear a picture as I could of the experience Graham had, while allowing for us to explore areas of uncertainty.

Graham soon outlined a view of what he felt would be helpful and this was to try and free himself of the onslaught of the feelings and his more compulsive behaviours. I wasn't yet sure about what he meant and I asked:

M: Meaning?

At this point Graham described a number of behaviours that he felt were quite destructive and quickly went on to talk of more interpersonal pain. He also showed that he had some insight into the nature of his depression:

G: Cutting myself, drinking when I shouldn't. What I really need is to find, ... What I really want is a 'partner', someone to love, someone to look after ... I keep finding people that I could love, that I am attracted to but they never seem to return the feeling. They always seem to have a different agenda. Just wanna be friends ... That's when it happens really. That's when I really feel depressed, when they don't return the feeling.

Graham's genderless description suggested it could be difficult for him to be open about his sexuality. This guardedness is often protective for lesbians and gay men who have experienced sanction due to anti-lesbian and gay prejudice. It was at this point that I clarified:

M: This partner, male or female?

G: (looking uncomfortable) um, ... , um, ... male, ... yeah, male.

After a short period wherein Graham appeared nervous and uncomfortable, he discussed sexual and gendered identities enthusiastically and the meanings that they held for him. One view to emerge through his description of family, friends and work was that there was a certain way to be a 'man' and anything different was seen as less masculine and 'wrong'. I asked him:

M: Wrong? What do you mean?

G: I ... I ... You're not supposed to not play football, not want to have sex with women, ...

Graham did not see 'wrongness' as attributed (and constructed), but as a given state. He went on to talk about 'the boyfriend' over the course of the session, noting the

qualities a boyfriend should possess. He would be attractive, have a particular history and he and Graham should 'click' together. The boyfriend would also be someone to whom Graham would release his need to control and this might be pleasurable.

In deciding how to intervene with clients I often reflect on the nature of the initial encounter. Graham seemed to value interventions that challenged the meaning of his statements. He didn't appear to need me to direct this activity for him and so a challenging phenomenologically oriented therapy seemed quite appropriate. I also reflected on how I had experienced at least two modes of being with Graham. There were times that were characterised by a conscious checking out of material in an attempt to tune into his experience as much as possible. This mode was characterised by questions of Graham, such questions as:

M: Can you tell me more about that?

M: What was that like?

M: There was a lot there wasn't there. Can you describe it to me again?

This mode was also characterised by questions that attempted to ask for more information, a description of phenomena that hadn't been raised by Graham. Questions such as;

M: 'Tell me more about what you think about when you lie awake at night',

M: 'What is the experience of seeing a possible partner but not being able to speak with him?'

Graham responded quite enthusiastically to probing for rich description and in this way appeared to respond well to a phenomenological approach which is characterised by attention to what is presented and what is kept private. It can therefore attend to

material given and that which is absent.

I also needed to reflect on the possibility that these focussed questions might reflect the difficulties that I, as therapist, experience in 'not knowing'. I needed to consider whether I was asking for descriptions that were useful and meaningful to Graham or whether they were attempts to comfort me in 'knowing'.

Another mode of interaction I recognised was more associative and this was characterised by the provision of descriptive feedback to Graham. This helped clarify his descriptions and ensured that the meeting was a human encounter.

Graham initially attributed his depression to being a gay man. His family was aware of his sexual identity and on the whole he felt they were supportive and accepting of his gay identity. He also described most of his friends as having been "*OK about it all*".

Although recognising the limits of developmental models of 'Coming Out' which can be prescriptive and linear, they can be useful, allowing the therapist to recognise the wider context/experience (see Coleman, 1985). Research participants, as reported in chapter three, have valued reflecting on such models.

Graham found the 'gay scene' overly sexualised and different to the values he held about romantic relationships. I also noted that his manner of living with dilemmas was to attempt to avoid them - by way of anxiolytic medication, losing himself in activity, his cutting, the consumption of alcohol and avoiding relationships with others.

The concept of *Dasein* was useful in helping me see Graham in context rather than as an independent psyche. Graham's experience of depression was intentional. He felt it was related to aspects of the world about him, rather than being an entity that occurred to him or a chemical imbalance that changed him. The possibility of attitude and attitudinal

change however, isn't simplistically a matter of individual choice, but a situated Freedom. Consciousness, social discourses and practices all limit choice.

I was uncertain about Graham's previous experiences and I asked:

M: We've talked a lot about what it's like now, but I don't know much about where or how you grew up, what that was like?

Graham talked of feeling isolated and experiences of uncertainty. His family had moved a great deal, both internationally and in Britain. At one school he was called a 'sissy' and only escaped being assaulted by joining in with some homophobic bullying of a classmate. His sense of being an 'Outsider' had become consistent and led to a sedimented self-construct. This experience could be interpreted using a range of therapeutic models. I was aware that I could entertain notions of punitive Super-ego structures, but such a structural formulation didn't lead to anything meaningful in relation to Graham. Alternatively, a schema-focussed cognitive approach would have allowed me a developmental formulation. However, this was not necessarily missing from an existential formulation and Graham appeared to be working hard without the need for me to be directive at this point.

I could identify with some of the dilemmas Graham outlined (being gay, having moved while growing up, etc) and I needed to bracket any assumptions I might have about his experience being the same as mine. However, this insider knowledge may also have been useful in allowing me to enter Graham's worldview and challenge the rigidity of meanings rather than the meaning itself.

Towards the end of the assessment session I reflected on the meeting and on his response to a challenging, existential approach. I thought there were early signs that he

could find a time limited existential psychotherapy beneficial, useful and bearable – signs such as increasing responses to questions, using time to reflect and deepen his description of the phenomena being explored. In essence an enthusiastic grasp of responsibility in therapy. I asked Graham whether he had any questions. He said that he didn't and so, I gave an outline of what I was able to offer him:

M: As long as you feel you can work with me, I suggest that we meet every week for 12 weeks. At that point we will review the therapy and most likely end there, ...at least for a while. While sometimes at the review we might decide that another series of sessions, another module might need to start straight away, generally it is useful to have a chance to have a break, to see what it is like living with the insights you might gain in therapy.

The therapist needs to be open to the client saying 'Yes, I can work in this way', or 'No, I can't'. Graham accepted the offer and we agreed dates, times, frequency and a final session. I had been sure to mention that in some circumstances another module would be agreed without a break as this allows the therapist to respond to extreme distress at the point of termination without losing therapeutic credibility.

“Being” together

The next session was missed completely and Graham arrived 10 minutes late for another. I found myself worrying. Would he arrive? Would he engage? When we did meet it appeared to be excruciatingly difficult for Graham to start the session. It seemed that the uncertainty of the moment felt overwhelming. How might he start? What would be the right thing to say? Wouldn't I set the agenda? This became a clear revelation of his way of being in therapy and the other worlds in which he lived. A world in which

others were expected to take over and determine Graham's experience.

When uncertain, Graham would experience a range of different feelings. In order to try and make sense of these, he would try and rush to evaluate them using the views of others as certain, correct criteria for what to feel or what not to feel. He hoped this would help avoid the difficult feelings. The difficulty that this presented was that in reality he couldn't know what others *did* feel. He found it difficult to ask them, and he felt that if he were to ask them he wouldn't necessarily believe their responses. Once he found a meaning that he assumed the other would hold, he would then use this to question or deny the reality of his own feelings. If this became too much he would withdraw to his personal world where he would find relief and space from this traumatic way of relating. This relief was short lived as he would become acutely aware of his isolation and the lack of the idealised partner. Thus a pattern of engagement and withdrawal was evident.

A question that soon emerged was 'Who defines one's identity?' Is it set, given, unchangeable? If so, why did he feel different with different groups (family, heterosexual friends, gay friends) or in different settings (gay clubs, heterosexual pubs, at work)? With Graham this theme was linked to a number of polarities. Was identity his responsibility or that of another? He had a self-construct that he was confident with in private, and this was emotional and at times depressed, sexual and aggressive. Alternatively in public he had a different identity, one of being jovial, happy and intellectual. Both positions had meaning. How would he decide which *one* he was?

Graham was encouraged to clarify his desire and to question his responses to his desires. There were advantages to these views, as on the one hand the identity that the

other sees and maybe creates, can be denigrated, the 'Other' can be seen as inaccurate and therefore pushed away. Alternatively in his private world Graham could be himself. When this became difficult he could deny, or avoid some of his more difficult feelings. Either way, these positions allowed him, to temporarily deny uncertainty. Because of his degree of engagement and obvious work between sessions, I felt that these were useful interventions.

On recognising this pattern Graham became more depressed for a while. He thought about suicide again. Suicide was linked to the idealised boyfriend as both fantasies had the possibility of escaping the difficulties of life. On hearing these thoughts I became aware of my own thoughts about life and death, both in the present and in the past, my responsibility as a professional and a degree of impotence that is present in the living of another's life. I was partly pleased that he was engaging with such a fundamental aspect of Being-in-the-world, but I was also a little concerned, both for his well being but also for the impact it would have on me.

Suicide is linked with consciousness, emotion and intentionality. The emotional experience of depression is painful and filled with hopelessness, and thus suicide can have great meaning. It can be an act of nobility, strengthening the self-construct as able and powerful, a heroic way out of difficult experiences. One might expect to see suicide as the meaning to grasp when all other meaning has been lost. It is therefore important that the therapy address suicide in the same way it addresses other experiences and intentions – i.e. with a thorough consideration of its meaning – allowing for alternative meanings to emerge. At the same time the therapist needs to be prepared to identify emergency options and containing strategies.

Therapy progresses

As therapy progressed, the nature of therapy changed somewhat. In Graham's case it became more and more evident that he lived through thinking, in both the content and process of therapy. In this way Graham's assumptions about himself, the world, others and phenomena came to light. I recognised some of the parallels between aspects of cognitive-behavioural therapy and existential therapy when engaged with a client's way of Being-in-the-world (Edwards, 1990), e.g. Graham tried to think his way through the anxiety he felt at the beginning of each session, rehearsing the session on the way to therapy. We were able to see that the uncertainty at the beginning of sessions was similar to the uncertainty and anxiety he experienced in other relationships. Uncertainty meant a lack of power. Would I get bored with the silence and reject him? When he was able to start the session immediately he felt assured as uncertainty was being avoided.

I found myself with my own dilemmas. On the one hand I recognised I wanted to step in, at some points I had plenty of questions that would both have kick started the session and would also have allowed us to avoid the discomfort and interpersonal anxieties about what the uncertainty meant. Again, at this point I was aware that I could take a more structured approach, akin to classic cognitive therapy, but it transpired that this was akin to the experience his friends had, moving from friendship to taking a controlling, responsible role in the relationship. Rather than act on this, I decided to talk about it with Graham.

Uncertainty also manifests itself in Graham's natural world. Graham would talk about how difficult it was for him to get to sleep. While we did consider this in relation to 'the depressive's' disturbed sleep pattern, there was more to it. The period between lying

down and actually falling asleep was entering uncertainty itself. Would he fall asleep or would he lie awake worrying? If he slept would he wake up, on time or at all? We considered the function worrying had and it became evident to Graham, that worrying was something he recognised, an activity that was a part of him. Worrying was a way to avoid the uncertainty that stared him in the face on sleeping. *"At least I'm looking for certainty"*, He smiled as he said this, recognising that he wasn't thinking of suicide at this point, but being interested in the way he was.

We considered at length the meaning of different identities and how he might accept or reject them, experience them as self or non-self. Rejection of possible identities was difficult for Graham as to risk an identity that wasn't immediately known and recognised by the other risked feelings of what I recognised as 'engulfment' (Deurzen, 1998). We worked hard to consider whether or not social gender roles were accurate and really reflected the reality of individual men and women. This was done by way of eliciting a richly descriptive narrative. He experienced this as potentially liberating, but was frightened by a sense of uncertainty and meaninglessness at the thought of losing the certainty of 'social' masculinity and developing an experience of his own masculinity.

Graham came to experience the challenging aspect of therapy with interest. One construct that existed was one of 'not aggressive'. He took pride in not being violent, not having gotten into fights and not having rows. This was 'proof' that he was not aggressive. I challenged this.

M: As well as that though, aren't you, or haven't you been aggressive to yourself? Your suicidal ideas? Your cutting?

There was a long silence at this point where he thought about this. It seemed that by accurately describing the phenomenon rather than forcing a meaning, he became engaged. It may be that the statement, "*As well as that ...*", was an important aspect of the intervention.

It is evident that one of the initial themes, sexuality, moved from being a core issue to being *an example* of fundamental aspects of Dasein. His sexuality was only one example of how skilful he had become at relating to others by being different. Equally important was having had a range of illnesses in childhood. These meant that while he would often watch the other boys play sports, he didn't have to engage in the rough and tumble, the competitive nastiness and the uncertainty of whether or not he was adequately masculine. His self construct as different created problems when entering a "*gay environment*". In a gay club, Graham had the chance to experience himself as 'the same as' other men. This was new, novel and uncertain. Uncertainty in terms of social skills and the competitiveness he had constructed as 'not nice'. But also the risk to himself to not be 'different'.

The narratives surrounding sexual behaviour, experiences and hopes are particularly important in outlining the central concerns of a client. This is not to say that as therapists we need to attempt to foreground sexuality over all else – indeed to do so would be problematic for clients (Milton, 1998). It would be theory driven and therefore unphenomenological. But by listening to sexual stories, we may witness the rawest illustrations of a person's attempts to struggle with issues of dependence, control, inferiority and relationship. The task is for the therapist to explore the meaning rather than the sexuality itself.

I used personal language in our discussions. I have considered disclosure at length in supervision, research (see chapter three) and in print (Milton, 1996) and feel it is important to remain flexible, although cautious with the meaning of self-disclosure to clients. Overt acknowledgement of the therapist's sexuality may be useful at times, but it might also be an irrelevance. Rather than making rash claims to similarity, I found myself using such terms as 'we' with Graham. It indicated a commonality - both as a fellow Dasein and at other times the possibility of us both being gay was available to Graham if it was relevant to him. This proved useful in giving permission for Graham to use shorthand. He gained confidence that I did not need every nuance of his social and emotional context outlined and defined. We could allow ourselves to define only what needed elaboration and clarification.

Ending

As with many clients, the fact that our meetings were transitory started to become an issue for Graham. Transitions often have a resonance with change, uncertainty and the issue of authority and these resonated with Graham's history of frequent and difficult relocations.

One way that we got a grasp of this was through his associations to historical events, e.g. the difficulty he had experienced as a child in adjusting to his brother's serious illness and then the shift back again when his brother recovered. There was also his leaving of Northern Ireland due to the troubles. Graham noticed that his associations were about transitions as dangerous and uncertain. Was he living with an assumption that endings mean conflict or a danger to his self-construct? We looked at a number of these issues in the last few sessions and noted that maybe more importantly than the

content of his associations was an increased ability to bear anxiety, as well as a growing ability to find it of interest.

Three sessions before termination, I deliberately mentioned the upcoming ending:

M: I'll see you next week then, for our penultimate session.

G: Hmm, but that's OK. I'm feeling better now, ... this is just a professional relationship.

M: OK then, ...

G: It's almost like it only came about to fulfil a purpose.

In the last two sessions there was an increasing sadness and tearfulness and in the last session I described how I experienced him:

M: You've become more tearful in the last two sessions. This is somewhat different to earlier on in the therapy

G: Maybe I was kidding myself, maybe I do feel more than I thought. Maybe its the same reaction all over again, here I am denying my feelings so I don't have to face not coming anymore, and the worry that that causes.

To Graham, this meant he was more able to trust me with his feelings and wanted me to know that therapy (and ending) was difficult. Graham had challenged himself in therapy and engaged in a relationship in a very different manner to previous relationships. By allowing himself to risk having me know him, he risked conflict and not knowing to what degree I would remember him. If I didn't keep him in mind would the way I knew him be lost to him? In his own way Graham strengthened the possibility of being remembered (and maybe of being able to keep his identity himself) by giving me a gift and a metaphor that summed up his experience of therapy:

G: I feel a bit like a newly hatched chick. I've been ready to hatch for a while but I stayed inside, maybe too long – but I was away from the dangers of the farmyard. Now I'm hatched, I know there are risks, but I can spread my wings now. I can make a noise and run. In some ways maybe I'm safer now than I was hiding in the egg. The fox may still be there but it hasn't eaten me yet.

We ended therapy as originally agreed. There were no further appointments scheduled but we discussed how Graham could get in touch with me again if he felt we should engage in another module of therapy.

Evaluation

Evaluation must be informed and driven by a number of concerns. Some of these include the fact that publicly funded services demand reassurance that the therapy offered is 'worth it'. More importantly, another consideration is that of the client. Evaluation can be undertaken in a number of ways, client self reports and customer satisfaction questionnaires, such validated tests as Depression and Anxiety scales (Beck et al., 1961, 1993; Zigmond and Snaith, 1983) and rating of symptoms and social interaction.

With Graham, evaluation occurred in three ways:

1. By way of pre and post therapy scores on the Beck Depression Inventory (Beck et al., 1993) where his scores changed from 35 (pre-therapy) to 15. This indicates a markedly decreased depression (extremely severe to mild-moderate).
2. Awareness of his social and emotional engagement at different points in therapy. Relationships and mood had shown substantial change during therapy.

3. Constant reflection on change, consistency and stuck-ness and what these meant to Graham.

Reflection

This description of a therapeutic relationship that lasted for only twelve sessions attempts to outline my clinical practice. A secondary aim is to outline the manner of existential-phenomenological therapy in a time-limited form.

As can be seen in this description, the 'process' of therapy is primary rather than content or technique (Todres, undated). While some of the client's experiences are known, in a lived, felt way, we must also be sceptical about knowing. The challenge for both the therapist and the client is to 'not know' for a period of time. This can help us to see what meanings emerge and become available for consideration. This is what the therapist aspires to in efforts to 'bracket' their knowledge and theory. The focus is not primarily on the therapist's evaluation of content but on what is experienced as important to the client. However, the process of interpretation "too often serves to interrupt [] 'process relatedness' by prematurely attempting to make content-sense out of the phenomena that are occurring" (Todres, undated: 101). Uncertainty and paradox thus plague the role of the therapist.

Where the client values the experience of developing a shared worldview with the therapist two purposes may be served. At the level of process the encounter opens up the possibility of different ways of engaging and making sense of the world, an experience of difference with the promise of other useful differences in the future. Secondly at the level of content it allows new meanings to be attached to previously held certainties.

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CHAPTER FOUR
Depression and the Uncertainty of Identity

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