

Issues in Psychotherapy With Lesbians and Gay Men

A Survey of Psychologists



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In 1984, a task force of the American Psychological Association (APA) Committee on Lesbian and Gay Concerns was charged with investigating bias in psychotherapy with lesbians and gay men. The task force surveyed a large and diverse sample of psychologists to elicit information about specific instances of respondent-defined biased and sensitive psychotherapy practice. Open-ended responses were used to separately identify major themes of biased and sensitive practice and to illustrate each with concrete examples. Results suggest that psychologists vary widely in their adherence to a standard of unbiased practice with gay men and lesbians. To bring individual practice into accord with APA policy will require continued and expanded efforts to educate practitioners about sexual orientation.

In 1975, the American Psychological Association (APA) took a strong stance regarding bias toward lesbians and gay men, resolving that "homosexuality per se implies no impairment in judgment, reliability or general social and vocational abilities" (see Appendix A for the full text of the resolution). The APA urged psychologists "to take the lead in removing the stigma of mental illness long associated with homosexual orientations" (Conger, 1975). In recent years, attention has been drawn to ways in which a client's ethnicity, gender, sexual orientation, or physical disability can affect clinical judgment and treatment strategies. There has been a corresponding effort to develop guidelines to help practitioners avoid bias in psychotherapy (APA, 1975). Recognizing that practice does not spontaneously or quickly follow policy changes, the Committee on Lesbian and Gay Concerns (CLGC), sponsored jointly by the Board of Social and Ethical Responsibility in Psychology (BSERP) and the Board of Professional Affairs (BPA),¹ formed a task force in 1984 to investigate the range of bias that may occur in psychotherapy with lesbians and gay men. This article is an abridged report of the task force's research, findings, and recommendations.²

The therapeutic process is inevitably affected by the values and biases of therapists (Lopez, 1989; Murray & Abramson, 1983). The mission of CLGC's Task Force on Bias in Psychotherapy with Lesbians and Gay Men

was to describe the range of problems that gay male and lesbian clients can face in psychotherapy and to provide an empirical basis for the development of guidelines and suggestions for practice. In addition to those relatively few psychologists who choose to specialize in working with lesbians and gay men, most nonspecialist therapists will also see gay male and lesbian clients. There are many ways, subtle and obvious, in which bias can occur, and issues inherent in treating these populations competently are complex. The data obtained by this survey should be used as a starting point for the development of educational materials and model curricula for graduate and professional training.³ There is a growing body of literature on sexual orientation that should be more widely disseminated to practicing psychologists. Suggested readings regarding bias in therapy with lesbians and gay men as well as gay-affirmative therapy are listed in Appendix B.

This article is an abridged report of the results of a survey conducted in 1986. It relies on methodology adapted from similar work done by the BPA Task Force on Sex Bias and Sex-Role Stereotyping in Psychothera-

This article is based on the work of the Task Force on Bias in Psychotherapy with Lesbians and Gay Men. The first two authors of this article are task force cochairs; other members who contributed substantively are listed in alphabetical order. Task Force members included cochairs Linda Garnets, Kristin A. Hancock, and Alan Malyon, and members Annette Brodsky, Laura Brown, Susan Cochran, Terry Gock, Jacqueline Goodchilds, Alan Gross, Stephen Morin, Roy Neuner, Letitia Anne Peplau, Allan Pinka, and Michael Storms. We wish to acknowledge Alan Malyon, whose vision and determination launched this project, but who was unable to see his hard work come to fruition because of his untimely death in 1988. Partial funding for this study was provided by the American Psychological Association's Practice Directorate, the Committee on Lesbian and Gay Concerns, and Division 44.

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¹ The Committee on Lesbian and Gay Concerns has been a standing committee of APA since 1980. At the time this report was completed it reported to the Board of Social and Ethical Responsibility in Psychology (BSERP), and it now reports to the Board for Psychology in the Public Interest (BAPPI), which superseded BSERP in 1990. The Board of Professional Affairs falls under the auspices of the Practice Directorate.

² The full report is available from CLGC, APA, 1200 17th Street, N.W., Washington, DC 20036.

³ On May 10, 1991, the Arizona State Psychological Association formally adopted a standard of practice with lesbian and gay male clients based on the results of this survey.

peutic Practice (APA, 1975). Three major limitations of the survey are acknowledged. First, practitioners may not always be aware of a client's sexual orientation. Unlike gender or race, or frequently, ethnicity, the sexual orientation of a client may or may not be obvious or revealed to a therapist. A client may never disclose his or her sexual orientation or may disclose it at any point during the course of the treatment. The invisibility of sexual orientation raises complex therapy issues that we do not address in this article. Second, when the survey was conducted in 1986, there was much less public awareness of acquired immunodeficiency syndrome (AIDS), few respondents mentioned AIDS issues, and we therefore do not deal with the serious therapeutic and ethical issues in that area. Third, we do not address gender differences in the therapy experiences of lesbians and gay men. Although the task force decided to approach issues of sexual orientation as a generic category, there are doubtless many ways in which the gender of a gay male or lesbian client and the gender of the therapist may combine to affect the psychotherapy experience. A full exploration of this complex issue would require a careful comparison of the therapy experiences of lesbians versus gay men with male versus female therapists, an undertaking beyond the scope of this article.

Method

The survey was developed to elicit instances of biased care as well as examples of beneficial care provided to gay male and lesbian clients. The four-page survey also contained questions that elicited demographic data and information about the respondents' professional background and provision of psychotherapy. Respondents were asked whether they knew of "any specific experiences of lesbian or gay clients in psychotherapy" from friends or colleagues, from their own professional practice, or from their own experiences as a client in psychotherapy. Those who knew of incidents were asked to respond to the following three critical incident questions:

1. Describe any incident where a therapist provided biased, inadequate, or inappropriate care to a gay or lesbian client in psychotherapy. For each incident, indicate your source of information (e.g., "A friend or colleague told me about it." "I was the client." "My client told me." "I observed it.")
2. Describe any incidents where a therapist provided care demonstrating special sensitivity to a gay or lesbian client in psychotherapy. For each example, indicate your source of information.
3. In your opinion, what professional practices are especially *harmful* in psychotherapy with lesbian and gay clients?
4. In your opinion, what professional practices are especially *beneficial* in psychotherapy with lesbian and gay clients?

Data Collection

To obtain a large and diverse sample of critical incidents involving both lesbian and gay male clients in psycho-

therapy, we solicited opinions from a broad group of psychologists. The goal was to include psychologists who, regardless of their own sexual orientation, would be likely to have knowledge of the provision of psychotherapeutic services to gay male and lesbian clients, as well as gay male and lesbian psychologists who may themselves have received psychotherapeutic services. We were also interested in the knowledge that psychologists may have from observations or conversations with colleagues, students, or friends. To ensure a response rate adequate for analysis, we used 1986 APA membership rolls to survey all members, fellows, and associates of Divisions 44 (Society for the Psychological Study of Gay and Lesbian Issues) and 35 (Psychology of Women), and a random sample of 4,000 licensed members of APA (balanced by gender) who were not members of either of those divisions. The anonymous questionnaire, accompanied by an explanatory cover letter and a postage-paid envelope, addressed to APA Central Office, was fielded in November 1986 to a target sample of 6,580 psychologists. The cover letter explained that

This survey is designed to collect information about the experiences of lesbians and gay men in psychotherapy. You may know about this topic from friends or colleagues, from experiences you may have had as a client, or—if you have engaged in practice—in your role as therapist. Our goal is to obtain a wide range of information from diverse sources.

Of the 6,580 questionnaires mailed, 45 were returned as undeliverable. From the remaining 6,535 questionnaires, 2,544 were completed and returned. This is a response rate of 38.9%.

Results

The survey succeeded in obtaining information from a diverse sample of psychologists. The 2,544 respondents ranged in age from 26 to 86 years (mean = 46.5 years, median = 44 years). Reflecting the oversampling of women in the sampling frame, 69% of respondents were women. Nearly all participants were White (96%), with only 2% Black, 1% Hispanic, and less than 1% Asian. Respondents came from all areas of the United States, with a scattering (1%) from Canada. Eighty-five percent self-identified as heterosexual, 11% as gay male or lesbian, and 4% as bisexual. Among women, 87% self-identified as heterosexual, 9% as lesbian, and 5% as bisexual. Among men, 81% self-identified as heterosexual, 15% as gay, and 4% as bisexual.

Of the total sample, 1,481 respondents (58.2%) indicated that they knew of psychotherapy experiences of gay and lesbian clients and provided critical incident material. This subgroup (hereafter referred to as "the sample") is the focus of the report. These individuals also constitute a diverse sample, differing from the entire group of respondents only in that a somewhat larger percentage (23% vs. 15%) self-identified as gay male, lesbian, or bisexual.

The majority (93%) of the sample were licensed psychologists. The median year of licensure was 1978. About 87% were currently providing psychotherapy services.

Among providers, more than one third had been in practice less than seven years.

Reflecting the diversity of the psychotherapy field, respondents reported varied theoretical orientations to the practice of psychotherapy, with 85% of the sample reporting both a primary and secondary theoretical orientation. Of the options provided, an eclectic orientation was most frequently cited. Sizeable percentages also indicated analytic-psychoanalytic, relationship, cognitive, and behavioral orientations as either primary or secondary. Only 5% reported a gay-affirmative orientation to therapy. Of those respondents who were lesbians or gay men, 29% reported a gay-affirmative orientation. This contrasts with 2% of bisexual providers and less than 1% of heterosexual practitioners.

Nearly all of the psychotherapy providers (99%), regardless of sexual orientation, reported that they had seen at least one gay male or lesbian client in psychotherapy at some point during their careers. The average respondent reported that 6% of their current clients were gay men and 7% were lesbians. Only 1% of service providers had never worked with gay male or lesbian clients, and 38% had seen more than 20 such individuals in their careers. Twenty-two percent of the practitioners in this sample specialized in providing services to gay men or lesbians. Among lesbians and gay male practitioners, 71% specialized in treating homosexual clients, compared with 42% of the bisexual providers and only 9% of the heterosexual providers.

It should be noted that these materials are not based on or intended to be a representative sample of APA members. The sample is neither representative of psychologists in general (as 95% of the sample were practitioners), nor of practitioners (as 67% of the sample were women, compared with 31% of practitioners in APA who are women).

Analysis of Open-Ended Responses

For each of the four open-ended questions, a work group was formed, consisting of task force members (one of whom served as leader of each group) and additional psychologist volunteers from the Los Angeles and San Francisco areas. Group members, working individually with typed copies of verbatim responses, identified specific themes in the responses. Each group then discussed and revised the wording of themes and selected illustrative responses for each. Task force members consolidated the results from the four separate work groups and organized all materials into three broad categories: strategies of intervention, issues of special relevance to lesbian and gay male populations, and issues about therapists' expertise and training.

In the search for major themes, it was decided to combine responses to the two negative questions and to the two positive questions. Each pair of questions addressed two convergent sources of information about the same general issues (e.g., specific examples of biased practice and more abstract statements about the nature of biased practice). Finally, task force members reviewed

the thousands of open-ended responses to select examples that most clearly reflected the meaning of each theme and the range of comments provided by respondents.

The goal was not to chart the frequency of particular types of bias or to identify the most common types of beneficial or harmful practices. Rather, we sought to identify the full range of possibilities, to categorize both harmful and beneficial practices, and to illustrate these with concrete examples. In the following section, we first present 17 themes illustrating biased, inadequate, or inappropriate practice in three major areas. Next, we present 14 themes that illustrate exemplary practice in the same areas. Each theme is accompanied by verbatim examples from open-ended responses. In some instances, the biased and beneficial themes represent opposite sides of the same issue—for example, contrasting a therapist's lack of knowledge about social prejudice against gay men and lesbians with a therapist's special sensitivity to social prejudice. In other cases, somewhat different issues emerged in the negative and positive descriptions, and these are reflected in our reporting somewhat different themes.

Biased, Inadequate, or Inappropriate Practice: Key Themes and Illustrations

Assessment

1. A therapist believes that homosexuality per se is a form of psychopathology, developmental arrest, or other psychological disorder:

I'm convinced that homosexuality is a genuine personality disorder and not merely a different way of life. Everyone that I have known socially or as a client has been a complete mess psychologically. I think they are simply narcissistic personality disorders—see the description in the *DSM-III*—that's what they have looked and acted like—all of them.

2. A therapist automatically attributes a client's problems to her or his sexual orientation without evidence that this is so:

A client sought treatment for depression because of job loss and physical disability. Client was told by a therapist that the latter would only help client if the client was willing to consider "dealing with the client's sexual orientation"—meaning changing it—as part of the treatment process.

3. A therapist fails to recognize that a client's psychological symptoms or distress can be influenced by the client's own negative attitudes or ideas about homosexuality:

I have had clients describe . . . therapists' outright denial that a client has experienced societal homophobia or therapists' failure to recognize internalized homophobia as a source of depression and low self-esteem.

4. A therapist automatically assumes a client is heterosexual or discounts a client's self-identification as gay or lesbian:

The therapists I have seen have either avoided talking about sexuality all together or when they have talked about it, have

assumed me to be heterosexual, making it harder for me to bring up the issue.

My client indicated another therapist told her she "wasn't really gay" and was acting out problems related to her father. This woman consistently self-identified over the years (she was mid-thirties) as lesbian in sexual orientation.

Intervention

5. A therapist focuses on sexual orientation as a therapeutic issue when it is not relevant:

I have seen several gay patients and in each case the person reported that even though their previous therapist said that he or she accepted their homosexuality; the therapist continued to focus upon their being "gay" as "the problem" rather than upon what the person sought help for such as relationship problems, trouble handling guilt about it with family or work, general social anxiety, or other problems totally unrelated to being gay.

6. A therapist discourages a client from having or adopting a lesbian or gay orientation, makes the renunciation of one's homosexuality a condition of treatment, or in the absence of a request by the client seeks to change the sexual orientation of the client:

A therapist kept insisting that a client had latent heterosexual orientation which should be brought out instead of accepting the client's stated preference for homosexual relations.

A client was pressured to become "normal," to change conscious sexual fantasies (daydreams) to heterosexual ones.

A lesbian told me about her first therapist who encouraged her to date men and give up her ideas and feelings regarding women as intimate partners.

7. A therapist expresses beliefs that trivialize or demean homosexuality and gay male and lesbian orientation or experience:

A lesbian struggling with her sexual identity was challenged by her therapist, "If you have a uterus, don't you think you should use it?"

A colleague told me she "couldn't help" expressing astonishment and disgust to a male client who "confessed homosexuality."

A lesbian client dropped her male therapist who said in vengeance to her disclosure that she was "into women" that I don't care, I have a client who is "into dogs."

8. Upon disclosure of homosexuality, a therapist abruptly transfers a client without the provision of appropriate referrals to the client or assistance with the emotional difficulties associated with the transfer:

A 19 year old male client . . . had been receiving therapy from a University athletic department's sports psychologist. . . . The student-client developed transference toward the psychologist and in the seventh session shared with the psychologist his affection/positive feelings—referring to being "surprised that he could feel love for a man that way." The psychologist became angry, immediately terminated the session and all therapy.

Identity

9. A therapist lacks understanding of the nature of lesbian and gay male identity development, for example by considering a gay male or lesbian identity possible only for adults, by viewing lesbian or gay male identity solely in terms of sexual behavior, or by interpreting a client's gay male or lesbian identity as a "phase" that will be outgrown:

My therapist treated being gay only as a sexual activity, not as a way of viewing life or my self-concept or identity.

I was a client in first year grad school. The psychologist I was seeing insisted I was not gay, only going through an identity crisis. I was gay since age 12 or 13. It was my first experience in therapy and it only served to continue my confusion for several more years. I discontinued therapy after 4 sessions and was seriously depressed.

10. A therapist does not sufficiently take into account the extent to which lesbian or gay male identity development is complicated by the client's own negative attitudes toward homosexuality:

My partner went to a heterosexual female therapist. She consistently minimized "coming out" fears and homophobia in the culture. She may have had therapeutic reasons for doing so, but my lover felt misunderstood and her struggles unappreciated.

11. A therapist underestimates the possible consequences of a gay male or lesbian client's disclosure of his or her homosexuality to others, for example to relatives or employers:

A lesbian friend told me about a male therapist who tried to convince a young gay man (18-20) to come out to his parents—even though his parents were likely to be abusive. The therapist seemed unaffected by knowledge of society's or parents' homophobia.

Relationships

12. A therapist underestimates the importance of intimate relationships for gay men and lesbians, for example by failing to support the maintenance of or encouraging dissolution of a client's relationship solely because it is a homosexual relationship, or by failing to provide or recommend couples or family therapy when it would be the most appropriate intervention:

A friend told me of a lesbian, dying of cancer, being advised by her therapist to cut off all relationships and contact with lesbian friends in order to reconcile with her religion and find peace in herself.

A gay male couple seeking assistance with inhibited sexual desire on the part of one partner . . . were told the problem indicated the one partner probably really wasn't gay and that the recommended intervention was to break up their relationship.

A lesbian couple, seeking relationship therapy, was advised that such therapy was not applicable to their "type" of relationship, that it should not be considered a permanent relationship, and that they might consider going to "gay bars" to meet other people like themselves.

13. A therapist is insensitive to the nature and diversity of lesbian and gay male relationships and inappropriately uses a heterosexual frame of reference:

A lesbian [client was] told to read a book about heterosexual marriage problems because they were "the same" as the issues in her lesbian relationship.

A therapist dealt with gay clients, explicitly stating that all gays played either "butch" or "fem" roles—for both women and men.

Family

14. A therapist presumes a client is a poor or inappropriate parent solely on the basis of a gay or lesbian sexual orientation, for example by automatically attributing a child's problems to his or her parent(s) being lesbian or gay without evidence that this is so, or by opposing child custody to such parents on the grounds that their sexual orientation in itself makes them unfit:

In the agency in which I formerly worked, a lesbian client whose son was the identified patient was told to move her "friend" out of her home because it was harmful to her son's sexual identity.

A lesbian client related to me that a psychologist seeing her, her lover and two grammar school aged boys for family therapy related to child behavior problems/child management concerns, told her that if her boys were to see her dating a man at least once, they would "mind" better and would comply with her more frequently. The psychologist continued that if she were to have the male date spend the night and have breakfast with her and the boys the next morning, he was sure that their "masculinity crisis" would be cured.

15. A therapist is insensitive to or underestimates the effects of prejudice and discrimination on lesbian and gay male parents and their children:

I explained to my therapist that my son was being teased in school because I am gay. The therapist told me that all kids get teased and that I should just ignore it.

Therapist Expertise and Education

16. A therapist lacks knowledge or expertise, or relies unduly on the client to educate the therapist about gay male and lesbian issues:

I have heard from clients of inadequate care from therapists who claim understanding of the problems that are faced but who, in fact, are quite naive about the problems and offer rather sophomoric solutions applicable to heterosexual situations. Some have been so poorly informed about the lifestyle that in their dismay of the way in gays/lesbians are treated, they have "bent" confidences and come dangerously close to exposing their clients.

My client told me of a male therapist (heterosexual) who treated her by mainly asking questions about her lifestyle. She felt this was inappropriate and that he didn't know enough.

17. In an educational context, a therapist teaches information about lesbians or gay men that is inaccurate or prejudiced, or actively discriminates against gay male and lesbian students or colleagues:

In a clinical case presentation by a psychology intern who was providing appropriate treatment to a gay client, a senior psychology faculty member stated "this guy is a faggot—don't you have any reaction to that?"

A [gay] clinical psychology student was required to get aversion therapy from a professor as a condition of his remaining in the program once he was discovered.

Exemplary Practice: Key Themes and Illustrations

Assessment

1. A therapist understands that homosexuality, in and of itself, is neither a form of psychopathology nor is necessarily evidence of psychopathology or developmental arrest, and recognizes that gay men and lesbians can live fulfilling lives:

In my own experience as a client, I have felt that my lesbianism has been treated with respect, as a key part of my identity, but never as a sign of psychopathology per se.

My therapist encouraged me to read a book on gay couples to help me see how many gay men have long term satisfying relationships. She helped me to work through my own biases which assumed that gay men could not have happy lives.

2. A therapist recognizes the multiple ways that societal prejudice and discrimination can create problems that lesbians and gay men may seek to address in therapy:

A therapist asked a client questions about discrimination and harassment and believed the client that some problems were external (and real) to her.

I worked with a therapist once who really looked at the different problems I had as a lesbian. These problems were viewed as stemming from society's alienation of us, not as something inherent with homosexuality.

3. A therapist considers sexual orientation as one of many important attributes that characterize a client and does not assume that it is necessarily relevant to the client's problems:

I have had clients tell me they feel a special sensitivity from me in dealing with this issue because I don't treat them as if their sexual orientation is the distinguishing characteristic about them to the exclusion of all others.

I worked with a depressed patient who had, among other things, relationship problems. She told me after quite some months of therapy that a comment of mine, early in the therapy, helped her feel safe and that she could trust me. Apparently I had asked her whether being lesbian was currently an issue for her and "believed her" when she said "no".

4. A therapist recognizes the possible synergistic effects of multiple social statuses experienced by ethnic minority gay men and lesbians:

I know of therapists who clarify the racism that exists within the gay community and how it affects the development of a positive self-image among ethnic minority lesbians and gay men.

Many ethnic minority gay and lesbian clients have expressed much frustration and feelings of isolation in the gay community and tend to [attribute to themselves feelings that] it is related to [their] being gay rather than the racism they experience.

Intervention

5. A therapist uses an understanding of the societal prejudice and discrimination experienced by lesbians and gay men to guide therapy and to help gay male or lesbian clients overcome negative attitudes or ideas about homosexuality:

A male client I worked with came to therapy expressing dissatisfaction with his heterosexual relationships. During the course of therapy it became apparent that this young man was fearful and ashamed of his attraction to men. The patient was able to deal with this in the supportive therapeutic context and later was able to express and accept his homosexuality.

6. A therapist recognizes that his or her own sexual orientation, attitudes, or lack of knowledge may be relevant to the therapy and tries to recognize these limitations, seeking consultation or making appropriate referral when indicated:

When a lesbian client says "I am a lesbian, is that all right with you?" or "Is that a problem for you?" (or in some other way tells me she is gay), I am aware that my "straightness" is part of what that question's all about, and I talk about it directly: "I am straight and that may be a problem for you. I trust myself to be a gay-affirmative therapist, but it will probably take a while for you to test that out and trust me." I find this is very helpful because it communicates my understanding . . . of what it's like for a gay person to open up to a straight person in our homophobic society.

As a therapist who is straight working on occasion with lesbian women, I allow myself to ask questions when I don't understand, rather than mask my inadequacy, and to use a network of lesbian colleagues and friends as resources when I need information, i.e. books, referrals or consultations to be an appropriate therapist for my lesbian clients.

I have personally sought out specific training in counseling gay/lesbian clients, becoming aware of my own homophobic attitudes/practices, which has led to greater effectiveness on my part.

7. A therapist does not attempt to change the sexual orientation of the client without strong evidence that this is the appropriate course of action and that change is desired by the client:

In my own private practice, I had a male client who expressed a strong desire to "go straight." After a careful psychological assessment, his wish to become heterosexual seemed to be clearly indicated and I assisted him in that process.

My therapist has been very sensitive to this issue of "going straight as the solution for a gay patient." She has consistently portrayed the attitude that being gay is ok and not something that is sinful, awful, etc. She has very sensitively maintained that there are societal hassles associated with being gay.

Identity

8. A therapist assists a client with the development of a positive gay male or lesbian identity and understands how the client's negative attitudes toward homosexuality may complicate this process:

One client of mine went into therapy in his early 20s to confess his sudden realization that he was gay. The heterosexual therapist was immensely supportive of his coming out and encouraged him to make contact with the gay community.

I have a patient whose identity and negative self-esteem were developed very early in response to feeling bad/wrong about being lesbian. I have helped her integrate this as one aspect of growing up lesbian in an anti-lesbian family and society as well as looking at her specific early family developmental concerns that weren't related to her being lesbian.

Relationships

9. A therapist is knowledgeable about the diverse nature of lesbian and gay male relationships and supports and validates their potential importance for the client:

My therapist understood that although many gay men have open relationships, it was important for me and my partner to have a monogamous one.

My lover and I saw a therapist who explained to us that there were a variety of different models possible in establishing gay relationships. The therapist encouraged us to work out our own relationship, rather than to live up to someone else's standards.

10. A therapist recognizes the potential importance of extended and alternative families for gay men and lesbians:

A friend told me how when she was coming out her therapist suggested family therapy for her and her lover and her lover's children together and facilitated creating the new family unit.

11. A therapist recognizes the effects of societal prejudice and discrimination on lesbian and gay relationships and parenting:

I worked with a long-term therapy case of an older gay male whose long-time (20+ years) partner was admitted to a nursing home for terminal care of cancer. Issues of privacy and expression of caring and grief in the presence of primarily heterosexual men were especially salient. The patient's dealing with the burial arrangements while not being recognized as a legal spouse or family member were particularly stressful.

I take care to validate the pressures on gay and lesbian parents due to their lifestyle. For example, I helped a lesbian couple develop strategies to deal with the ostracism they were experiencing from other parents at the child's school because they were gay.

I wanted children, but doubted that this was a wise decision, because I am a lesbian and couldn't provide a traditional home environment. My therapist helped me to understand that I could be a good parent, and that I had bought into societal attitudes about lesbians raising children.

A gay parent came in to see me about a problem with his son. He felt that if he weren't gay, his son would not be having these problems. After assessing the situation, it became clear that his son did have some difficulties, but they were unrelated to the father's gayness. I helped the client to address his own attitudes that contributed to his blaming his son's problems on his homosexuality.

12. A therapist understands that the family of origin of a lesbian or gay male client may need education and support:

A colleague (a heterosexual male) discussed with me that when he was seeing a family disturbed by the disclosure that their 17 year old son was gay, he corrected the parents' misinformation, gave them accurate information about sexual preference. Then he assisted the family in maintaining close contact/involvement with their gay son, and assisted the 17 year old in developing a positive image of himself as a gay man.

Therapist Expertise and Education

13. A therapist is familiar with the needs and treatment issues of gay male and lesbian clients, and uses relevant mental health, educational, and gay male and lesbian community resources:

A gay man, a client of mine, age 20, told me he particularly appreciated my willingness to gather information about coming out, including meeting with campus representatives, which he was not yet ready to do, having just concluded in therapy he was gay.

14. A therapist recognizes the importance of educating professionals, students, supervisees, and others about gay male and lesbian issues and actively counters misinformation or bias about lesbians and gay men:

A colleague told me of how they changed the intake forms at the agency to include gay/lesbian and space for "significant other" identification instead of spouse.

I observed a colleague, at a case conference, ask the presenter if he had asked his single male patient about homosexual experience. The presenter had assumed that because he had never had a girlfriend or been married, he was asexual.

Recommendations

The task force identified and categorized a broad range of harmful practices in the provision of psychotherapy to gay male and lesbian clients. Some of these biased, inadequate, or inappropriate practices are already proscribed under existing APA ethical guidelines (e.g., APA, 1981, Principle 2, Competence; Principle 7, Welfare of Client). Unfortunately, many other practices that the task force found to be both questionable and disturbing are not covered. Greater awareness of the potential problems and difficulties encountered by lesbian and gay male clients identified in this survey may help clinicians to avoid bias.

Problems with biased, inadequate, or inappropriate care are common. Fifty eight percent of the psychologists surveyed knew of negative incidents, including cases in which practitioners defined lesbians or gay men as "sick"

and in need of change, and instances in which a client's sexual orientation distracted a therapist from treating the person's central problem. The provision of responsive psychotherapy services to all lesbian and gay male clients remains a challenge, but a challenge the profession can meet. A key step is to develop guidelines for appropriate psychotherapy with gay male and lesbian clients and to ensure that all psychologists receive adequate training.

The results also show that psychologists, regardless of their own sexual orientation, can provide appropriate and sensitive care to lesbians and gay men. The beneficial practices identified in this survey suggest issues and strategies that may help therapists provide ethical and competent care and that may point the way toward the development of lesbian- and gay-affirmative practice.

The issues identified by this survey do not fully exhaust the range of concerns about bias in the psychotherapeutic treatment of gay male and lesbian clients. Important issues not addressed in this study include AIDS; the potential invisibility and complex disclosure issues of gay male and lesbian clients during therapy; gender differences in the therapy experiences of gay men and lesbians; the possible relevance of the therapist's own sexual orientation; specific issues for gay and lesbian therapists (e.g., multiple roles in small communities); and issues that are covered in other APA ethical guidelines (e.g., sex between therapist and client).

Despite APA's 15-year-old nondiscrimination policy regarding lesbians and gay men, bias and misinformation persist among some psychologists. In this survey, 99% of the psychotherapy service providers reported having at least one lesbian or gay male client. It is therefore vital that the profession take the additional steps necessary to make the policy a reality. This can be achieved through education and training, expanded ethical and professional guidelines, and research. There is a clear need for further education to provide accurate information and to train psychologists to be sensitive to bias based on sexual orientation. Such training should be undertaken in every setting in which therapists are trained: graduate school (courses and supervision), professional in-service training, and continuing education programs. Graduate professional education must include instruction in this area for all new psychologists, not only for those who will specialize in the provision of psychotherapy to lesbians and gay men.

The results of this survey provide a starting point for the development of educational materials and model curricula for graduate and professional training. There is a growing research literature on sexual orientation (Garnets & Kimmel, 1991). This work should be disseminated widely to practicing psychologists. Some suggested readings regarding bias in therapy with lesbian and gay men as well as gay affirmative therapy are presented in Appendix B.

Moreover, the survey results raise new and challenging ethical issues. Some of these may not be addressed by existing ethical guidelines and must be discussed within the profession in terms of their implications for practice.

Further research is needed to identify when bias based on sexual orientation occurs, to increase understanding of the processes through which biased judgements develop, and to test models to reduce bias.

The task force was impressed by the high response rate, by the high proportion of respondents who knew of incidents, and by the thousands of detailed responses and opinions provided in respondents' replies. We were also dismayed and disheartened at the evidence that, despite APA's formal, repeatedly stated nondiscriminatory policies, understanding, acceptance, and adherence to those goals are seriously lacking.

The APA must continue to promote its nondiscriminatory policies about homosexuality. New ways to enforce these policies among its members and to help practitioners achieve goals of nondiscriminatory, gay-affirmative practice must be found. For two decades, APA has taken the lead in encouraging mental health professionals to remove the stigma of mental illness from homosexuality and to provide unbiased and appropriate services to lesbians and gay men. The 1990s should be a

time for renewed commitment to this important principle.

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APPENDIX A

Resolution Passed January, 1975, by American Psychological Association the Council of Representatives

The American Psychological Association supports the action taken on December 15, 1973 by the American Psychiatric Association, removing homosexuality from that Association's official list of mental disorders. The American Psychological Association therefore adopts the following resolution:

Homosexuality, per se, implies no impairment in judgment, stability, reliability, or general social or vocational capabilities: Further, the American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations.

Regarding discrimination against homosexuals, the

American Psychological Association adopts the following resolution concerning their civil and legal rights:

The American Psychological Association deplors all public and private discrimination in such areas as employment, housing, public accommodation, and licensing against those who engage in or who have engaged in homosexual activities and declares that no burden of such judgment, capacity, or reliability shall be placed upon these individuals greater than that imposed on any other persons. Further, the American Psychological Association supports and urges the enactment of civil rights legislation at the local, state, and federal level that would offer citizens who engage in acts of homosexuality the same protections now guaranteed to others on the basis of race, creed, color, etc. Further, the American Psychological Association supports and urges the repeal of all discriminatory legislation singling out homosexual acts by consenting adults in private.

APPENDIX B

Bias in Therapy and Gay Male and Lesbian Affirmative Therapy: Suggested Readings

Bias in Therapy With Lesbians and Gay Men

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