CREATING ACCESSIBLE COUNSELLING SERVICES FOR LESBIANS AND GAYS

BY

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A Thesis
Submitted to the Faculty of Graduate Studies
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Abstract

The author explores the barriers faced by gays and lesbians in accessing relevant and non-biased counselling services. The investigation utilizes a qualitative research design that borrows procedures from a grounded theory model for research. The first goal of this study is to review the ways in which helping professionals have historically responded to homosexuality. Current obstacles to participation in counselling are then investigated through interviews with ten lesbians and gays. Respondents identify barriers to service as including concern about interventions aimed at reorientation, the client's comfort level with their own sexual identity and heterosexist bias within the therapeutic approach. Given the sense of alienation individuals describe in relation to conventional helping systems, the author reflects on the variety of alternatives to counselling that lesbians and gays may employ in addressing problems. As most participants report having had some form of contact with counselling practitioners, the researcher examines how clients determine comfort within a therapeutic setting. Assessments about suitability of service inform decisions related to 'coming out' to the helper and proceeding or terminating with participation in counselling. The study concludes with a series of recommendations about the development of a more accessible approach to clinical service. The respondents advise that practitioners commit themselves to a process of reeducation that entails challenging internalized bias and expanding their knowledge base with regard to gay and lesbian issues. It is suggested that accessibility is enhanced through the counsellor's efforts to outline agency confidentiality policies; adopt inclusive language; ensure the presence of physical indicators of a lesbian and gay clientele; and, the promotion of a visible profile within the sexual minority communities. The author argues that counselling professionals have a responsibility to advocate for the rights of those citizens who belong to the gay and lesbian minorities.

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Chapter One

Introduction

A tradition of abhorrence toward homosexuality in Western culture has created and upheld enormous social barriers for gays and lesbians. The current attitudes of the dominant heterosexual majority continue to be influenced by hostility, myths and stereotypes. Lesbians and gays must strive for stable, fulfilling lives in isolation from visible role models, legal protection from discrimination and other social supports enjoyed by heterosexuals. While sexual minorities have historically been alienated from helping professionals, political efforts towards social visibility and equality suggest that counsellors are increasingly likely to receive demands for service from lesbians and gays. As a profession committed to providing equitable services to under-served populations, social work is faced with an important opportunity to adapt theory and practice toward an informed and accessible clinical response to the needs of sexual minorities. This study aims to identify the conditions that have served as barriers to lesbians and gays who seek counselling and to advance a set of recommendations for the development of an accessible approach to clinical intervention.

Rationale

The origins of my research date back to 1994 when I initially began a practicum with the objective of completing a Masters of Social Work. As my undergraduate training had been targeted almost entirely toward service provision with more traditional forms of family, the goal of this project was to develop clinical skills that would be specific to providing conjoint therapy to gay male couples. After advertising the practicum in various community newsletters,

counselling agencies and gay organizations, I set up an answering service to collect and screen requests for service. Regrettably, after several months had passed and I had repeated my attempts to promote the project, the practicum had received an insufficient number of contacts from potential participants who demonstrated an intention to commit to ongoing involvement in the therapeutic process.

In determining how to proceed with the study, I took the opportunity to examine these failed attempts to locate a client base. It was clear that despite my caution to promote the practicum in a manner that communicated qualities of confidentiality, respect and sensitivity for the gay experience, I was unable to stimulate participation. Interestingly, however, a review of the situation revealed that contacts did include numerous instances where potential clients scheduled but did not attend appointments. Some men informed me that due to concerns about confidentiality, they were prepared to engage solely in counselling over the telephone. In addition, the answering service recorded an unusual number of telephone hang-ups. Furthermore, the advertisement attracted three requests for consultation with other helping professionals and I received two invitations to deliver public education seminars at a gay discussion group. The publicity of such a service appeared to have generated a degree of interest that somehow could not transcend the barriers to actual participation in counselling. I began to consider my initial experiences as an exploratory phase in an overall process of learning. Within this context my efforts did not appear futile as they ultimately served to redirect my attention toward an exploration of the possible conditions that obstruct access to gays and lesbians seeking counselling.

As I came to revise my study objectives toward an examination of the relationship of the counselling professions to the lesbian and gay minority, a number of initial questions emerged. A review of the literature as it relates to the historical response of clinicians toward lesbian and gay clients stimulated an inquiry into the current obstacles to accessing therapeutic services. I began to question the ways in which an individual might come to determine the appropriateness of a particular helper. This direction of inquiry suggested a study plan that was vastly different from my original aim to develop my therapeutic technique. Therefore I selected a thesis format rather than continuing to pursue a practicum. It became my intention to speak directly with members of the lesbian and gay communities in order to develop an understanding of people's experiences and perceptions. Through a series of interviews with past and potential consumers of counselling and a review of the clinical literature, I set out to advance a set of recommendations that might aid a clinician in the task of modifying practice so as to facilitate greater accessibility for lesbian and gay clients.

Chapter Two

Literature Review of The Historical Social Scientific Approach to Homosexuality

Throughout history the regulation of sexual behaviour has been enforced through the authoritative voice of religious, legal and mental health institutions. Homosexuality has been relegated outside of the range of social acceptability through the assignment of a succession of labels such as 'sin', 'crime' and 'sickness'. Remnants of all of these perspectives have been preserved to some degree in certain sectors of contemporary Western society. Overcoming current barriers to accessible counselling requires sensitivity to the historical context in which social institutions have responded to gays and lesbians. Sociologist Gary Kinsman advises that "examining historical experiences can help us understand from where lesbian and gay oppression has come, where it may be going and the possibilities for change" (Kinsman, 1987, p. 23). This chapter aims to chronicle a range of clinical approaches that practitioners have employed in the historic quest to manage homosexuality.

The roots of religious proscriptions against same-sex erotic conduct may be traced to the ideals and values that were espoused by the ancient Hebrews and early Christians (Conrad & Schneider, 1980). During much of the past two thousand years, ecclesiastic traditions in Western culture have tended to consider nonprocreative sex to be in violation of the holy order, as it has been ordained by God (Parrinder, 1980). With pleasure as the sole purpose, homosexual behaviour was perceived as a transgression from the citizen's reproductive responsibility to the wider community. Such conduct was

proclaimed to be a shameful vice that endangered the very survival of the human race.

As the authority of religion was gradually overshadowed by the emergence of the modern state, the condemnation of same-sex activity increasingly became the province of secular law. Homosexuality came to be defined as not only a sin but a crime against nature. Gary Kinsman indicates that "in the Consolidated Statutes of Canada, drawn up in 1859, 'buggery' with man or beast was punishable by death" (Kinsman, 1987, p.92). Similarly in England, until 1861 criminal prosecution for homosexual sex carried a penalty of death (Bayer, 1987). However, post-Renaissance society gradually transferred authority away from both legal and religious institutions and looked to science as the appropriate agent for the social control of deviance. "Sinful, and particularly sexually sinful, behaviour became not only wrong but also unhealthy" (Conrad & Schneider, 1980, p. 212). The concept of same-sex erotic behaviour as a physical or psychological illness eclipsed the moral and legal discourse on homosexuality.

Social science research typically set out to examine homosexual behaviour as the result of either biological or social influences. These approaches were based upon the assumption that such conduct represented a pathological condition that had to be explained. Despite the existence of homosexual behaviour in animal populations, across a range of cultures and throughout human history, etiological questions have dictated the direction of scientific research. A traditional mental healthcare perspective on homosexuality was founded upon this historic search for cause. Whether a practitioner's clinical rationale was informed by biological theories, genetics, psychoanalysis or

behaviourism, intervention tended to focus on providing gay and lesbian clients with a 'cure' from psychopathological illness. The theories and practice of counselling professionals have served to govern behaviours that are perceived to exist outside of Western social norms.

Early Biological Theories of Homosexuality

In the 18th century, scientific studies of sexuality were primarily based upon theories associated with the human physical constitution. Physicians stressed the importance of maintaining the equilibrium of the human nervous system. Orgasm was perceived as a threat to that stability given that it served as an expenditure of energy that would be followed by fatigue. This belief "...yielded the conclusion that too much sexual activity, and particularly deviant sexual activity, could be detrimental to one's health"(Conrad & Schneider, 1980, p179). Acceptable sexual activity was prescribed in moderate quantity and for the sole purpose of procreation. Sexual excess and masturbation in particular came to be associated with physical and mental illness. Medical authorities of the day commonly identified masturbation as causing erotic attraction toward one's own sex (Taylor, 1970).

It was not until 1869 that Karoly Maria Benkert developed the terms 'heterosexual' and 'homosexual' in order to categorize distinct sexual types (Conrad & Schneider, 1980). Same-sex erotic attraction had previously been considered solely in relation to deviant behaviours as opposed to a classification of a specific group of people. The conceptualization of an 'homosexual type' failed, however, to delineate between lesbian and gay male identities. While much of this early scientific conjecture appears to have been derived from

research conducted with gay males, applicability to both women and men was commonly assumed. In a review of the history of research on homosexuality, biologist Anne Fausto-Sterling states:

> Most of the researchers in the world have been male and most male researchers are not interested in women. They don't work on women and they don't even work on female rats. They don't think female organisms are worth studying or they think are too difficult or complicated to study. They menstruate and do this messy stuff, so their hormones change each month and it's just all too complicated to control. So it's just easier to have an all male sample (Hirsch & Monette, National Film Board of Canada, 1995).

The conceptualization of a distinct homosexual type influenced researchers toward explorations of factors associated with biological make-up. 19th century scientific explanations for sexual deviance came to rely increasingly on the principles of heredity and evolution. Homosexuality was explained as a hereditary predisposition. The influential publications of naturalist Charles Darwin outlined the theory of natural selection which defined homosexuality as a maladaptive biological failure that ultimately threatened the progress of the human species (Karlen, 1971). In 1887, physician Paul Moreau identified same-sex sexual behaviour as a congenital impairment that might be likened to being born blind or deaf (Conrad & Schneider, 1980). As reviewed by Karlen (1971), medical doctors Johann Ludwig Casper and Ambroise Tardieu advanced theories relating to how science might locate homosexuals through physical means and thus more efficiently enforce legal accountability for deviant behaviour. Casper advised that the 'sexual invert', might be best identified through the examination of the rectum as it was presumed to have been altered through the practice of sodomy. Tardieu described the homosexual male as having "a slender, underdeveloped penis with a small glans, tapering from root to tip like a dog's. He maintained that even before sodomy took place, the

homosexual's rectum was smooth and lacked radial folds" (Karlen, 1971, p.186). Paola Mantegazza went on to advance that some gay men were born with genital nerves situated in the rectum (Karlen, 1971).

The influential work of Cesare Lombroso was reminiscent of Darwinian thought in its depiction of the homosexual as representative of a less evolved stage of human development (Steakley, 1997). "To prove his point...Lombroso measured the skulls, bodies and features of criminals, prostitutes, idiots, arsonists, the poor and homosexuals" (Karlen, 1971, p. 189). His 1893 research linking prostitution, physical masculinization in women and masturbation to lesbianism was a stimulus for the widespread study of prostitutes and lesbians. Karlen (1971), suggests that it is from this fervor of investigation into biological differences that Karl Ulrichs concluded that homosexuals cannot whistle; Magnus Hirschfeld described a tendency toward left handedness; and Dr. Bernhardi, suggested that due to an absence of spermatozoa, gay men were not in fact male. In examining the physical characteristics of lesbians, Havelock Ellis formed a similar conclusion to Bernhardi. He suggested that the more 'masculine partner' in a female couple is a member of a third sex that is neither female or male (Downing, 1991).

Richard von Krafft-Ebing, in his 1887 publication of 'Psychopathia Sexualis' described homosexuality as a perversion that is determined by the interplay of both biological and social factors. Given a biological predisposition to masculinization in females and feminization in males, Krafft-Ebing advised against legal recriminations against homosexuality (Ellis, 1965). "The pervert may need to be segregated to protect the community, as is the patient with

cholera, but he is no more to be condemned for his disorder than the latter is, for sexual psychopathics are illnesses" (Rees & Usill, 1955, p.138).

Through the early 1900's, biological arguments for legal and social reform were advanced by German scientist and homosexual advocate, Magnus Hirschfeld. As a gay man himself, Hirschfeld went on to establish a centre for research referred to as 'The Institute of Sexual Science'. His studies proposed that same-sex attraction is determined by glandular secretions and is therefore inappropriately treated as a punishable offense (Plant, 1986). Ironically, the psychiatrists of Adolf Hitler's Nazi regime would later concur with Hirschfeld's biological theories of causality and set out on a course of torturous experimentation and systematic extermination of Germany's lesbian and gay citizens (Heger, 1980). At the conclusion of World War II "the world was ripe for another change of ideas. The recent Nazi horror left both scientists and society deeply suspicious of biological explanations for human behaviour. Psychoanalytic and behaviourist theories gained ground" (Hirsch & Monette, National Film Board of Canada, 1995).

The Freudian Perspective

In 1885, Sigmund Freud's early clinical efforts relating to homosexuality were as a pupil of Dr. Jean Charcot. Together they found the application of hypnosis to be unsuccessful in 'curing' homosexuality (Brill, 1960). Freud quickly abandoned hypnosis as a therapeutic tool in favour of clinical methods associated with the psychological analysis of the human unconscious. His work came to incorporate attention to both constitutional and environmental factors in the development of human sexuality. To pinpoint his specific position on the issue of homosexuality is complicated by the fact that his theories were

continually evolving throughout his life's work. Although Freud would frequently retract from propositions he had made in earlier periods of his career, the whole of his writing on the subject of homosexuality would remain influential in psychoanalytic thinking and practice.

Freud asserted that all human beings are born with a bisexual orientation and that it is only through interaction with parents and the environment that a distinct sexual preference is determined (Carl, 1990). Although he described all people as passing through a period of same-sex attraction, Freud believed that heterosexuality represented the normal achievement of psychosexual development. While scientific investigation had always targeted homosexuality as a condition that had to be explained, Freud took the radical position that the formation of an heterosexual orientation must also be accounted for (Lewes, 1989). He outlined an influential theory on the role of infantilism in the development of all human sexualities. He believed that infants begin life in a stage of 'polymorphous perversity', where without the restrictions of a socially imposed morality, sexual pleasures are received through a limitless range of activities in all parts of their bodies (Freud, 1905). 'Libido' or the energy of sexual instinct, soon becomes invested in the mouth and its activities which are the main sources of gratification in this early stage (Brill, 1960). He understood the child's personality to be primitive as it is concerned only with immediate pleasure. Infants live in a state of almost complete dependency on their mothers during this developmental time which Freud called the 'oral stage'. The primitive personality, which he referred to as the 'id', begins however to develop the capacity to take action and have some control over the world. This emerging part of the personality, the beginnings of the 'ego', was thought to result in the child

having greater control of its own body and developing a greater capacity to take independent action (Freud, 1905).

Freud advised that as the newly acquired ability to control processes like defecation were experienced as pleasurable, libidinal energy becomes invested there. The process of toilet training becomes an important social interaction since the child is expected to use this newly developed control to please someone else (usually the mother). This stage was called the 'anal stage' (Freud, 1905). Because women were most commonly the rearers of children, mothers were thought to be the sources of pleasure and objects of desire for boys and girls in these early stages. However, Freud theorized that at about age three, an investment of libidinal energy is transferred to the genitals and children thus become very interested in these parts of their bodies as sources of gratification. As independent beings who now have developed wills of their own, children are curious and come to engage in an investigation of genitalia whenever possible. This exploration leads them to discover that while boys and men have big and extravagant organs of gratification, girls and women do not. Freud (1925) thought that upon this realization, boys experience fear about the possibility of being deprived of their penises. Recognizing that their father still possesses a penis, boys conclude that their mother has been castrated by the male parent and thus been rendered defective. The child's resulting 'castration anxiety' was largely related to a fear of the father. In this stage boys usually retreated from their mothers as a source of gratification lest their father be angered by the competition for her attention. Moreover, they now begin to comply with and internalize their father's rules for behaviour. The child would come to imitate and identify with the male parent so as to deflect his anger,

protect themselves from castration and to become powerful like him. This was thought to be the beginning of an heterosexual orientation. It also marked the development of the personality that Freud called the 'super-ego'- conscience, ego-ideal and source of guilt (Freud, 1910). Girls on the other hand, resented that their now less admirable mothers could not truly meet their needs for gratification (Freud, 1931). Freud thought that girls usually turned to their fathers as objects of desire and developed an heterosexual orientation because their fathers possessed the desired penis. They, too, internalized rules of behaviour to keep his approval and affection, but identified more with their mothers since, by being like her, they might similarly please the male parent. Freud (1924) called this the 'phallic stage', and referred to the dramatic developments of cross-sex attachment as the Oedipus and Electra complexes respectively for boys and girls.

Freud thought that heterosexuality was reinforced through the resolution of the Oedipus and Electra complexes. This task included a moratorium on sexuality. This involved a decision to delay the gratification of sexual desire until adulthood, when one could safely and successfully find and keep a mate of one's own. This phase was called 'latency' and was portrayed as a time when the child's energy was devoted primarily to learning the skills needed for adulthood (Brill, 1960). Through the 'latency stage', the 'ego' and 'superego' were thought to develop to the degree that the child became capable of more mature defenses against socially unacceptable or personally harmful impulses. At puberty the child would reinvest libidinal energy in the genitals. The more sophisticated social and personal skills developed in latency could now be used to channel energy into activities that were both socially useful and personally

gratifying. This involved the organization of affectional behaviour within the constraints of society's need for procreation and the orderly rearing of children.

Freud proposed a variety of explanations for the construction of a gay male sexual orientation. He believed that those individuals who continued to identify as homosexual in adulthood were somehow 'arrested' in an earlier stage of the developmental process. His theories were grounded in the assumption of an inherent frustration during the Oedipal phase of psychosexual development in combination with either an excessively gratifying or rejecting mother or a weak or absent father. These conditions were thought to lead to identification with sexual characteristics of the mother rather than the father, continued strong attachment to the mother (rather than delaying to the next generation for a 'mother-like' mate) or complete rejection of the mother and therefore all women as objects of gratification.

Freud advised that when boys who were overly attached to the female parent discovered that she had no penis, their reaction of horror and fear of castration would result in a severing of ties with the mother in favour of an erotic bond with a feminine male who was likened to a woman with male genitalia (Karlen, 1971). A second theory posited that due to the denial of sexual gratification from a female parent during the Oedipal phase, a boy would project an idealized image of himself onto a male partner so as to narcisstically offer to himself the love he desires from his mother (Tripp, 1975). Freud hypothesized that in other circumstances, a boy's experience of resentment toward the female parent for her attention to his father, might create an 'inverted Oedipus complex'. Given Freud's assumption of innate bisexuality, this involves the child being erotically drawn toward the male parent as he abandons the task of emulating

his father in order to secure love from him. Where the Oedipal struggle is intense and the boy is constitutionally feminine, he was believed to remain locked into an homosexual identity (Freud, 1905). Freud also proposed that where boys are fixated in anal erotic pleasures, the inverted Oedipal complex involves the pursuit of sexual gratification in a manner that imitates the woman's receptive sexual role (Tripp, 1975). Another of Freud's explanations for homosexuality was based again on a state of over-attachment to the mother. Here same-sex erotic attraction was believed to emerge as a defense mechanism. This involves the repression of intolerable violent fantasies in response to the mother's attention toward same sex siblings and the father. The child's unconscious decision is to remove himself from competition by transforming rivals into objects of erotic attraction (Lewes, 1989). Freud also advised that an ineffectual or absent father would fail to generate a sufficient level of fear to drive the male child away from his attachment to a nurturing mother (Freud, 1905). As was typical of early scientific speculations, these hypotheses about homosexuality tended to be about the gay male experience. However, Freud advised that the formation of a lesbian identity may be understood by simply applying these etiological theories in the converse (Carl, 1990).

Despite Freud's assertions about the influence of environmental factors in the development of an homosexual identity, his theories did not overlook the role of congenital determinants. Given that the same set of social circumstances appeared to yield an heterosexual orientation in some individuals and produce homosexuality in others, Freud concluded that sexual orientation is shaped by a combination of both environmental and hereditary forces (Bayer, 1987). In his

1905 publication of 'The Three Essays on the Theory of Sexuality', Freud soundly rejects the attribution of pathology to homosexuality. He observes that same-sex erotic attraction occurs in individuals that exhibit no other abnormalities and is common in those who are highly intellectually and ethically developed. He was skeptical with regards to the potential for therapy targeted toward 'reorientation' stating that "to undertake to convert a fully developed homosexual into a heterosexual is no more promising than to do the reverse" (Freud, 1920, p. 137). In a 1935 letter to a mother who seeks the reorientation of her gay son, Freud advises that the appropriate direction for clinical intervention is not about 'cure' but rather to assist the individual to attain comfort with his sexual orientation. He writes:

> By asking me if I can help, you mean, I suppose, if I can abolish homosexuality and make heterosexuality take its place. The answer is, in a general way, we cannot promise to achieve it...in the majority of cases it is no more possible....What analysis can do for your son runs a different line. If he is unhappy, neurotic, torn by conflicts, inhibited in his social life, analysis can bring him harmony, peace of mind, full efficiency, whether he remains homosexual or gets changed (Downing, 1991, p. 43).

In contrast to Freud's position on reparative therapy, his work served to invite theorists to equate homosexuality with pathology. While he presented repressed same-sex erotic attraction as a universal phenomenon, such urges were depicted as having an exaggerated role in the mental life of the psychologically disturbed (Karlen, 1971). Paranoia was understood to be a defense against the intolerability of same-sex yearning. Although Freudians who published between 1900 and 1930 tended to adhere to the perspective that homosexuality represented an arrested psychosexual development, much attention was focused upon the relationship of delusional and paranoid thinking to repressed same-sex urges (Lewes, 1989). Given that a representative sample of lesbians

and gays was improbable at the time, scientific research was largely based on a clinical population. These early studies tended to reinforce an association between homosexuality and psychological disturbance and thus imply that an appropriate clinical response involves the emancipation of the client from a pathological state.

Reparative Therapy

Like Freud, most early practitioners of psychoanalysis were skeptical with regard to the potential for affecting a 'cure' for homosexuality. However, proponents of environmental arguments for the etiology of homosexuality, provided a sense of optimism for practitioners who favoured interventions based on reorientation. Lewes (1989), cites Abraham Brill, Felix Broehm and Isadore Sadger as examples of prominent analysts who professed in the early twentieth century to have had limited success in 'restoring' heterosexual functioning.

Therapeutic efforts referred to as 'radical treatment' describe clinical intervention that is directed toward a complete conversion of the homosexual client to heterosexuality. In contrast, a 'palliative treatment' approach does not seek to change the direction of one's orientation but merely aims to curb the sexual impulse so as to persuade the individual away from overt homosexual behaviour (Rees & Usill, 1955). These forms of therapy have utilized psychoanalytic methods, hypnosis, or the administration of hormones. While practitioners identified limited success in affecting complete reorientation, those clients who remained erotically drawn to their same sex were commonly portrayed as lacking sufficient motivation toward normalcy. The least likely candidates for reorientation were identified as those individuals who exhibited any degree of comfort with their homosexual condition (Ellis, 1965).

By 1911, Alfred Adler had divorced himself from popular psychoanalytic theories based on instinctual determinants. He equated the homosexual with a spoiled child who is unprepared to face the demands of adult life without a mother's protection. Gay males were portrayed as having a perception of the self as incapable of attaining masculine role. It was assumed that a gay identity was therefore adopted in order to compensate for a sense of inferiority and to avoid the possibility of defeat in the tasks of normal adulthood (Rees & Usill, 1955). Similarly, Adler proposed that the lesbian fails to believe in her capacity to succeed within the role of a woman. He viewed her as attempting "to equal or outdo men on their own terms - power, dominance, aggression. This 'masculine protest', as Adler called it, may produce an angry, mannish feminist with menstrual troubles and relative frigidity. Or it may produce a lesbian...who felt from early childhood that they could never win any man's real love or interest" (Karlen, 1971, p.286).Unlike Freud, Adler's therapeutic intervention avoided unearthing past trauma and instead promoted the curing of homosexuality through a re-education process that centered on overcoming feelings of inferiority and learning to adopt 'healthier' behaviour patterns and goals (Harper, 1959).

The psychological research of the 1930's and 1940's continued to be influenced by Freudian postulations. Scientific attention was largely focused upon expanding theories of arrested psychosexual development. Despite insubstantial evidence to support the possibility of 'cure', psychoanalysts laboured under the assumption that to unblock the individual's paralysis in psychosexual development was to free him/her to choose an heterosexual orientation (Lewes, 1989). Scientific speculation about homosexuality throughout

this time period appears to have been formulated primarily on data derived through research on gay males.

Some of the psychoanalytic conjecture specific to female homosexuality was outlined by Cornelia Wilbur (1965). Wilbur believed that a fixation toward either her mother or father could thwart a girl's capacity to form attachments with the male sex. The 'aggressive' lesbian was considered to envy the male sex organ which would result in fantasies of possessing a penis and achieving sexual gratification through insertion. Wilbur suggested that heterosexuality would be repressed if a female child was parented by a 'mothering father' while maturing through the Electra complex. Should a girl perceive the male parent as rejecting of her, it was theorized that she would come to renounce not only her father but males in general. Childhood circumstances that involved a prolonged absence of the female parent, were believed to elicit hostile fantasies in relation to abandonment that result in the search to secure a surrogate mother. Wilbur concludes her review by pronouncing that "with adequate motivation and cooperation, successful psychotherapy resulting in reversion to exclusive heterosexual behaviour is possible" (Wilbur, 1965, p. 281).

Psychological research into male homosexuality continued to be guided by classical psychoanalytic principles. Anna Freud emphasized the feminine desires of the 'sexually passive' gay man who was believed to project his 'estranged' male identity onto a 'sexually active' partner so as to regain a sense of masculinity. She claimed that through invoking a sexual crisis within a therapeutic context, problematic issues from childhood could be reawakened and resolved in order to renew a masculine heterosexual drive (Lewes, 1989). As reviewed by Bieber et al. (1962), the publications of Karl Abraham and Ernest

Jones illustrate other psychoanalytic spin-offs from Freudian theory. Abraham proposed that male homosexuality represented a failure to assume the normal path toward resolution of the Oedipal complex by replacing the female parent as the object of affection with the father. Jones identified two determinants of homosexuality as including a strong degree of sadism and an intense oral fixation.

In 1932, Melanie Klien modified Freudian theory through her assertion that male same-sex attraction represents a disturbance in psychosexual development that occurs prior to the Oedipal complex. In consideration of the psychological demands that accompany weaning in the 'oral stage', Klien hypothesized that an infant's frustration results in cannibalistic fantasies towards the mother's breasts. She advised that the child would come to project these violent thoughts onto the external world. "This results in an unconscious fear of being devoured by the love object. The vagina, which is unconsciously equated with the mouth, comes to represent the castrating, devouring organ" (Bieber et.al, 1962, p.103). Analysis was directed toward facilitating the renewal of the client's belief in his mother's essential goodness and in his ability to gratify her with his penis. (Bayer, 1987).

In 1933, Eidelberg and Bergler also explored pre-Oedipal influences on male homosexuality. As in Klien's theory, fixation in an oral stage was assumed to result in an avoidance of women due to the disappointment and hostility experienced from weaning. Referring to this phenomena as the 'breast complex', they suggested that the penis comes to symbolize the mother's breast. As semen becomes a substitute for the individual's urge for milk, the vagina was

portrayed as representative of the child's cannibalistic fantasies (Bergler, 1959). Bergler states that:

> In his organ language he unconsciously expresses the denial of dependence on Mother's breast by proving to himself that he could not have been disappointed by another as he himself possessed the organ with which the disappointment would have been executed. By unconsciously identifying breast and penis, he makes himself 'independent' of mother and, in consequence of the entire female sex. He tries to duplicate his clever trick by choosing as partners only those who possess the duplication of his own defense mechanism - the penis....Homosexuals are not man-lovers; they are merely frightened fugitives from the fantasy of the 'cruel' mother they themselves created (Bergler, 1950, p.107).

Edmund Bergler advised that there is no such thing as a healthy homosexual (Bergler, 1956). He boasted of a 9.9 percent success rate in curing homosexuals by provoking recollections of 'the mother's act of deprivation' during the process of weaning. He proposed that through this re-emergence of pre-Oedipal trauma, analysis would resolve the client's hostility toward the opposite sex and unleash heterosexual functioning. He predicted the male client would experience an initial struggle with premature ejaculation which is representative of an attempt to avenge himself for his mother's withholding of milk. Lesbian coupling was presented as a reflection of a distorted mother-child relationship whereby a woman would develop a destructive level of dependency toward a female partner who functioned as a parental figure (Conrad & Schneider, 1980). Bergler, whose publications spanned well into the 1960's, is credited by Lewes (1989) as being partially responsible for the gay community's mistrust and animosity toward counselling professionals. He characterized homosexuals as being psychologically disturbed reprobates who harbour an intense longing to experience emotional suffering. Bergler stated that the homosexual personality is:

> a mixture of superciliousness, fake aggression and whimpering ....they are subservient when confronted with a stronger person, merciless when in power, unscrupulous about trampling on a weaker person. The only language their unconscious understands is brute force....you seldom find an intact ego (Bergler, 1956, pp. 28-29).

In 1938, W. Silverberg renewed attention to the Oedipus complex. He advanced the idea that 'passive' homosexuality resulted from the male child's unconscious attempts to separate the parents by drawing the father's phallic appetite toward a same-sex relationship (Beiber, 1962). The child believes that once freed from her husband's sexual demands, the mother would become available to meet the child's needs for enjoyment. Silverburg insisted that homosexual relationships were unworkable as the 'passive' partner is attracted only by men who are desired for sexual intercourse by women. Condoning the mistreatment of sexual minorities, he stated that "since the passive homosexual is trying to extinguish the race...society is justified in its violent feelings toward him and...in taking steps against him" (Lewes, 1989, p.115).

Karlen (1971) describes the work of Sandor Rado in the 1940's as a departure from Freud's conceptualization of an innate bisexual drive. Rado instead introduced the theory of 'latent heterosexuality' which suggested that within every lesbian or gay man lay a natural proclivity toward heterosexuality (Bayer, 1987). Treatment was thus targeted toward unearthing the client's 'natural' heterosexual tendencies. Refuting the notion of a constitutional component to instinctual drives, Rado asserted that male-female pairing represented the only natural form of sexual adaptation and that it is cultural influences that determine an homosexual orientation. He redefined the same-sex erotic urge as an attempt to procure sexual gratification where resentment and

fear had created obstacles to 'normal' relations (Beiber, 1962). Equating homosexuality with schizophrenic disorganization, "Rado pointed to what he believed was the otherwise inexplicable nature of the choices made by homosexuals - their selection of partners who despite their biological endowments took on features, at least subjectively, of the opposite sex." (Bayer, 1987, p. 29)

Dismissing Freud's instinctual drive theories, Wilhelm Stekel attributed the existence of male homosexuality to a psychological conflict that directed the individual to make choices that allowed for the avoidance of difficult challenges (Karlen, 1971). The repulsion that Stekel believed gay men felt toward women was viewed as a defensive reaction against lust. He further advised that gay men, whom he characterized as intensely jealous, equate heterosexual intimacy with a sense of vulnerability to the possibility of a woman's infidelity. Stekel asserted that, given the individual's extremely jealous nature, his 'natural' heterosexual orientation becomes sublimated in an attempt to cope with his own potential to murder a female partner. Through short-term, problem-centered therapy, aimed at re-education, Stekel claimed to have radically, reoriented four homosexual clients (Rees & Usill, 1955). He emphasized that although his 'successes' were few, these case examples provided evidence that contrary to Freud's position, 'cure' was possible.

Albert Ellis, the founder of 'rational emotive therapy', began writing about reparative treatment in the 1950's. His theories explained the condition of homosexuality through a combination of biological, cultural and familial factors in relation to irrational, self-defeating thought patterns. As evidence for unrealistic thinking he cited the choice of an homosexual orientation amidst severe social

and legal prohibitions; closed-mindedness about sexual experience with the opposite sex; the avoidance of responsibility and long range planning that characterizes an heterosexual lifestyle; an irrational fear of the opposite sex; and a belief that all homosexuals are psychotic or suffer with other emotional disturbances (Ellis, 1965).

Ellis ascribed a greater degree of sickness to lesbians than gay men as he did not observe the intense hostility toward the opposite sex in male homosexuals that he perceived in lesbians (Karlen, 1971). Much of the early scientific conjecture on homosexuality suggested that "the mannish woman was characterized as a threat to the private realm of the family - nothing short of a woman on strike against marriage and motherhood" (Terry, 1997, p. 274). In defence of conventional female sex roles, Ellis stated that:

> ...women can be heterosexual despite frigidity, since they don't have to achieve and maintain erection....A male trying to cure himself of homosexuality may not be able to get a girl so easily....So women who cop out on the female role and become lesbians are giving up on a relatively easy role to assume, and they are often very disturbed (Karlen, 1971, p. 224).

Ellis thought that since feelings of guilt and self criticism would further entrench the homosexual in illogical choice, the therapist must adopt a position of acceptance about the client's right to make a mistake. He advised therapists to combat the client's tendency toward self blame, while educating about unhelpful cognitive styles so that more rational beliefs and values could emerge. Critical of the passive approach taken by traditional psychotherapy, Ellis insisted that successful reorientation requires persistence in challenging excuses and correcting irrational thinking so as to persuade the client toward openness to the

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opposite sex. The therapist was directed to provide homework assignments that involved dating and having heterosexual intercourse (Ellis, 1965).

A Return to Biological Theories

Reparative therapy was met with some degree of skepticism where theoreticians attributed homosexuality to an inborn constitutional condition. While etiological explanations throughout the 20th century focused primarily on psychological causes, some investigators continued to explore biological factors. In the early 1900's, Sandor Ferenczi distinguished between types who are erotically drawn to the same sex and those who identify themselves as being the opposite sex (Karlen, 1971). Clinical objectives with regard to those merely attracted to the same sex, involved efforts to harness the patient's sense of sexual urgency and alleviate what he perceived to be an hostility toward the opposite sex. Ferenczi found that for many of his patients who identify as being the opposite sex, the choice of erotic partner would not be altered through treatment (Lewes, 1989). He concluded that gender confusion was rooted in the individual's biological make up and was therefore unchangeable. Although, Henry Havelock Ellis reported moderate progress in reorienting bisexuals, he described constitutionally based homosexuals, whom he viewed to be a category of hermaphrodite, as 'incurable' (Rees & Usill, 1955). While Ferenczi directed clinical intervention toward the psychological adjustment to one's congenital orientation, Ellis insisted that it was "outside the province of the physician to recommend his inverted patients to live according to their homosexual impulses" (Ellis, 1936, p. 342).

Arguments for a genetic cause were based upon studies that sought to trace hereditary lineage. In 1940, Magnus Hirschfeld reported that approximately 35%

of gay men have siblings or other close family members who are homosexual (Ellis, 1965). In 1952, F. Kallman published similar evidence for a genetic hypothesis. His study identified that while less than half of 45 dizygotic sets of twin brothers shared a common homosexual orientation, a full 100% of 40 sets of identical twins were similar in relation to an homosexual orientation.

Research also examined a 'body type' hypothesis to explain same-sex attraction.

> This early scientific discourse...was a fascination and obsession with the body - its structure, motions and behaviours - as a territory of perversions. Through techniques of clinical surveillance and diagnosis, homosexual bodies were objects to be measured, zones to be mapped, and texts to be read by scientists..." (Terry, 1997, p. 274).

In 1936, Havelock Ellis, after examining 10 homosexual women, noted that lesbians exhibit small, undeveloped clitorises (Ellis, 1965). In that same year, Hirschfeld proposed that even before puberty, a lesbian is identifiable by her boyish appearance, while the gay male is of a more feminine build (Ellis, 1965). In 1940, W. Sheldon measured and photographed thousands of women and men in order to match their personality types to categories of body types he referred to as 'endomorph', 'ectomorph' and 'mesomorph'. From this study, he described homosexuals as physiologically fragile, with poor endowment and physical characteristics of the opposite sex (Karlen, 1971). In 1941, Dickinson declared that lesbians have early onset of menstruation, frequent erectility of the nipples and glans clitorises that are one third larger than in heterosexual females (Ellis, 1965). A 1961 study by Nedoma and Freund, reported that gay men have a lower body weight and a larger width of penis (Karlen, 1971).

Rees and Usill (1955), review the work of Wright who discovered an abnormal ratio between male and female hormones in gay men. As late as 1971, R.C. Kolodny concluded that gay men have lower levels of testosterone and androgen in the blood, lower sperm counts and misshapen sperm cells (Masters & Johnson, 1979). Such discoveries directed practitioners toward the use of hormone therapy in order to regulate and eradicate homosexual behaviour. Radical treatment involved administration of large doses of testosterone. While this approach appears to have increased the sex drive, it was not shown to redirect the male's erotic desire toward heterosexuality (Allen, 1958). A palliative treatment approach entailed either the administration of oestregen or castration. Throughout the 1930's and 1940's castration was performed on gay men in Denmark, Sweden, Norway, Finland, Holland, Greenland, Iceland and Germany (Karlen, 1971). While the administration of oestregen was found to weaken the sexual impulse, effectiveness is dependent upon the individual's willingness to comply with treatment. Endocrinologist, Peter Scott advised that "the psychopaths and generally unstable types, who most need it if they are to keep out of trouble, are the ones who can least be relied on to do so...but as those who are taking it tend to put on weight the doctor has some check on it (Rees and Usill, 1955, p.130).

In contrast to etiological models based on sickness, researchers such as Karl Ulrichs and Magnus Hirschfeld maintained that the discovery of a biological basis for homosexuality would substantiate the 'naturalness' of same-sex attraction and ultimately lead to social and legal reform (Kennedy, 1997). They argued that evidence for congenital determinism implied that homosexuality merely represented a constitutional variation in sexuality. However, the suggestion that homosexuality is inborn and natural did not preclude attempts to

control and manage it through medical means such as hormone treatment and castration. Despite the assertions of Ulrichs and Hirschfeld, an association between homosexuality and pathology prevailed. Evidence of a biological predisposition contributed to a redefinition of same-sex erotic attraction as an inherited pathological condition that was to be pitied rather than simply seen as an immoral choice.

Behaviourist Theory on Homosexuality

In contrast to biological theories, behaviourism conceptualized the etiology of homosexuality to be based on learned behaviour. Reorientation was sought through aversion therapy which utilized the administration of corrective punishment for 'undesireable' behaviour. Karlen (1971), reviews the work of behaviourists Louis Max, D. Smec and D.Freund and D.F. Clark. In 1935, the first use of aversion techniques was reported by Max, who described using heavy electric shocks to a gay male while presenting him with erotic photographs of men. Max insisted that the lower shock intensity that was utilized with other kinds of patients would prove ineffective with the homosexual. In 1953, Smec and Freund claimed to have successfully reoriented 25 gay men by supplementing conventional shock therapy techniques with sleep deprivation and the administration of a nausea inducing drug. By 1963, Clark further developed Smec and Freund's approach by introducing the deprivation of food for seven days and six nights. He attributed his success at reorientation to induced nausea in such a manner that the client would be exposed to a picture of himself each time he had to vomit.

Joseph Wolpe and Philip Feldman made further refinements to aversion therapy. By 1969, Wolpe combined traditional aversion techniques with

assertiveness training and insight oriented therapy that aimed to erode the client's fear of heterosexual functioning (Karlen, 1971). In 1971, Feldman provided the client with the controls to both the electric shock and slides of erotic figures with the instruction that the picture must remain in view until it is no longer experienced as sexually exciting. Feldman and other practitioners who employed aversion therapy techniques became a prime target of gay and lesbian protest in the 1970's (Bayer, 1987). A growing political movement of homosexual activists adopted a position that 'aversion techniques' constituted an inhumane and unethical approach to treatment.

Normalizing Homosexuality

Against a backdrop of unwavering popular and scientific support for the medical, pathological perspective on homosexuality, Alfred Kinsey undertook his monumental studies of sexual behaviour in America. The first volume, Sexual Behaviour in the Human Male, was published in 1948 and was followed in 1953 by Sexual Behaviour in the Human Female. These publications served to challenge the traditional dichotomy between what is popularly viewed as normal and abnormal sexual behaviour (Lewes, 1989). Whereas previous scientific research had depended on small, clinical samples, Kinsey conducted interviews with 5,300 men and 5,940 women. On the basis of his sample, Kinsey concluded that 37% of the adult male population in the United States, at some time in their lives, had experienced an erotic homosexual contact that included orgasm. Assuming that behavioural differences were a matter of degree, he examined his data along a continuum ranging from those who had participated in solely heterosexual erotic contact to those who identified as exclusively gay. Kinsey indicated that 10% of his male sample had engaged in only homosexual sex for at least 3 years between the ages of 11 and 55. His later research identified that

a third to half as many women are exclusively homosexual; that compared to gay men, a smaller number of lesbians live in a distinct subculture; and, that lesbians share a physical resemblance with other women more than they resemble men (Karlen, 1971).

Kinsey used his findings to dismiss traditional therapeutic approaches to homosexuality. He asserted that mental health professionals had internalized and merely acted to reinforce the rigid prohibitions of a restrictive culture (Lewes, 1989).

> For Kinsey the statistically normal could not be psychologically abnormal....he believed that the capacity of an individual to respond erotically to any sort of stimulus is basic to the species....Sexual preferences were no different from those involving food or clothes (Bayer, 1987, p. 44).

Kinsey proposed that homosexuality represented a learned behaviour rather than a description of who an individual is (Pillard, 1997). In contrast to the conventional etiological focus of science, he questioned why a significant portion of the population overlooked their potential for diverse sexual experiences. His confirmation of large numbers of American homosexual citizens served to introduce the possibility of community to a minority population that had long struggled with issues of isolation and alienation. Bayer (1987) credits Kinsey's research with the emergence of a new confidence within lesbian and gay organizations that would come to challenge conventional psychoanalytic orthodoxy.

Kinsey's depiction of homosexuality as a normal behaviour that has been culturally suppressed was substantiated in a 1951 study by Cleland Ford and Frank Beach. In examining 70 civilizations outside of the United States, they

identified 49 cultures where homosexuality was defined as natural for some community members (Karlen, 1971). Ford and Beach extended their investigation to the sexual behaviour of animals and concluded that homosexual behaviour exists, regardless of the availability of an opposite sex partner (Bayer, 1987). In 1957, Evelyn Hooker presented a further challenge to the pathological perspective. She questioned the notion of scientific objectivity by identifying the bias caused by the use of clinical samples in the vast majority of studies on homosexuality. By employing two clinical experts to administer the Rorschach and written psychological tests to a 'nonpatient' sample, Hooker found that homosexual subjects were indistinguishable from heterosexual subjects and were assessed as having an average or better than average psychological adjustment (Karlen, 1971).

The Conservative Approach

More conservative scientific researchers continued to develop theory based on clinical samples. In opposition to Kinsey's efforts to normalize homosexuality, "they used case histories of homosexual mental patients in order to argue that lesbianism and male homosexuality were indeed morbid pathological conditions" (Terry, 1997, p. 277). Irving Bieber et al. (1962), addressed etiological questions on male homosexuality through a scientific exploration of the prognosis for successful reorientation. Like Sandor Rado, Bieber proposed same-sex orientation to be an environmentally determined psychopathologic state, and that within every homosexual, a 'normal' heterosexual identity could be unearthed (Pillard, 1997). Data was comprised of descriptive information from 77 psychiatrists with regards to 100 heterosexual and 106 gay patients. He found that in 69% of his sample, the homosexual male's family of origin was characterized by an overly intimate and domineering mother and a distant,

hostile father. Similar findings were evident in only 32% of the heterosexual control group. Bieber concluded that mothers of gay men retard sexual development through hostility toward his natural heterosexual drives; frequent expressions of emasculating attitudes; interference with his relationship to his father (seeking to preserve her bond with the son whom she commonly prefers over her husband); and, the discouragement of independence and 'normal' male peer relationships. Due to the father's emotional distance, the gay man was believed to be in a desperate struggle to recover withheld male affection. Bieber considered all gay relationships to be destructive and unstable because of the pathological nature of this search for intimacy. He remained committed to a belief in the effectiveness of reparative therapy despite being able to identify only 19% of his sample as converting to exclusively heterosexual behaviour. Although Bieber's writing did not identify specific clinical techniques, he suggested that the most promising prognosis for reorientation occurs when the client reports an improved relationship with the father; exhibits strong motivation for change; is under 35 years old; has had past heterosexual experience; and, identifies some degree of erotic heterosexual dream content.

Cornelia Wilbur (1965), utilized Bieber's conceptualization of an overbearing mother and a passive, detached father to account for female homosexuality. The excessively controlling mother was believed to transmit messages that depict heterosexual relationships as dangerous. Wilbur characterized the mother-child bond as being contaminated by a competitive struggle that served to disrupt the daughter's 'normal' identification with the same sex parent. Furthermore, given the father's emotional absence, the daughter was seen to lack a masculine ideal with which to relate.

Wilbur perceived lesbian pairing as a mere imitation of heterosexual functioning. She advised that each woman assumes either a male or female role. She described the 'masculine' partner as using sex as an outlet for hostility while the 'feminine' counterpart seeks erotic gratification through insertion. Wilbur asserted that lesbian "relationships are characterized by great ambivalence, by great longing for love, by intense elements of hostility, and by the presence of chronic anxiety. These relationships are unstable and often transient. They do not contribute to the individual's need for stability and love" (Wilbur, 1965, p. 281). Wilbur expressed optimism about reorientation as the lesbian's presumed desire to have a baby was evidence of her 'latent heterosexuality'. Treatment was believed to require two to four appointments per week for a period of three to four years so that symptoms of 'psychosis' might diminish and allow for an adaptation to heterosexual functioning.

In analyzing Bieber et al.'s 1962 data from a clinical population, psychiatrist Charles Socarides asserted that all homosexuals show evidence of psychopathology - 50% of lesbians and gays suffer with paranoia, schizophrenia or manic depression, while the remainder are merely obsessional or phobic (Bayer, 1987). From Bieber's conceptualization of the pathological, pre-Oedipal attachment to a domineering mother, Socarides proposed that if the gay male attempted to form an heterosexual bond, anxiety about separation from the mother, fear of engulfment and a loss of self identity would result. He proposed that male coupling, the projection of one's self onto a partner, represented a desperate "hope to achieve a 'shot' of masculinity in the homosexual act. Like the addict, the homosexual must have his fix" (Bayer, 1987, p. 36). Socarides understood the lesbian partnership to be founded upon an intense dependence and mutual protection, with little actual sexual involvement (Karlen, 1971). With

this underlying pathological motivation for union, the same-sex couple was described as a continuous source of disappointment and pain.

Socarides (1975) claimed to have achieved successful reorientation of over 50% of patients who possessed strong motivation for conversion and who attended sessions four to five times per week. His intervention aimed to allay fears of the opposite sex and to resolve pre-Oedipal disturbance in order that suppressed heterosexual interest might flourish. Socarides wrote critically of those clinicians who would assist the individual to adapt to an homosexual orientation. Throughout the 1960's and 1970's, he vehemently dismissed the arguments for lesbian and gay resistance to reparative therapy as being based upon propaganda. Although Socarides perceived all sexuality as culturally determined, he offered dire warnings that to stray from the natural evolutionary course, is to threaten the human species.

Preventative Approaches

Given that many clinicians were less confident in the effectiveness of reparative techniques than Bieber, Wilbur and Socarides, a preventative approach to homosexuality came to be promoted by mental health professionals. Parents were cautioned to avoid conditions that might result in the child becoming fixated in the early phases of his/her psychosexual development. Rees and Usill (1955) advised that the process of weaning a child from breast feeding should occur in an affectionate environment. "When the time comes to wean the baby it should be done by satiating it, by feeding it from a spoon...and not by painting the nipple with aloes or anything of the sort....It is unkind to force milk puddings on a child who is trying to overcome its longing for milk" (Allen, 1958, p. 65). It was further advised that toilet training should be unemotional so

as to prevent an association with bladder or bowel functioning and fear or obtaining affection (Rees and Usill, 1955). Parents were counselled to avoid administering enemas to children as such an action might stimulate the rectum. Infants over six months old were to be kept away from the parental bedroom as the experience of witnessing sexual intercourse may be interpreted as an assault towards the mother and this create an aversion to coitus.

Clifford Allen (1958) stressed the obligation of parents to create a happy home environment and to avoid divorce at all costs. He advised that heterosexual feelings are most likely to develop where the mother teaches feminine attitudes to her daughter and offers a tempered degree of affection to her son. Allen cautions that parents must not tease a child as s/he exhibits their first interest in the opposite sex. Rees and Usill (1955) were strong proponents of co-educational schools so as to protect against the temptation toward homosexual play. They advised that where children show early signs of homosexual tendencies, immediate treatment may be successful in achieving reorientation but that the child should be removed from school so as to prevent the seduction of other children. Where a child was found to be engaged in homosexual play, they insisted that the accompanying lectures must emphasize the unhappiness inherent to an homosexual lifestyle and that corporal punishment must not be administered on the buttocks so as to avoid stimulation of the rectum.

With the responsibility for homosexuality being attributed to early childhood socialization, parents were charged with the duty of safely navigating their sons and daughters through the resolution of psychosexual developmental tasks. The avoidance of a same-sex orientation meant governing children's behaviour

within the rigid parameters set by traditional sex roles. Psychiatric assumptions about homosexuality had infiltrated the daily routine of the family system. As scientific suppositions came to extend beyond the offices of mental health institutions, a discourse emerged between gays and lesbians. The very subjects of scientific research began to question expert-controlled definitions of their own life experience.

Depathologizing Homosexuality

The emergence of the 'lesbian/gay liberation' movement is rooted in the formation of the 1950's social activist groups, 'The Mattachine Society' and 'The Daughters of Bilitis'. Both organizations undertook a mandate targeted toward the resistance of stigmatizing interpretations of homosexuality. Through the 1960's and 1970's, these demands for social change were heightened through the creation of other similarly oriented organizations. With concerted challenges to religious and legal definitions of homosexuality underway, activists began to target efforts toward the mental health profession (Conrad & Schneider, 1980). Gays and lesbians challenged the notion of an inherent pathology. They attributed their psychological struggles to repressive social attitudes that had been systematically reinforced through the activity of counselling theorists and practitioners. Lesbian activist, Barbara Gittings stated that:

> The homosexual community...increasingly sees psychiatry as the major enemy in the battle against deeply rooted societal prejudice....The homosexual community looks upon efforts to change homosexuals into heterosexuality...as an assault upon our people comparable in its way to genocide (Pillard, 1997, p.228).

While prominent conservative clinicians such as Edmund Bergler, Irving Bieber and Charles Socarides had articulated positions that vehemently opposed attempts to normalize same-sex erotic behaviour, the American

Psychiatric Association (A.P.A) provided a more authoritative clinical source for maintaining a pathological perspective on homosexuality. In the 1952 edition of the A.P.A.'s Diagnostic and Statistical Manual, homosexuality was officially classified as a 'sociopathic personality disturbance' (Pillard, 1997). By 1968, its registration in the list of mental illnesses had been modified to an inclusion in the category of 'sociopathic personality disorder'. Within the diagnostic manual, homosexuality was located alongside an array of 'sexual deviations' that included pedophilia, exhibitionism, sadism, masochism and other conditions deemed to be pathological. This diagnostic label was preserved within the psychiatric profession's official nomenclature until 1973.

Bayer (1987) reviews the process through which homosexuality officially came to be eliminated by the A.P.A. from the Diagnostic and Statistical Manual of Psychiatric Disorders. He credits this shift in the official position of the mental health professions as arising from the demands of political gays and lesbians who had begun to speak out against the repression they had experienced under the guise of reparative therapy. Through protests staged at the conventions of the psychiatric industry, activists voiced demands for consultation with clinicians rather than to merely be the subject of professional discourse. Bayer suggests that this outcry was an unexpected development given that clinicians popularly viewed their profession as a humanitarian agent who had served to protect homosexuals from moral and legal prohibitions through applying a label of illness.

In 1973 the A.P.A. conceded that the inclusion of homosexuality as a mental disorder was both unwarranted and unscientific. Due to the opposition of traditionalists like Bieber and Socarides, a referendum was held and a new

category of illness was created. 'Ego-dystonic homosexuality' came to describe the condition whereby an individual experiences dissatisfaction with their own homosexual orientation (Diagnostic and Statistical Manual of Mental Disorders, 1980). It was not until 1986, that 'egodystonic homosexuality' was deleted from the A.P.A. diagnostic manual. Bayer's central analysis of these developments suggests that just as the pathologizing of homosexuality was a cultural and political process, so was the 'depathologizing' and eventual redefinition of homosexual individuals as members of a sexual minority.

The removal of homosexuality from the A.P.A's list of mental disorders marked a significant beginning for lesbians and gays in the struggle for non-biased representation within the field of mental health. A study by Morin (1977) suggests that between 1967 and 1974, research about homosexuality was focused almost entirely on issues of diagnosis, etiology and reorientation. In 1986, Waters identified that while the number of studies conducted on homosexuality had almost doubled between 1979 and 1983, research had tended to examine relationship and identity issues with only 1 percent of studies being focused on reorientation. Where traditional approaches to clinical intervention would have attributed all of a client's presenting problems to an homosexual orientation, gay and lesbian informed practitioners would be more likely to identify counselling objectives in relation to facilitating self acceptance within an hostile social environment (Harrison, 1987). A growing body of clinical literature that is specific to the psychological and social needs of gays and lesbians has begun to emerge since the 1970's. While far from an exhaustive account of the literature, some of the specific areas that have been addressed include same-sex relationship issues (Berzon, 1988; Hawkins, 1992; Terry, 1992); gay and lesbian families (Dahleheimer & Feigal, 1991; Ariel & Stearns,

1992; Gunter, 1992); homosexual identity construction (Cass, 1979; Grace, 1992); same-sex domestic abuse (Island & Letellier, 1991; Farley, 1992); and, antigay/lesbian violence (Comstock, 1991; Bridgewater, 1992). In concert with the development of a specialized knowledge base, within large, urban centers, clinical services have emerged that have been created and delivered by gay and lesbian counselling professionals (Klien, 1991).

Despite the movement toward a non-biased therapeutic framework that has occurred since the 1970's, sexual minorities continue to face obstacles to participation in established counselling institutions. Many traditional counsellors have remained committed to a perspective that views homosexuality as a pathological condition that must be explained and cured. Other clinicians continue to operate from the heterosexist assumption that all consumers of service are heterosexual (House & Holloway, 1992). Supposedly more progressive practitioners assume a commonality of experience between lesbian, gay and heterosexual clients that disregards the effects of social stigmatization. The distinct therapeutic needs of sexual minorities may be overlooked where the worker applies an heterosexual model for clinical intervention to all clients (Markowitz, 1991). As a non-biased counselling approach is in opposition to the prevailing homophobic values of Western culture, insufficient efforts have been made to extend services beyond a majority client population (House & Holloway, 1992). The practitioner's internalization of homophobic bias may in itself serve as a barrier to the provision of an affirmative service (Harrison, 1987). Given the social invisibility and stigma associated with homosexuality, there continues to be a lack of attention given to lesbian and gay issues within training curriculums of the various counselling disciplines (Dworkin, 1992). The

inclusion of lesbian and gay content is typically not a required area of learning in most professional training programs (Newman, 1994). While the introduction of an educative objective based on providing accurate clinical information may be relatively uncomplicated, the often subtle and ingrained nature of homophobic assumption is likely to make the process of challenging prejudicial values convoluted. Bayer (1987), advises that "only when their conventional orientations have been challenged by extraordinary occurrences have therapists been forced to assume a more self-reflective posture" (Bayer, 1987, p.179).

Conclusion

Reviewing the history of scientific exploration into homosexuality illustrates how the mental health professions have functioned as a marginalizing influence on the lives of sexual minorities. Despite the assumption of scientific objectivity, "it is historically and sociologically naive to imagine that science is a pure, descriptive pursuit of nature's truth, independent of the political interests, social concerns, or the cultural and religious values surrounding the practice of science" (Rosario, 1997, p. 2). Whether etiological theories were founded upon assumptions of environmental or biological determinants, the concerted aim of counselling practitioners was the control and eradication of 'sexual deviance'. Despite the official elimination of homosexuality as a category of mental disorder over twenty years ago, practitioners have been slow to reconceptualize appropriate models for counselling. While the implications for depathologizing homosexuality suggest focusing intervention toward a positive adjustment to sexual orientation, "therapists were given no guidance as to how to think about or work with their gay and lesbian clients" (Markowitz, 1991, p. 28). Despite the reality that the lesbian and gay communities experience the same variety of

mental health problems as the heterosexual population, many clinicians continue to define a same-sex sexual orientation as the central cause as opposed to the social context for the client's presenting problem.

Given a long history of misguided attempts to provide psychological and medical intervention, lesbians and gays may be rightfully suspicious of the heterosexist indoctrination of currently practicing clinicians. The advances that arose from the gay liberation movement may still be regarded with caution. It is difficult to assess their influence on popular and scientific thinking about homosexuality. The A.P.A. decision of 1973, cannot be assumed to have obliterated the long-standing social bias against a same-sex sexual orientation. Lesbians and gays are currently faced with a growing negative reaction to the progress achieved though the struggle for social justice. American researcher, Jennifer Terry reminds us that :

> public displays of homophobia bring rewards these days: from Pat Buchanan's self-satisfied homophobia at the 1992 Republican Convention, to the officially sanctioned brutality toward gays and lesbians in the military, to the staggering rise of homophobic bashings in city streets, to the suspension of child custody for lesbian mothers around the country, to the local campaigns against lesbian and gay rights. It is clear that lesbians and gays are surrounded by growing numbers of enemies (Terry, 1997, p. 287).

Chapter Three

Research Methodology

Rationale

As a social worker who is committed to promoting social equality and justice for all people, I sought an approach to research that would challenge biased clinical assumptions and be compatible with service provision to clients from minority cultures. The values underlying this study are informed by a profeminist approach to research. While a feminist research model advances the understanding of phenomena through the investigator's experience as a woman, within a profeminist approach the researcher is male (Ganley, 1991). As the investigator "does not have the phenomenological experience of being female, he uses his experiences as a male whose understanding of himself, of all men, and of women has been transformed by feminist analysis" (Ganley, 1991, p.6). As such a model seeks to validate personal and cultural diversity in a manner that avoids pathologizing and strives to diminish power differences, heterosexuality and homosexuality are promoted as equally valid, healthy and natural orientations. Feminism, having thoroughly explored the relationship between larger political systems and individual women, grounds investigation in the informant's experience of social and institutional heterosexism and homophobia. As a fundamental tenet of feminism holds that research must remain accountable to the study participant, "the voice of the 'subject' is actively heard; the subject interacts with and influences the nature of the research project. The knowledge produced is accessible to those studied, informs an understanding of oppression, and suggests liberatory strategies" (Hyde, 1994, p.173).

Studies relating to gay and lesbian populations have commonly been compromised by an inappropriate selection of research method. The validity of findings may be questionable given the common use of evaluative instruments that have been designed under an assumption that all respondents are accurately represented by the experience of the sexual majority. Accuracy becomes disputable where an investigation utilizes conventional measurement tools that have been based on norms obtained from an heterosexual population (Pope, 1992). Furthermore, attempts to locate a representative sample are complicated by the degree of social invisibility that is common to the experience of sexual minorities (Tully, 1992). Given the level of social stigmatization associated with homosexuality, the impersonal nature of quantitative measures is unlikely to ease the participant's suspicion and facilitate open and trusting disclosure. Research instruments that have been developed specifically to study lesbians and gays commonly reflect a bias in terms of the selection and formulation of problems concerned with etiology; the choice of a non-representative, clinical sample population; and, an interpretation of results based on heterosexual norms and values (Brooks, 1992). Feminist researcher, W. K. Brooks, asserts that "just as sexist bias resulted in the creation of a 'psychology of man', heterosexist bias has resulted in the creation of a 'psychology of heterosexuality' that is so deeply embedded in the world of mental health research that it is...wholly nonconscious and relatively unchallenged" (Brooks, 1992, p. 203).

Research on homosexuality has historically focused on the issue of etiology in the interests of upholding a clinical perspective that equates a same-sex orientation with pathology and directs intervention toward cure. In seeking to

reject stereotypes and labels of deviance, a more liberal approach to research has emerged. This perspective promotes a commonality of human experience that serves to disregard the experiences of lesbians and gays as being in any way unique from that of heterosexuals. Furthermore, evaluative instruments have frequently been administered to both gay men and lesbians without sensitivity to the differing experiences of women and men. In response to these methodological concerns, and in an effort to ensure accountability to the population under study, I have employed a qualitative approach to conducting this research.

My research method was selected with an intention to capture data that are relevant to clinical practice. Qualitative investigator C.K. Reissman suggests that, all too often, "social work research presents depersonalized accounts that do not help 'in the trenches'....Workers do not use empirical findings to select interventions or evaluate them" (Reissman, 1994, p. ix.). Since quantitative studies are rigidly bound to a method that aims to replicate the same conditions for each respondent, measures may not be sensitive to more subtle individual differences. Rigid adherence to a standardized set of questions that must be asked in a particular order may stifle the potential to gather a detailed narrative (Weiss, 1994). Conversely, an open-ended qualitative interview format provides an opportunity to talk in a free and personal manner with the subject. It seems appropriate that the choice of information-gathering method be consistent with the projects central concern for establishing trust and rapport between the professional and client. I sought procedures that would allow for the direction of interview content to be influenced by the themes of greatest priority identified by the participants. This approach is perhaps better able to provide data that is rich in depth, diversity and detail, so that greater insight into the respondents'

experiences and perceptions of helping professionals is possible. By grounding the final report in direct quotations from intensive in-person interviews, it is my intention that the reader will be drawn more closely toward the actual life experience of the participant. The presentation of data in a manner that more genuinely reflects the viewpoints of lesbians and gays is intended to contribute to the development of information that is readily adaptable to practice.

Selecting Participants

The recruitment of participants from within a marginalized and socially divergent population presents challenges. Social science research has commonly portrayed gays and lesbians within a monolithic category that disregards the experience of such influences as sex, race, culture or class. I have sought instead to recognize the diverse nature of the sexual minority communities and to avoid promoting a narrow recipe for intervention that overlooks individual needs. Given that the study is not bound by goals of generalizability, random sampling has been avoided in favour of a recruitment technique referred to as 'snowballing'.

More conventional forms of recruitment, such as advertising for informants, tends to attract "'joiners', professional interviewees, the highly educated, persons with an overtly political analysis, and individuals who see themselves as central to the population in question" (K.Weston, 1991, p. 10). In contrast, the use of 'snowballing' meant beginning the interview process with two contacts with whom I was already familiar. These individuals were told that I was seeking lesbians, gays or bisexuals who had either participated in counselling or had at some time considered attending therapy but ultimately decided not to pursue it. They agreed to canvass for referral to other potential participants that matched

this profile. Participation from individuals with a range of experiences was gradually generated by seeking further contacts from these initial referrals (see Appendix A). Given this reliance on referrals, a particular weakness in the use of the 'snowballing' method is the failure to attract involvement from people who are more socially isolated. I did however, manage to interview three individuals who described themselves as isolated from the lesbian and gay communities. Furthermore, the fact that 'snowballing' means that all participants have some level of social connection with another respondent included in the study, suggests that data may tend to be reflective of a more uniform world view.

The participants consist of five females and five males who self-identified as either gay or lesbian. The decision to include both women and men in the study does not presume a common frame of reference but reflects an intent to explore contrasting as well as shared experience. No individuals who identify as bisexual or transgendered were referred for inclusion in the study. The age of subjects ranges from 28 to 53 with a mean of 36.6. To have increased this range may have provided more information on the effects of changing social attitudes toward homosexuality. Greater variance in response may have been evident given the experience of older lesbians and gays in relation to living in times of greater intolerance compared to younger individuals who enjoy a degree of greater social acceptance. The data is somewhat weak because it does not reflect the wide diversity of cultural and racial identities that are present within the lesbian and gay communities. Three individuals identified as Aboriginal while seven were White. One participant identified as culturally Jewish. While the income levels of interviewees range from $15,000 to over $40,000 per year (see Appendix A), I failed to attract variance in educational backgrounds as all but one respondent had received some level of university training. Of the ten

interviewees, seven were in long term relationships while three were single and one had only recently begun to date someone. One individual discussed his experience within the context of being HIV positive. While participation was intended to incorporate the perceptions of those who had attended as well as those who had not attended counselling, nine of the interviewees had received some form of clinical service. Individuals had received counselling from a range of therapeutic approaches including psychiatry, psychology, social workers, generalized counsellors, school guidance counsellors and Christian counsellors. Some of these practitioners were described as using a feminist model of intervention. While some had participated in counselling for over five years, others had an initial contact and chose not to return. Only one individual was receiving counselling services at the time of the interview. Further demographic detail is provided below.

Demographics

1. Charlie
Sex - female
Sexual identity - lesbian
Age - 28
Racial/cultural identity - White
Current relationship status - dating 3 mos.
Employment status - waiter (unemployed)
Highest education level - some university courses
Annual income - $10 -15,000
Counselling experience: family therapist

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2. Jeff
Sex - female
Sexual identity - lesbian
Age - 28
Racial/culural identity - Aboriginal
Current relationship status - single
Employment status - factory worker
Highest education level - some university courses
Annual income - $10 - 15,000

Counselling experience: social worker; substance abuse worker; feminist general counsellor; psychologist; Christian counsellor

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3. Mark
Sex - male
Sexual identity - gay
Age - 53
Racial/cultural identity - White
Current relationship status - living with partner - 19 yrs
Employment status - health care worker
Highest education level: graduate school
Annual income - $40,000 +
Counselling experience: psychiatrist; psychologist

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4. Melvin
Sex - male
Sexual identity - gay
Age - 37
Racial/cultural identity - Metis
Current relationship status - living with partner - 5 years
Employment status - unemployed
Highest education level - undergraduate degree
Annual income - $10- 15,000
Counselling experience: none

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5. Oscar
Sex - male
Sexual identity - gay
Age - 34
Racial/cultural identity - White
Current relationship status - living with partner - 9 years
Employment status - artist
Highest education level - undergraduate degree
Annual income - $15 - 20,000
Counselling experience: Christian counsellors; school guidance counsellor

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6. Paul

Sex - male
Sexual identity - gay
Age - 44
Racial/cultural identity - White
Current relationship status - single
Employment status - teacher
Highest education level - graduate degree
Annual income - $40,000 +
Counselling experience: psychiatrist; psychologist; social worker

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7. Rose
Sex - female
Sexual identity - lesbian
Age - 31
Racial/cultural identity - White - Jewish
Current relationship Status - living with partner - 4 yrs
Employment status - community development worker
Highest education level - undergraduate degree
Annual income - $20 - 25,000
Counselling experience: psychologist; lesbian feminist social workers

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8. Sammy
Sex - female
Sexual identity - gay woman
Age - 48
Racial/cultural identity - Metis
Current relationship status - living with partner - 12 yrs
Employment status - teacher
Highest education level - graduate degree
Annual income - $40,000 +
Counselling experience: Christian counsellors; social worker; feminist general counsellor

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9. Sara
Sex - female
Sexual identity - lesbian
Age - 32
Racial/cultural identity - White
Current relationship status - single

Employment status - community development worker
Highest education level - undergraduate degree
Annual income - $15 - 20,000
Counselling experience: feminist social worker; feminist general counsellor

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10. Sky
Sex - male
Sexual identity - gay
Age - 31
Racial/cultural identity - White
Current relationship status - living with partner - 5 years
Employment status - youth employment worker
Highest education level - high school
Annual income - $25 - 30,000
Counselling experience: Christian counsellor; social worker; psychiatrist

Data Collection

Ten interviews were conducted between March and December of 1996. Each individual was scheduled to meet with me for approximately one hour. I explained my purpose as twofold - to learn about their experiences in counselling and to examine the conditions that they perceive as facilitating access a service. While it is difficult to pinpoint the motivation of those who agreed to participate in the study, some respondents appeared to have had specific concerns about their counselling experiences that they wanted to have noted in the research. Given the diverse make-up of the lesbian and gay communities in terms of political views, race, class and religion, there is no one research participant whose narrative can be interpreted as representing a uniform perspective of the wider minority population. However, all respondents drew a link between their sexual orientation and their experience and needs within a counselling setting.

I initially believed that the interview content would be focused around process issues that did not necessitate the disclosure of the intimate details that precipitated the individual's decision to seek help. However, it quickly became evident that participants had a willingness and perhaps for some, even a need to share personal background. This discovery stimulated a consideration for how I might avoid replication of the power differential that individuals had typically experienced between themselves and counselling professionals. Through briefly providing information about my own position in relation to the thesis topic I aimed to develop rapport and facilitate a sense of safety in relation within our discussions.

Anthropologist, Kath Weston, emphasizes "the importance of recognizing the researcher as a positioned subject" (Weston, 1991, p.13). I considered that the gathering and interpretation of data could not escape the influence of my own values, beliefs and social position. I theorized that the nature of discussion and the willingness of participants to engage in open dialogue would likely have been very different, if as an interviewer, I was heterosexual and/or female. In seeking to avoid the pretense that my own experience could somehow be free from bias, I briefly took the opportunity to inform participants about my own background. I disclosed my own gay identity, my professional background as a social worker and that I had myself been a consumer of counselling services. Within our discussions, I was often conscious of my thought process and outward response alternating among these three positions.

The researcher's choices in regards to use of interviewing language, topics to pursue and the determination of what content will be analyzed, emphasized or discarded are all decisions laden with bias. It is difficult to accurately

determine the degree to which I influenced the subjects' participation and the content of the interview. However, it is my perception that my own sexual identity contributed to the development of rapport. Given the presumption of a common frame of reference, participants were free to speak without having to explain the context of their experience as a lesbian or gay person. Given the nature of my employment, I was careful to develop a sense of safety by openly declaring my belief that homosexuality is not a pathological condition and that lesbians and gays have the same right as heterosexuals to access counselling services.

Before conducting the interviews a proposal outlining my research methods was submitted and approved by the University of Manitoba Ethics Committee. Given the social hostility toward homosexuality, particular caution was taken to protect the confidentiality of participants. The issue of privacy was especially relevant in relation to the choice of field site. Winnipeg is a mid-sized city where openness about sexual identity is not always perceived as safe. Individuals selected a pseudonym that was used throughout the entire process of investigation so as to ensure anonymity. Although three people stated that they did not see the use of pseudonyms as necessary, I insisted on this procedure so as to ensure against any unintended consequences that might arise due to respondents being identifiable. At the outset, participants were informed that they could terminate involvement with the project at any point during the research process. Three women (Charlie, Jeff and Sammy) selected names that are traditionally considered male. While at times this may be confusing for the reader, in the interests of respecting the participant's right to self definition, I did not request that they choose another name. All ten respondents maintained involvement throughout the duration of the project. Everyone agreed that their interview could be audiotaped and transcribed for the purpose of data analysis.

On one occasion, an individual who had particular concerns about confidentiality, requested that I turn off the audiotape so that he could discuss an event that he did not wish to be included in the study. Respondents were guaranteed that all recorded interviews would be stored in a locked cabinet and would be erased at the conclusion of the study. Each participant was provided with two copies of a 'participant agreement form' (see Appendix B) prior to proceeding with the interview. A signed copy remained with me while a second copy was given to the respondent for the purposes of reference.

A list of questions was originally formulated in preparation for the potential themes to be explored in the research. This functioned as a guide for the interview but was intended solely for establishing a starting point for data collection. It did not confine inquiry to the specific set of questions but instead posed a general direction for initial exploration. This flexibility allowed me to stray from preconceived lines of questioning so as to capture reports of experience I had not previously recognized and to adapt the interview to the specific and unique concerns of each respondent. The first interview was conducted and analyzed with the intent of beginning to identify further categories to be explored in succeeding interviews. This process of generating and shaping questions through the examination of data continued throughout the entire period of information-gathering. The initial themes are as follows:

A. Perception of Accessibility

Can the respondent recall a time when s/he contemplated seeking counselling? What types of thoughts and feelings did s/he experience as a part of considering help? What kind of service seemed the most inviting to the respondent given

his/her sexual orientation? Was s/he prepared to disclose her/his sexual identity?

B. Experience in Counselling

Is the respondent currently receiving counselling services? If so, how did s/he go about selecting a service provider? Has the respondent received counselling in the past? How did s/he go about selecting that counsellor? Does the individual perceive any difficulties in relation to the disclosure of his/her sexual orientation and the services s/he received? If the answer is yes to the above question, the interviewer will ask the respondent to elaborate. If the answer is no, what does s/he attribute her/his positive experience to?

C. Barriers to Service

Has the respondent wanted to receive counselling services but chosen not to? What prevented him/her from seeking help? What would have allowed her/him to proceed with seeking services? What would the individual have needed to know about a particular professional or agency in order to proceed? What resources or coping mechanisms did the respondent employ as an alternative to counselling? Were these alternatives effective in helping to meet his/her goals?

D. The Identification of Helpful and Accessible Service

How does the respondent describe a helpful approach to counselling? What qualities must be present for an agency or counsellor to be considered accessible and informed regarding a gay or lesbian sexuality? Does the individual perceive a difference in comfort if the counsellor is male; female; lesbian; gay; or, ambiguous with regards to sexual orientation? How does the respondent perceive addressing a situation where a counsellor exhibits an heterosexist or homophobic bias?

Data Analysis

Borrowing from a grounded theory model of data analysis (Hyde 1994; Reissman 1994; Strauss & Corbin 1990; Weiss 1994), I have aimed to ensure that the direction of my inquiry is informed as much as possible by the research participants themselves. This method is not utilized in its pure form as I questioned my capacity to adopt a position of neutrality in conducting the research. The possibility for discovering concepts from the data itself could not be divorced from my familiarity with the literature and my personal as well as professional experience with the topic. All of these factors surely influenced how I categorized data, formulated questions and determined the relevance of quotes in compiling this final written report. To address this issue, I attempted to maintain a consciousness of my own relationship to the topic through the creation of a file documenting my reflections throughout the duration of the project. In contrast with grounded theory, it is from these notes as well as the transcribed interviews that the themes included in the final report have been determined.

Using grounded theory research methods as a guiding framework, I purposely gathered and analyzed data simultaneously. This preliminary phase of analysis facilitated greater familiarity with the data, enhanced theoretical sensitivity and set the direction for future inquiry. From having immediately transcribed the very first observation, I employed 'line by line' coding so as to begin to provide labels to examples of specific behaviours, events and perceptions that were described in the interview sessions. This phase of the analysis entailed a "process of breaking down, examining, comparing, conceptualizing and categorizing data" (Strauss & Corbin, 1990, p. 61). In

examining the emerging data I was able to reconsider my preconceptions about the topic and acquire new insights and sensitivities into the participants' experiences with helping professionals. As a result I was able to add and modify questions that had been formulated in the interview guide so as to explore for the presence of the emerging themes in subsequent interviews. This task of generating and shaping questions through the examination of data occurred throughout the entire period of information-gathering in an ongoing process of verification and comparison of themes.

A second stage of analysis involved organizing and testing the emerging themes against the data as well as beginning an evaluation of the relationship between thematic content. Over the course of the study, transcribed interviews were repeatedly reviewed in order to determine whether the previously assigned codings still appeared valid. Codings were organized into content files. At the completion of the final interview 31 files of themes were created. I developed a summary to describe the significance of each file as it related to the overall research topic. Similarities and differences between participant responses were considered in relationship to the wider theme. Variations in responses were evaluated for a lack of support or as representative of possible conditions of diversity amongst interviewees. Files were discarded where they appeared to hold little relevance to the objectives of the study or where they proved redundant and could be merged into one theme. For example, while the issue of fear was identified repeatedly within the data, excerpts from this file were eventually distributed amongst various items related to assessing safety within the counselling setting.

The final phase of analysis involved developing a conceptual framework for understanding the data. The task of developing a summary for each theme had stimulated an investigation into possible relationships between themes. This process involved verifying these associations within the data. Analysis was aided by the development of a chart outlining the proposed thematic relationships (see Appendix C). Three core conceptual categories of themes were identified in order to describe the primary phenomena to have emerged through the research. These include 'barriers to accessing service', 'assessment of safety within the counselling setting', and 'recommendations for enhancing accessibility'. This framework provided an outline for organizing each area into a logical order in preparation for this final report.

Professional Literature

Literature served as an important resource in the data analysis. In addition to my preliminary review of the literature, I made ongoing efforts to become familiar with material which related to the themes that were being described in the data. As concepts emerged, the literature was referenced so as to validate findings with established theory. Of particular significance was the continual references participants made to more overtly biased counselling approaches of the past. In this final report, I have included an historical overview of the relationship between lesbians and gays and the counselling professions so as to trace the development of current clinical approaches to sexual minorities. In seeking to represent the variety of counselling responses that have been constructed to address homosexuality, I have deliberately included references to literature that extends beyond the most recent publications. Past professional literature continues to be influential as it has served to shape the understanding and clinical approach of clinicians who continue to practice today. I have

avoided presenting rebuttals to the range of counselling theories that are included in the text. I have instead directed my attention to using the literature to describe the evolution of counselling perspectives and employing the participant's narratives to illustrate the impact these approaches may have on accessibility.

Terminology

A discussion of terminology is necessary as the final report seeks to straddle two contexts which have not always been in partnership. Readers may have a knowledge base that is more heavily grounded in either counselling theory or lesbian and gay cultures. Some of the primary concepts that are utilized throughout the study are explained below:

Accessibility:

The term accessibility is used to describe the degree to which a particular service is perceived as being approachable by potential consumers of counselling services. Conditions that contribute to a client's perception of accessibility may include relevance to his/her individual life situation, the professional's knowledge base with regards to the social and cultural context in which the presenting problem occurs and the level to which service is perceived as free from value judgment.

Counselling Disciplines:

Counselling consumers may receive clinical services through a range of different professionals including psychiatrists, psychologists, educational psychologists, social workers, human ecologists or more generalized counsellors. Despite my own background in social work, the terms 'counselling disciplines', 'counselling professions' and 'service providers' will be used generically throughout the study

so as to capture the breadth of experience identified by the research participants.

Reorientation or reparative therapy:

These terms are used to describe clinical interventions that aim to modify a client's lesbian or gay orientation toward an heterosexual orientation. Therapeutic strategies based on reorientation are founded upon an assumption that homosexuality represents a pathological state that is most appropriately addressed through medical and psychological attempts to locate a 'cure'.

'Coming out':

Given that mainstream society is organized around an assumption that all people are of an heterosexual orientation, gays and lesbians grow up struggling with a sense of dissonance between the experience of inner self and the role one is expected to fulfill within the larger social world. The term 'coming out' refers to the process whereby an individual achieves a sense of congruency between private and public aspects of the self through the task of unveiling an homosexual orientation. The initial stage of this process involves acknowledging a gay or lesbian identity to oneself (Lee, 1992). Later phases are focused upon a more public disclosure that includes revealing one's sexual orientation to friends, family and others. 'Coming out' tends to represent a sense of personal liberation through increased opportunities for the expression of the authentic self. However, the decision to risk openness is typically characterized by a sense of vulnerability and fear that one's disclosure will be met with moralistic judgment, rejection and the severing of significant social relationships (Weston, 1991).

Communities and cultures:

The concept of community has come to have great significance in the lives of sexual minorities given the common struggle with issues of isolation and alienation. However, its actual meaning is somewhat obscure. Kath Weston (1991) describes community as potentially having reference to "the historical appearance of gay institutions, the totality of self-defined lesbians and gay men, or unity and harmony predicated upon a common sexual identity" (Weston, 1991, p.122). For many lesbians and gays a sense of commonality prevails despite a high degree of diversity in relation to ethnic, political, religious, cultural and social backgrounds. Similarly, the majority of research participants made reference to the notion of shared experience within lesbian and gay subcultures. Klien (1991) suggests that because of the barriers to participation in mainstream heterosexual culture, a subculture has emerged that is marked by a sense of shared identity, norms, history, recreational styles and political activism. She suggests that "upon entering the gay subculture one's status changes from one of social stigmatization to one of relative worth" (Klein, 1991, p. 62). In recognition of the variation in individual experience within a group context, the writer will use the terms community and culture in their plural form.

Heterosexism:

This concept refers to the social exclusion of gays and lesbians due to an assumption that all people are of an heterosexual orientation (Pharr, 1988). Given this lack of acknowledgment for the reality of those individuals who exist outside of the sexual majority experience, lesbians and gays are typically excluded from open participation in mainstream social institutions.

Homosexuality, gay and lesbian:

Labels that describe a same-sex orientation have strong political connotations. Historically, the power to define an individual's identity rested with a majority

culture which typically promoted an image based on misinformation and stereotypes. The term homosexual is commonly associated with a more clinical description of same-sex sexual behaviour. The civil rights struggle of the 1960's promoted the adoption of the label 'gay' with the intent of eroding an image based solely on sex so as to incorporate all aspects of the individual's identity (Conrad & Schneider, 1980). To self-identify as 'gay' represented a deliberate strategy "...to deemphasize the one-dimensional image imposed by traditional and particularly medical definitions. In many regards, 'homosexual' could be seen as itself an oppressive term that grew out of a need to defend rather than assert one's human rights" (Conrad & Schneider, 1980, p.202). While the term is most commonly used to describe males, women are also frequently referred to as gay. However, use of the word 'lesbian' is specific to women. The experience of lesbian women and gay men cannot be uncritically classified under one label. While gay men still benefit from many of the social privileges of being born male, lesbians experience diminished opportunities from two sources of oppression - the experience of being women as well as being lesbian. The social reality of women has long been rendered invisible by the assumption that terminology that is specific to the male experience provides an accurate account of women's experience. "Given differences in the social organization of gender as it affects our sexual lives, any use of a unitary homosexual category for both male and female experiences necessarily distorts lesbian experience to fit the male category" (Kinsman, 1987, p. 17). In deciding to include both men and women in the research, I have attempted to be attentive to gendered differences as well as shared experience. I have sought to avoid stifling the voices of lesbian respondents by purposely including references to women's perspectives as they have emerged in the narratives. The writer will exercise caution to avoid the

generic application of the term gay in recognition of the differences between men's and women's experience. It should be noted that one female participant, Sammy, expressed a preference for the label 'gay woman'. While she indicated a concern that her perspective as a woman may be lost under the umbrella term 'gay', she asserted that for her, the word 'lesbian' has powerful connotations of oppression and is therefore not reclaimable. In exploring this issue with her, she described the term as "dehumanizing", "depersonalizing" and "perverted." In seeking to include her perspective, I have tried where appropriate to use the word 'gay' in isolation from the more commonly used phrase 'gay man'.

Homophobia:

The concept of homophobia was originally coined in 1980 by D. Kessler, to describe a phobic response to lesbians and gays (McWhirter & Mattison, 1984). The term is now commonly used to depict any reaction of repulsion and hatred "based in a belief system and set of priorities that assert heterosexuality as normal and superior and asserts that homosexuality is deviant, abnormal, a crime or a sin" (Lesbian Advocacy Committee of the Minnesota Coalition for Battered Women, 1990, p.28). The phrase 'internalized homophobia' recognizes that within varying degrees, lesbians and gays are likely to have absorbed beliefs and attitudes from the anti-homosexual environment in which they were socialized.

Sexual minority:

The term sexual minority describes a range of stigmatized and disempowered sexual and gender categories which are a numerical minority in relation to the dominant heterosexual population (Klien, 1991). Beyond gays and lesbians this may include individuals who identify as bisexual or transgendered. In conceptualizing a minority status based on sexuality, a parallel is asserted with

other groups who have been marginalized because of a majority intolerance for diversity in relation to factors such as ethnicity and race. Although this study failed to draw respondents from outside of the lesbian and gay populations, the term 'sexual minority' is deliberately utilized to emphasize the differential in social power between lesbians and gays and the dominant heterosexual majority.

Overview of the Final Report

Following the introduction to the research, chapter two provides an historical outline of the shifting perspectives of clinical theory and practice as they relate to counselling lesbians and gays. Inclusion of this overview was intended to create a context in which to view the narratives of research participants. Chapter four introduces the perspectives of respondents in an exploration of the current barriers that are faced by sexual minority consumers who attempt to access clinical services. Given that many gays and lesbians are likely to make contact with helping professionals despite significant obstacles to participation in counselling, chapter five examines the ways in which accessibility is determined. I conclude by advancing a set of directives for workers who aim to modify practice so as to create an approach to service that is informed by lesbian and gay experiences. It is my sincere hope that this study has been successful in representing the voices of those who agreed to lend their participation to the research and that their wisdom will serve as a resource for helpers from a range of counselling disciplines.

Chapter Four

Barriers to Accessing Service

Despite gay and lesbian informed theories and therapies that have begun to emerge since the civil rights struggle of the 1970's, significant barriers remain between the helping professions and sexual minorities. Counselling services are typically provided through generic agencies to a client population that is assumed to be represented by the interests of the majority culture. The adoption of a lesbian or gay identity has long been associated with the renunciation of participation in such mainstream institutions. The welfare of those citizens who have historically been classified as sexually deviant is commonly disregarded within the mandate of conventional helping systems.

This chapter explores obstacles that arise for lesbians and gays who seek to obtain therapeutic service. The reader will be introduced at this time to the voices of the ten research participants. The inclusion of particular themes is intended to represent the discussion we shared about barriers to access. This includes issues such as therapeutic interventions aimed at reorientation; the construction of a lesbian or gay identity within an homophobic environment; and, counselling approaches that reflect heterosexist bias. Given the deterrents to accessing service, the chapter concludes with an outline of some of the alternative strategies for coping that were identified by the participants.

The Implication of Counselling Based on Reorientation

Conceptualizations of homosexuality from a range of counselling disciplines have tended to mirror and reinforce societal bias. In exploring questions related

to human behaviour, "theoreticians and practitioners are concerned with the central question of how individuals psychologically develop from childhood to adulthood" (Greenspan, 1983, p.9). Psychological health is a social construction that has traditionally been evaluated against a hypothetical norm for human development based on the heterosexual experience. Deviation from the norm has been assumed to suggest illness and to require scientific explanation. Dr. Edmund Bergler insisted that "homosexuality is a disease and is curable. There is no more glamour in homosexuality than there is in...a case of typhoid fever" (Bergler,1959, p. ix). The etiological focus that has characterized the social scientific response to homosexuality is embedded in principles originating within a medical model. The approach to intervention has therefore has been to locate the cause of this 'illness' in order to effect a 'cure'.

Current perceptions of mental health professionals may be justifiably tainted in the gay and lesbian communities given a history in which "through confrontation, subtle persuasion, exploration of childhood trauma, or even electroshock, the goal was to reclaim the homosexual from the ranks of social misfits"(Markowitz, 1991, p. 27). While service-providers are currently less likely to employ methods that are overtly aimed at conformity, the field of counselling may still be perceived as representing the interests of an heterosexist ideology. Practitioners have long functioned as agents of social control in their powerful role as experts in constructing definitions of health and pathology.

It is from within this historical context that gays and lesbians approach counselling professionals with requests for service. As a 44 year old gay man who has had a long history with counselling that included curative interventions, Paul expresses his enduring suspicion toward therapy.

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> If they are going to deal with gay and lesbian people they should realize that that's a huge issue for gay people as to whether or not they can actually see you as a human being and not something pathological - 'cause, you know there are still very strong schools of thought that regard any sexual deviation as pathological. They're not gone, those schools of thought.

A potential consumer's perception of accessibility may be shaped by awareness of the historical alliance of the mental health field with a homophobic value system. As a proponent of reorientation efforts, the counselling profession has upheld societal intolerance for variation from the majority culture. Psychological theory and practice offered 'scientific' credibility to justify discrimination against gays and lesbians. The emergence of new theories and approaches since the depathologizing of homosexuality in 1973 has not served to eradicate the sense of alienation and suspicion that lesbians and gays associate with the mental health profession. Despite her uncertainty regarding the nature of current therapy methods, Rose maintains an ongoing position of distrust and resistance toward counselling.

> I don't want to be diagnosed with a mental illness. Like I know that they don't do that now and they probably don't administer shock therapy but I don't trust them. I think that it's more about the medical model and the patriarchal aspect to that model and what that has done historically to gays and lesbians. I don't need to be a part of that. I don't want to be medicated and fixed.

Charlie advises that culturally sensitive intervention occurs within a context of awareness and sensitivity to the experience of lesbians who underwent treatment aimed at reorientation. While it might be assumed that curative efforts represent counselling approaches from a distant past, she reminds us that many gays and lesbians may still be affected by their past exposure to these tactics.

> More than likely if they are dealing with someone within the lesbian community who has had counselling experience prior to coming to them, they will be dealing with someone who has had some kind of negative experience. Possibly they will have seen someone who has tried to 'cure' them in the past. They should be aware of the negative counselling and psychology and psychoanalysis...

Many research participants provided an account of direct experience with therapeutic efforts at reorientation. The underlying assumption of the counselling they describe is that their homosexuality is not a fixed state and is therefore a matter of choice that could be modified through therapeutic persuasion. At the core of many of these approaches is an understanding of homosexuality as a symptom of faulty childhood socialization that evokes an incapacitating fear of the opposite sex. Interventions commonly assume that through increased exposure and comfort with the opposite sex, the individual's "natural" inclination toward heterosexuality will be unearthed. Psychiatrist Clifford Allen suggested that for the gay man "dancing is...most valuable and gives him a chance to meet and grow familiar with the opposite sex. In such a way his fears can often be removed and he will sometimes make such a spontaneous gesture as kissing a girl after a dance"(Allen, 1958, p. 74).

In the 1960's Mark entered therapy with the expressed goal of adopting a heterosexual identity. He outlines the prescribed homework tasks that were designed to facilitate this change.

> I had about three sessions with this psychiatrist which were mainly appropriate in view of my stated aim of becoming heterosexual or perhaps realizing my heterosexual potential. His main focus was to explore what my relationship with potential girlfriends had been. His questions were related to whether I had held hands - had I ever touched a girlfriend - how many girlfriends had I had -had I kissed any of them - had we embraced and so on. The line of his therapy was to encourage me to progress along a path of physical

> contact and intimacy....it was sort of along the lines of "well the next step for you obviously would be to when crossing in traffic to reach out and hold her arm or something like that." I was to feel free to have lots of different girlfriends. So in a sense there was homework. I would come back to the sessions and proudly announce that I had done this or that.

Rational emotive therapist Albert Ellis indicated that "the assignments given to homosexual patients are...specific assignments about dating girls, making overtures to them, and having intercourse with them." (Ellis, 1965, p. 121) Oscar describes an intervention based on similar assumptions about conversion through exposure to the female sex. In this instance, a Christian counsellor abandoned ethical boundaries in order to provide an opportunity for Oscar's 'normal' heterosexual self to emerge.

> I wanted to rid myself of this desire because I felt the desire was sinful. I'd been told that. I'd learnt that....She started to do like in-home sessions. She said she would help me with my problem and so I was going to her apartment. And she was supposedly helping me with counselling but it got pretty twisted....she kind of thought that she could give her body over to me for me to learn to be comfortable to with a woman.

A counsellor's assumption of reorientation as the appropriate objective of intervention may not be communicated in a direct manner. Sky reflects back on his sense of conflict with regards to the covert goals of his therapist.

> Every time I talked about something good or positive about myself, he had a hard time with that....I wanted to feel good about myself as a human being and he was trying to make me feel good about 'not being gay'. It really made me think that he - had some agenda to make me 'not gay'.

Assuming that the gay client is likely to exhibit a range of neurotic symptoms, Clifford Allen asserted that "sometimes it is not necessary to concentrate on the homosexuality, but to make the patient feel one is curing his neurosis" (Allen,

1958, p.75). Sammy suspects her therapist to have possessed an unspoken agenda involving the adoption of heterosexual orientation. Unlike Mark and Oscar, she indicates that she did not enter therapy with the expressed purpose of changing her sexual identity. This experience propelled her into an unsuccessful struggle to repress her sexual attraction to women.

> When I first went to the counsellor, I guess he was trying to do reorientation to me but I was so innocent that I didn't even know. In a way they partially succeeded in that for a long time I was afraid. I tried to go straight. I started going out with guys even though I really, really had a reaction to guys. But the strength of my sexuality was such that even the threat of hell couldn't hold me back.

Proponents of reorientation strategies have commonly explained a lack of success in treatment as resulting from the client possessing an insufficient motivation toward the attainment of 'normalcy'. Albert Ellis advises that gays and lesbians "are usually evaders and goofers, and tend to work very little on therapy, just as they work very little at many other aspects of their lives" (Ellis, 1965, p. 112). Mark's reaction to a psychoanalyst questioning his motivation to conform to a heterosexual orientation illustrates a sense of despair over the inability of the counselling profession to rescue him from the diminished life opportunities he associated with homosexuality.

> The second time I went, I was ten minutes late for a fifteen minute appointment. I was really very lucky she said "I just don't think that you are interested in being cured." But I was of course desperate to be cured at that time. I was absolutely desperate. I was devastated by what she said and thought it was very cruel...I felt rejected. I suppose that at some level I felt this was an acknowledgment on the part of the medical profession that they could not cure me although they were laying the blame on my shoulders that I didn't want to be cured. I felt very bereft of help and support. I had a serious attempt at suicide around that time.

While reorientation interventions may largely be associated with counselling practices from the past, there has recently been a resurgence of such approaches. The current social and political climate is increasingly influenced by the conservative views of Christian fundamentalists. Within the media, the 'religious right' are seen to target homosexuality as the enemy through associating gay/lesbian rights with the demise of the family and 'healthy, traditional' values. More extreme factions have associated gay male sexuality with pedophilia or stressed that homosexuality is a mere 'choice' relating to deficient role models for masculinity and femininity or reactions against past abusive partnerships. Faith based counselling organizations such as 'Exodus International' and 'New Directions for Life' have arisen to provide resources for lesbians and gays who want to live as heterosexuals. Through counselling, support groups and the acceptance of Christian fundamentalist doctrine, the individual is promised an opportunity for membership in the majority culture. Jeff's contact with a local chapter of Exodus International suggests to her that the organization's haste to equate lesbianism with dysfunction provides an inaccurate portrayal of female relationships.

> They ended up sending a big package of testimonials and I read the testimonials. They just sent me lesbian ones and all the lesbians were in abusive relationships and they were totally disillusioned by their homosexual lifestyle because they said they wanted the lovingness of women and they ended up with these 'psycho-dykes' who abused them. But then they turned to this ministry to give them the love they needed. That really offended me because - fuck, man - they didn't need to totally turn off their sexuality. I believe once you are gay you are always gay. What they needed was to get out of the abusive relationship and get some skills to not be in that again.

While some Christian organizations have made strong public statements of condemnation toward this portrayal of homosexuality, many gays and lesbians

perceive an encroaching backlash against any advances made in terms of social justice. Respondents express a deep sense of skepticism toward such faith based efforts at reorientation. Sammy insists "I am solidly who I am and nothing in the world is ever gonna change that." Oscar questions the possibility of 'cure'. He states "I have a fantasy of going in there and seducing a male counsellor up to the point that I know that they would have sex with me and then say 'sorry buddy. So much for your cure, eh?" Charlie suggests that such interventions are misguided in their location of the problem within the individual rather than the larger social context. "They were more interested in the causes of homosexuality - the reasons why rather than the issue of dealing with life." Sammy associates reorientation strategies with an act of cruelty for which practitioners should be held responsible.

> I think it is so sad that people go through Christian brainwashing and these reprogramming cult things....They were raised like that or because they can't cope with the oppression in society and so they'll do anything to undo who they are....I feel very strongly that I was born a gay person. Nothing made me this way. Nothing. It wasn't trauma, no bad family experience - nothing.... I swear to you I was born gay. I know I was. So who has any right to say to me that I can't be who I am? People who try to reorient others, I don't know - they should be charged because they are taking away the human rights of another human being.

The historical relationship between gays and lesbians and counselling practitioners continues to pose challenges to the creation of accessible service. Whether through direct or indirect experiences with reorientation strategies, clients remain wary of encounters with mental health professionals. While most contemporary clinicians are likely to have adopted a nonpathological perception of homosexuality, models for more lesbian and gay sensitive practice must be informed by the social experience of marginalized clients.

Construction of Identity

It is from within a social context of intense aversion toward homosexuality that lesbians and gays develop a sense of self. The distorted perceptions and invisibility of homosexuality within standards for ideal mental health mirrors the position of lesbians and gays within society as a whole. To enter into therapy is to encounter the very system that has been endowed with the authority to evaluate the individual against a presumed heterosexual norm for human development. Any discourse on the development of accessible counselling service demands a recognition of the enormous power inherent in the dominant heterosexist ideology.

All men and women are socialized to assume an heterosexual identity. The social structure of Western culture has provided no acceptable alternatives to this presumed sexual norm. Non-biased representation of the homosexual experience has historically been absent from public discourse. Parents, teachers, religious leaders and therapists have all served to enforce compulsory membership in the heterosexual majority. Heterosexuality has been promoted as the sole model for achievement of a healthy and fulfilled life and homosexuality has commonly been associated with pathology, immorality and an existence characterized by solitude and loneliness. Recognition of one's difference from the majority occurs within a cultural environment in which there are intense pressures towards conformity.

A social interactionist perspective holds that the development of self concept occurs through encounters between the individual and his or her environment. Judith A.B. Lee describes identity formation as a "lifelong process which takes place in transaction with the environment from birth to death"(Lee,

1992, P.1). For gays and lesbians an overwhelming sense of alienation and confusion are likely to emerge upon the initial realization of one's propensity toward a stigmatized orientation. Confusion over sexual orientation becomes equated with danger as the implications for same-sex attraction include rejection, humiliation and physical danger. The individual struggles with self concept in isolation from social support, as adaptation typically involves efforts to conceal homoerotic feelings. Sammy's adaptation to a gay female identity is characterized by desperation in the absence of social visibility and support.

> I just thought it was hopeless because there was no support in my era. Nobody talked about it. You never heard about it in the media. Nobody even mentioned the word 'gay' much less the word lesbian and if anybody did it was always in a horrendous, stereotyped fashion. So basically we were just drowning in the closet - just dying, dying in the closet.

Homosexual identity construction occurs in isolation from the guidance of role models and accurate information about gay or lesbian issues. Gays and lesbians operate from a knowledge base that is founded upon the same system of homophobic beliefs that characterizes the attitudes of the general population. Having been socialized within a heterosexist environment, these societal messages become internalized and self-generating. The initial recognition of one's homosexual orientation is commonly accompanied by feelings of failure, guilt and uncertainty about one's ability to meet prescribed social expectations. Sky recounts his initial impressions about his gay orientation.

> I thought of gay people as child molesters and murderers and alcoholics and drug abusers. Even though I didn't see that when I 'came out', you still have these thoughts in the back of your head - you have all this baggage of what you think a gay person is so it is hard to be a positive person.

Individuals may be ill-equipped to cope with the moral and social implications of their homoerotic feelings. The anti-homosexual stance of the Christian church has served as a powerful ideological force in upholding a marginalized identity for gays and lesbians. Sammy describes her struggle to reconcile a lesbian definition of self given her religious upbringing. She states "I was a religious person and I always met other religious girls and we were always swishing around in guilt and being afraid that God would punish us." Biblical sources have long been used to justify the condemnation of a homosexual orientation. Individuals who have been socialized within these strictures must reconcile their own sense of morality with their same-sex attraction. Intense inner conflict may arise when the religious foundations which have brought meaning and value to individuals' lives serve to denounce their burgeoning homoerotic feelings. Oscar provides an account of his attempt to understand his homosexuality within the context of Christian doctrine.

> I was terrified that it was hopeless. Because one of the things that had been suggested and then I automatically thought it was true was that Paul, one of the major writers in the new testament, had a thorn in his flesh. It was like this burden that he had to carry his whole life and he never talked about what it was. There was speculation that he was gay. He never got married. There was speculation that that's what it was. He was gay. He had to live with it. He couldn't have sex with men and he couldn't get married. That was his thorn. So I thought that this was going to be the thorn in my flesh for the rest of my life.

The development of personal identity may be further complicated for individuals who hold membership in more than one marginalized community. Lesbians and gays are diverse in their ethnicity, race and class. Therefore, adaptation of identity may incorporate awareness of potential discrimination from a range of different sources of bigotry. Beyond encounters with homophobic

bias, women and members of racial minorities already experience a diminished social status and fewer options for attaining a positive self concept. Jeff's understanding of the self is located within her experience as an aboriginal lesbian and her sense of punishment in a God's determination of her social position.

> When I was a teenager I used to think God made me a woman, he made me Indian - I think He made me gay too. What an asshole! It was this big trauma thing that I had to keep secret. I think about it now and get scared - I think 'maybe it's true.'

Self-definition within a homophobic environment represents a complex task. Vivienne Cass (1979) outlined a six stage developmental model intended to illustrate the formation of homosexual identity. She suggests that initial confusion over sexual identity stimulates a task of comparing the self to the heterosexual majority. Given that the mere existence of homosexuality represents a threat to conventional sex roles and models of family, adaptation typically entails a sharp division between private and public aspects to the self. Despite one's internal reality, a heterosexual public image is maintained. Cass advised that movement through the various stages of identity formation is fueled by the urge to resolve a sense of incongruencey between covert reality and overt behaviour. Sammy describes this endeavor to achieve a sense of authenticity.

> It's about feeling powerless and having no outlets for expression. It's about really never being truly yourself. That has to eat away at the human psyche because we all desperately try to become truly ourselves. And that is the path to an integrated balanced life. I am a great believer in being one's self. I have had to struggle to survive.

Cass's continuum of stages involves: confusion about identity; tolerance regarding homosexual feelings; acceptance of the self; the development of pride in one's self and community; and, the formation of a stable lesbian or gay identity that integrates a congruent sense of the private and public self. While the integration of a gay or lesbian self concept ideally serves to increase one's sense of autonomy and self esteem, negative consequences of this process may include isolation, alienation and self-denigration. Cass emphasized that progression toward a congruent identity may be abandoned at any stage of the process.

Attempts to suppress or camouflage homosexual attraction may be the most palatable coping strategy for individuals who come to define their primary concern as survival rather than growth. Despite some recent gains societal acceptance and legal protection, Paul remains cautious about assuming refuge from social repercussions. He questions the degree to which the sense of vulnerability and isolation he experienced has truly been eased for the next generation of gay youth who must approach adult developmental tasks.

> For me...the whole idea of knowing that there was a gay world out there came when I was reading in high school, this silly little news magazine that lasted for about two months in Winnipeg. It talked about the gay community in Winnipeg. Before that I didn't have a clue that there was such a thing. That's how much I was living in the dark ages as a teenager. I would hope it's different nowadays. I suspect that for those that are able to adapt better and don't go through years and years of trying to fight it and hide from it and be unhappy about it, they would make more progress. But I actually do think that there must be a fair number that must be in the same boat. You know, that they're just having a horrible time because you have to face your family, your fears, your work. I mean anyone growing up gay now can at least say "well, it's in the human rights protection," but it wasn't there until '86. So alot of us had to do our whole growing up and find a career and make our way in the world, knowing that we were vulnerable. It's a big injustice.

The development of a gay or lesbian self image originates with an experience of intense turmoil relating to personal identity. The realization of one's difference from an intolerant majority fosters a sense of alienation and distrust toward heterosexual culture. Feeling threatened by heterosexual society, the individual loses the freedom of spontaneous and open expression in the larger world. Management of identity commonly involves distancing from the mainstream while encounters with a more segregated lesbian or gay community provide a social space where the individual can more comfortably experience an authentic aspect of the self. Through exposure to a shared set of norms and behaviour patterns, an opportunity arises to reconstruct self worth and acquire a greater sense of control over one's own existence. The division between majority and minority cultures is intensified. To enter an heterosexual environment is to return to a climate where the self is potentially marginalized, invalidated and misunderstood. Given that mainstream social institutions, such as counselling organizations, can be presumed to be founded upon the interests of a heterosexual population, gays and lesbians are likely to perceive significant barriers to participation outside of the minority subculture. Writer Dennis Altman suggests that:

> As we become more secure in our identities and less prepared to accept either outright hostility or grudging tolerance, gay women and gay men have tended to spend more time apart from the heterosexual world...and depend more on the special intimacy and understanding that comes from being with other gays." (Altman, 1982, p. 215).

Inquiry into barriers to accessing counselling service requires attention to the social context in which gay and lesbian identities are constructed. Adaptation to social marginalization involved the development of a considerable chasm

between the minority experience and systems that are perceived to represent the interests of the heterosexual majority. Mark's comments reflect a sense of alienation from the dominant culture. He asserts that "What got in the way of counselling was my distrust of heterosexual society and my social performance in it....that became the awkward dynamic from my perspective."

Bias in the Therapeutic Approach

Although current clinical training has increasingly shifted attention away from reorientation interventions, practitioners are not immune to homophobic and heterosexist attitudes. Individuals who provide counselling services are products of a culture and socialization process that reflects and promotes the perspective of the heterosexual majority. "As we become assimilated and educated by the dominant culture and its institutions, we are likely to absorb its values uncritically. As experts, we become prescribers or guardians of an established social order" (Korin, 1994, p. 82). Given the historical alienation between sexual minorities and mental health professionals and that the practitioner's own unconscious bias may create barriers to the development of therapeutic rapport, Harrison (1987) urges counsellors to enter into a process of evaluating their own indoctrination to heterosexual perceptions of homosexuality.

Markowitz (1991) advises that homophobia within counselling can be understood on a continuum. On one end, whatever the presenting issue, homosexuality is assumed to be the primary problem. At the other end of the continuum, the gay or lesbian experience is believed to be in no way different from that of heterosexuals. Either approach appears to misconstrue the actual

needs of the individual client. Oscar summarizes the approaches to counselling that would potentially create a sense of alienation between himself and the clinician. He states that the "issues could be numerous - whether they're outright homophobic, whether they just don't seem to have any knowledge of the gay and lesbian community or whether they right away want to talk about my homosexuality all the time."

If the therapist targets homosexuality as the primary problem, regardless of whether the client presents issues related to sexuality, the individual's true therapeutic goals may be overshadowed (Carl, 1990). Sara insists that "not every gay person who goes into see a counsellor has issues about their sexuality." In analyzing a presenting problem solely in relation to homosexuality, the therapist overlooks the range of concerns that are likely to be a part of the client's reality. Many of the issues that are faced by lesbians and gays are similar to those that are faced by heterosexual clients. Oscar states that "I'd be worried about the kind of person who right away wants to talk about my homosexuality all the time. That would not be what I want to be in there for." Sky asserts that:

> Being gay is not the issue. As long as the counsellor says "I know being gay is not the issue. There is a lot of different issues surrounding you - possibly because you are gay, possibly because of how you are feeling about yourself or how society feels about you or how you perceive society feels about you or whatever - um, but that's not the problem."

Similarly, Charlie identifies a fear that an insufficient social analysis could lead the clinician to pathologize her sexuality.

> I was concerned about somebody suggesting that the problems that I had were specifically related to my being lesbian rather than the greater aspects of my own experience. While I think that being

> lesbian perhaps creates problems in adjusting within society, I don't think that it is the 'be all and the end all' with the kinds of problems that I may or may not have had.

Gay and lesbian clients may feel misunderstood by counselling approaches that disregard their individual experience. Oscar indicates that "I'd be scared that they were trying to peg me into their theory rather than looking at me." The reality of the individual may be eclipsed by the counsellor's efforts to recognize client experience as being influenced by both the dominant culture and issues that are specific to gays and lesbians. Charlie states that the practitioner:

> should not assume that my experience would be the same as every other lesbian's or solely defined by every other lesbian's experience. It would be important that having a social analysis did not cloud an individual analysis. So there would be an understanding that while there is a community experience, within that community experience there are also a whole host of individual experiences that to a greater or a lesser degree reflect the community experience.

Unless practitioners are themselves lesbian or gay, it is unlikely that their own identity formation has been dependent upon relearning information relating to homosexuality. The counselling experience may thus be contaminated with bias if helpers have failed to resolve their own homophobia. Jeff describes a counsellor who she perceives to display empathy solely for individuals who reflect qualities identified with heterosexuality. "She seems to have the idea that certain homosexuals deserve to be the victims of homophobia because they look a certain way. Whereas if you are trying to assimilate, to look straight it is like 'oh, you poor victim.'" Having internalized distorted information about homosexuality, the counsellor may fail to accurately determine the etiology of the client's issues. Without sensitivity to the influence of social factors on the presenting problem, a therapist is likely to be inclined toward locating pathology

within the individual. This is of particular concern given that clients are likely to be in varying places in relation to resolving their own discomfort with same-sex attraction. The client may be in a position of vulnerability to the counsellor's prejudice. Jeff stresses that "the biggest problem is internalized homophobia for the counsellor and the person being counselled".

Markowitz (1991) describes the other extreme form of counsellor bias as involving a belief that lesbian and gay experiences are in no way different from the experience of heterosexuals. Clinical knowledge related to practice within an heterosexual context is presumed to be readily transferable to working with the gay or lesbian client. Such assumptions may be exacerbated by the lack of social visibility and underrepresentation of information about gays and lesbians in professional training. Without specialized knowledge, workers commonly enter into the counselling environment with a presumption that all potential clients share a majority sexual orientation. This type of prejudice communicates a lack of sensitivity to the actual needs of clients whose existence is not represented within the heterosexual culture. Oscar describes a practitioner's heterosexism as a major obstacle to receiving service.

> When I walk in the door, the counsellor should not make an assumption that I am heterosexual. They should not assume I need exactly the same things as a straight person. To do that right away would be to put up a barrier between us. It tells me that the counsellor thinks in a very, very heterosexual way and lives in a very heterosexual world or a world that they think is defined by heterosexuality.

Participants described an appropriate therapeutic approach as being affirmative, as honouring and valuing the unique experience of lesbian or gay clients while remaining able to respond to a range of issues that reflect

commonality with the majority culture. In Jeff's words, "they would be able to talk to you and not make an issue that it is a 'gay thing' - it would be a 'gay thing' but it wouldn't be an issue that is a 'gay thing.'" A thorough exploration of the client's goals for therapy may include an attempt to distinguish between those issues that relate specifically to sexual orientation and those issues that extend to wider concerns. Oscar suggests that his level of comfort is enhanced through such inquiry:

> "...are you coming because you have an issue around your homosexuality or is the issue completely separate from your homosexuality?" If they ask me that rather than me saying, "listen, my issue is not my homosexuality my issue is something else." If they asked me that first I would go, "oh, this person is kind of on the ball". My homosexuality could be my issue. I could have lots of internalized homophobia or self hatred. So they've checked both angles and they've made it clear to me that they see the issues as separate.

The practitioner's conceptualization of a client's presenting problem is likely to reflect the cultural experience with which she or he is most familiar. Understanding of the sexual minority experience is commonly interpreted through a majority frame of reference as opposed to comprehension based upon sensitivity to the client's particular reality. For example, same-sex partnerships have commonly been assumed to be organized within a conventional model for marriage where one partner is perceived to adopt the role of a woman while the other fulfills the function of a husband. Within a therapeutic context such assumptions disregard the unique coupling arrangements of same-sex partners. The counsellor's efforts are rendered to a position of irrelevance as the client comes to perceive their experience to be misunderstood. Oscar suggests that the provision of responsible service to sexual minorities must incorporate an educational component that informs the

practitioner as to the distinct perspective of the client. He voices concern that because of the social invisibility of lesbians and gays in comparison with other minority populations, helpers may neglect to educate themselves.

> I think it is irresponsible of people in the counselling profession to assume that there is no difference between a straight person and a gay person. If they make that assumption, I think they are wrong and I think that they are going to impede the counselling process. If they acknowledge that there is something different and they are going to offer services to gays and lesbians, I think there has to be work done on their part in order to educate themselves about the issues and about creating an environment and using language that would feel comfortable to a gay or lesbian person coming in to their space. I don't know - maybe I am suspicious but I don't think that people are doing that and I think that's irresponsible. I mean that people don't assume, when they are dealing with aboriginal people, they don't assume that it is the same as a white person. Hopefully counsellors dealing with aboriginal people have gotten some sort of education and done some sort of research or reading or whatever, in order to learn more about aboriginal people before they would assume to be able to help an aboriginal person. But I think because we're not visible necessarily, that people don't do that work.

In contrast Sammy discusses a positive experience in couple counselling where she and her partner were recognized in relation to their commonality with the majority culture. She suggests that "some people need to have a sense of being normalized more than others. I didn't need it as much as my partner needed it, I think. So that was one thing - being treated like a normal couple going through a normal power struggle." An appropriate approach to counselling thus requires careful judgment about the needs of particular clients when balancing issues that are unique to the individual, specific to the community and shared with the majority culture.

It is difficult for service-providers to completely divorce themselves from the influences of societal heterosexism and homophobia. Despite a gradual shift away from the medical model, counsellor bias remains a significant barrier to accessible service. Caution about the challenges to addressing counselling needs within the traditional mental health system, has led many lesbians and gays to seek resolution to life problems through alternative resources.

Self Reliance

Therapeutic service represents only one strategy for addressing emotional and psychological discomfort. Gays and lesbians have frequently chosen to avoid encounters with the counselling professionals. Many elect to conceal their sexual identity to practitioners for fear of moralistic judgment and inferior healthcare (Harowski, 1988). Considering the deterrents to accessible counselling, individuals may be inclined to explore alternative methods of problem solving. Suspicion as to the competence of professionals led Melvin to select his own solutions to the task of adapting to living with AIDS. He expresses concern that had he received professional help, his condition may have worsened.

> ...I would have been more panicky about things. Ya know - depending on who the counsellor was. Was he somebody who was afraid of AIDS or HIV himself and only had a certain amount of information on it? Because I know that before everybody thought that you could live for seven years, right? Seven, eight years was the life span and then you were gonna die. And so, even like myself I was getting panicky knowing it was around my eighth year. It was like "oh, no - now is when everybody dies." If I had had a counsellor who thought that, as well, it would have made me even more panicky or made me go towards doing drugs or whatever - thinking, "well, maybe you should get on AZT or whatever stuff is out there." I chose not to because I was able to go through that process myself and make that decision myself. So

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> who knows what somebody would have advised me on, depending on their knowledge of the disease, eh?...Without the counsellor I ended up taking a route that I chose myself.

"Theorists typically see homosexual identity adaptation as a process that may include regressions to earlier phases, stalling or incomplete movement through stages, and a tendency to repeat efforts at tasks not complete in a particular stage" (O'Connor, 1992, p. 5). Coping strategies may thus at times entail tactics that are associated with unhealthy behaviours. Some individuals seek to suppress unpleasant affective experience rather than look to professional intervention as a method of coping. When confronted with emotional challenges, Jeff states that "I just let it slide and the feeling went away." A deliberate strategy to evade pain may be aided by use of alcohol and drugs. Therapist Douglas Carl suggests that "it is no surprise that a population that has historically been very bar oriented and that experiences more than the normal struggle with self-image would turn to mood-altering substances as a partial solution to life's problems" (Carl, 1990, p.137). Paul describes his efforts at coping as the use of "Alcohol. Cigarettes. Tranquilizers. Antidepressants. Work. They're not really good." He understands his coping behaviour as an adaptation to his own sense of failure to derive the benefits of therapy.

> I begin to think that maybe it's all my fault these counselling things didn't work very well but they surely didn't for me. I've tried the whole gamut. This was in the past more. That's why I think these years I've just made myself so busy that I haven't had time for anything - or made time for it. I've just been withdrawn.

Similarly, Charlie describes a coping process that employs reliance on cognitive functioning so as to numb emotional discomfort. Such an approach is at the expense of addressing issues on an emotional level.

> ...I have repressed things. I have a long history of dealing with the problems that I have intellectually and therefore not having to deal

> with them emotionally....I go around things instead of going through them. My coping mechanism has been for a long time to not deal with things and to put them away and to remove myself from my emotional side. Instead I deal with things with my logical mind....I think that I have chosen for the most part to not go as deep into the problems as I could.

In contrast to thinking styles that are intended to suppress affect, the individual may adopt an internal dialogue that generates a more comfortable emotional response to one's circumstances. Gays and lesbians are likely to have many areas of competence within their life situations. As opposed to concentrating attention on dysfunction, the individual may emphasize all of the levels in which he or she has achieved mastery. Melvin maintains a positive sense of self through participation in his own life. He states that "...I don't actively sit down and try and work it out. Things come over time. Just by living you deal with it and you have a way of dealing with it." Sammy describes a similar approach to coping.

> I've had my share of traumas. Of course they made me unhappy. But mucking around in my psyche wouldn't have helped. I knew damn well where the trauma was and I could only do a certain amount with it. Then you have to let it go. The best way to deal with trauma that I know of is to go on having a good life. The longer you have a good life, the less power the trauma has over you....I think that the secret is that you learn to live as constructively and as well as possible in your current life and little by little the trauma eases up a bit.

Melvin adjusted to his HIV status through modifying the way in which he perceives the problem. Through a process of comparing his own circumstances with difficulties faced by others, he is able to construct a more palatable perspective.

> I guess, I sort of just worked it out by myself. I don't know if I worked it out but I sort of came to understand that - that, I guess I prefer to look at other people's lives - what they do - the different

> things and how other people deal with things, that have to go on and I'm no different from anyone else. So, I think I get my inspiration from other people and other people's stories. I think that's what helps me work things through, because I realize I'm not the only one going through this. There's alot of other people who have to go through it and live their lives - they are children, sometimes. Then I think of myself as being fortunate - lucky - so, I just deal with it that way.

Addressing psychological and emotional needs in isolation from intimate human relationships may complicate the task of problem resolution. Coping strategies are likely to employ efforts to activate a support network of like-minded people. Mark is inclined to meet needs for support through his partner. He declares that "I have been very, very fortunate in my partner. He really has enabled me to get through lots of difficult times. I don't think that I have always taken very good care of myself." Charlie's system of support is comprised of both friends and family. She characterizes the benefit of social connection in relation to qualities of both empathy and confrontation.

> I have availed myself of my friendships and my family relationships when I have been in times of crisis....when I have been in a position of extreme crisis, I have gone initially, probably mostly to my mother and then after my mother, to my father. Depending on what the problem was, I might talk to some friends that I trust very deeply to help me through those times....I have been fortunate in that, I have been surrounded by people who will help me and educate me and listen to me and tell me when I am being an idiot.

Distorted perceptions about homosexuality within mainstream society has led some gays and lesbians to rely on resources that specifically reflect the sexual minority experience. Change may be facilitated through reading about the lives of gays and lesbians. Jeff's comments reflect her creative response to an absence of relevant and visible social support. "I originally wanted to go into counselling to deal with my internalized homophobia. I couldn't figure out a

place to go and do that. So I just dealt with it on my own. I went to the library and started reading all these books." Similarly, Melvin says that reading about nutrition helped him manage depression and fear and ultimately informed his decision-making about behaviour change.

> I was going to go on AZT. I did get kind of depressed - I was getting kind of worried and scared. But somehow or other I just managed to pull myself out of it. I read more and that is when I started to look at how to eat and different herbs and going through the natural process. So, I did connect to some things.

Given the obstacles to participation in established counselling agencies, lesbians and gays are left to develop creative responses to problems that arise in their lives. Research participants discussed strategies for resolving life challenges that were aimed at suppressing discomfort, while other efforts were more directed toward growth. Oscar states:

> When you think about it, there is really very little reason for a gay or lesbian person to believe that counselling is something that could help them. So for the most part I think that gays and lesbians have done it on their own and with each other or if they have a supportive family, with their family. That is rather than going outside because going outside is either going to mean you are going to have to deal with educating them or you are going to have to deal with outright homophobia or you are going to have to deal with stupidity or ignorance on the issue. If you are going into counselling, you don't want to have to deal with another thing on top of that. That's why I think alot of people choose to deal with things on their own - through reading, through friends, through family or sometimes even finding ways to avoid it all.

Conclusion

Members of sexual minorities face the complex task of negotiating life problems without the aid of traditional systems of support. Despite the emergence of significant changes in social attitudes toward homosexuality, counselling

services may still be perceived to represent the interests of an heterosexist ideology. Practice may be influenced by the service provider's unresolved homophobic bias. Counsellors are frequently experienced by lesbian and gay clients as ill-informed with regards to specific clinical approaches that are sensitive to the needs of lesbian and gay clients. Social adaptation has thus commonly demanded creative methods for problem resolution.

Chapter Five

Assessing Safety

For the socially marginalized, protecting emotional and physical well being requires skepticism about assumptions of safety within unfamiliar circumstances. It is within this context of suspicion that gay and lesbian clients must determine the degree of risk associated with self disclosure to counselling practitioners. The individual is engaged in a continual state of monitoring the language, manner and behaviour of the clinician in order to determine the suitability of a particular service. The stress related to this process of assessing safety creates significant challenges to participating in therapeutic services. This chapter aims to examine how individuals determine a helper's level of sensitivity to gay and lesbian concerns, the process of selecting a counsellor, 'coming out' to service providers and decisions related to terminating or proceeding with the therapeutic relationship.

Determining Homophobic Bias

Adaptation to societal hostility requires that lesbians and gays develop a consciousness of the potential for prejudice and danger from the external world. Lesbians and gays commonly "recall the sense of threat that emerged early in their lives, often before a clear sense of sexual identity had crystallized - fears of physical injury, verbal humiliation, abandonment by loved ones, or rejection by specific individuals or society at large" (Grace, 1992, p. 37). Significant amounts of energy become allocated toward issues of survival and defense. Strategies for coping with homophobia commonly incorporate efforts to deliberately mask one's sexual orientation through careful adherence to heterosexual norms and traditional gender role behaviours. Behaviours are

structured to conceal feelings that would be classified as unacceptable within a mainstream context. Vivienne Cass (1979) outlined efforts toward self-protection that included the avoidance of potentially threatening circumstances; suppression of personal information; presentation of a public image of the self as heterosexual or asexual; and, the display of a detached attitude regarding gay or lesbian concerns. Social interaction comes to include a process of carefully evaluating the external environment to determine the degree of personal risk with regard to the disclosure of one's authentic self. Sammy identifies this process as a childhood lesson in self preservation. She has strived to incorporate this knowledge into her adult life at the expense of being able to participate spontaneously in social exchanges.

> Boy, when I was young I was gullible. I couldn't imagine that people would be so homophobic that they would treat what I had to say badly, because my gayness was so normal. I couldn't imagine that I would be treated any differently than anybody else. So that was the source of my gullibility. Plus I had a belief that that's who I was and that was okay. I didn't know there was a world out there and in many ways I still don't know there's a world out there that doesn't think it's okay. I just have to keep reminding myself. That's stressful and I shouldn't have to.

As the individual's personal reality is likely to be shaped by a fear of the potential for homophobic rejection and stigmatization, the experience of living safely and openly as lesbian or gay demands the acquisition of skills specifically related to self preservation. Adaptation thus becomes dependent upon developing an awareness of oneself in relation to the other so as to assess the capacity of the other to interact from a position of acceptance and affirmation. Oscar portrays this process of determining safety as a skill that is honed through the experience of being marginalized. He appears convinced about his accuracy in assessing attitudes toward homosexuality.

> Well, as a gay person and probably for lesbians as well, we are all very, very experienced at assessing people - assessing safety - assessing whether a person is either 'gay or lesbian positive' or whether they are gay or lesbian themselves. Because we have always been so undercover - and of course we are 'coming out' more and more - we have developed this kind of antennae that check out people right away and years of that experience means that in a situation like that, where I am just sitting in a room with one other person, I'd feel pretty confident that I could make an assessment pretty fast.

Over time one is likely to become more adept at identifying bias and negotiating security within social interactions. As individuals develop self awareness in relation to a gay or lesbian identity, they begin to anticipate the possibilities for open interaction with members of the heterosexual majority. Sky describes how the acquisition of this knowledge contributed to his perception of counselling professionals. He suggests that his initial idealization of service providers was based on assumptions that were formed prior to developing instincts for assessing safety. He frames his adaptation to the reality of practitioner bias as an essential lesson in the formation of his gay identity.

> I always assumed that social service agencies are 'gay positive'. I always have. I know that's not everyone's experience and I had to learn that they weren't. That was something that I went through and I was quite shocked when I was younger - about ten years ago when I was involved with the youth group. I had to be taught that "no, not everyone is 'gay positive'"....I was quite shocked because I thought being counsellors and in social work is about always trying to make positive changes in children's lives and people's lives and that these agencies would be 'gay positive'.

Melvin specifically credits his life experience since 'coming out' with having informed his sensitivity to practitioner bias. He theorizes that without the benefit of his own evolution, a homophobic clinician may have possessed greater

power to impart damaging suggestions that would complicate his struggle for self acceptance.

> If I was just first experiencing my own sexuality, I probably wouldn't be able to pick that up right away from a counsellor. But now I would be able to. It's just experience, I guess. I have lived as a gay person now for twelve or thirteen years, so I know alot more than I did than like ten years ago. Maybe if I had had a counsellor, I wouldn't have been able to pick those things up. For somebody who was new to it, with a counsellor who was ignorant like that, it would put you back into the closet for, how long? You know, screwed me up that much more.

Living as an openly gay or lesbian person facilitates an understanding that interaction with the heterosexual majority occurs within a larger social context. When individuals are public about their same-sex orientation, their mere existence may be perceived as a challenge to traditional assumptions about human sexuality, family and gender. It is from this awareness that the gay/lesbian consumer makes an evaluation regarding the helper's attitudinal disposition. Charlie identifies her social analysis as a protective factor that serves to shield her from the potential harmful effects of an homophobic counsellor. Like Melvin, she reflects on her vulnerability to the effects of practitioner bias prior to the development of her social perspective.

> I wasn't 'out' ten years ago to myself or to anyone else...I didn't have the kinds of political sensibilities then that I have now. So I think that if I had been seeking counselling ten years ago, I could potentially have ended up really messed up because I didn't have the analysis then that I have now. And I didn't have the self confidence then that I have now so I would have been far more pliable in terms of a relationship with a counsellor. I'd have been far more suggestible.

Charlie's narrative depicts the development of adaptive skills associated with self determination. For gays and lesbians, managing a stigmatized identity

means navigating precarious social encounters in a manner that protects one's own interests. Individuals commonly experience difficulty in perceiving themselves as possessing this type of authority in relation to mental health 'experts'. The capacity to negotiate conditions of safety becomes a primary component in transforming the role of a passive recipient of therapeutic service to that of a consumer. The concept of consumerism as it relates to the field of counselling advances the right of an individual to make informed decisions about healthcare. This includes both the selection of a particular clinician and the direction of therapeutic intervention. This task has historically been complicated by the fact that the client who appeared to question the authority of a clinical 'expert' has been considered as suffering from a neurotic problem and risked being labeled resistant.

Locating Service

Given the prevalence of homophobic prejudice and the social invisibility of lesbians and gays, individuals in search of counselling cannot presume that an unfamiliar clinician will have sensitivity, knowledge and training to meet their needs. Unless otherwise specified, one may expect that services are targeted solely toward the needs of a majority clientele. The client may anticipate that the helper's belief system is a reflection of the values and attitudes held by the general population. The task of approaching clinicians and determining their suitability is characterized by confusion, vulnerability and fear. Sammy's apprehension about locating service is based upon her past experience with non-affirming counsellors. She asks "...how does one choose a counsellor these days? When I was young I made all these mistakes. I blundered into people that proved to be most untrustworthy." Melvin comments that "I guess the part that

scares me the most is making that first move of going to see someone and having to feel that out. I get nervous." Paul states that:

> I am at the point where I want to work on a few things. - so I want to find the right place to be. I don't know what that is yet. So I am actually a person who in their forties feels there are some issues they haven't dealt with and I know it and want to find someone to work with. So I'm actually in that very vulnerable place of looking for somebody right now.

Respondents suggest that locating an appropriate and relevant service may be accomplished through recommendations by individuals from within the gay or lesbian communities. Social networks comprised of other gays and lesbians have served to compensate for a sense of alienation from the larger culture. The presumption of a shared set of community values and norms, suggests that such a referral represents an immediate endorsement of the practitioner's approach. Charlie's reliance on her community as a resource for referrals is grounded on the assumption that information about a professional will be relayed amongst other lesbians. She states "I mean within the gay and lesbian community, word of mouth is mostly how people are going to find out about you." Oscar also uses the gay community as a gate-keeper. He indicates that "I would go to the community first. It's just that people talk, you know? I would figure that there might be some sort of registry or something like that."

While individuals may seek out the advice of lesbian or gay professionals, many respondents identified friends as a primary source of guidance for the selection of a therapist. Paul remarks that "...I wouldn't have known where to go. I think that one of the reasons that gay people find it very hard is that we aren't sure what is safe and where to go. So I asked a friend of mine." The direct experience of others serves as a gauge for measuring safety. Jeff makes her

assessment of an helper through inquiring as to a friend's observations. "A friend of mine was going to see this counsellor and she was telling me how good it was. I asked her a bunch of questions about the counsellor because my biggest problem was about homophobia." A considerable degree of trust may be assigned to the endorsement of a clinician by an individual's peers. Rose reflects on how her absolute confidence in a friend's recommendation of a particular helper provided sufficient information for her to proceed into the therapeutic relationship. She recalls thinking:

> wow, okay. I'm gonna see this person and everything's gonna be okay. I know nothing about this human being....Nothing. Not anything about her at all. All I know is that she has been recommended and there's been some positive things said about her by this one friend of mine.

Where concrete demonstrations of an helper's perspective on homosexuality are limited, perceptions of accessibility may be based on perceptions of particular attributes of the practitioner. Clients may evaluate the potential for therapeutic compatibility through the meaning they attribute to the sex of the worker.

Sex Of Therapist

Emotional comfort tends to be determined through the recognition of a clinician's capacity to identify with the individual's life experience (Corey, 1991). Female counselling professionals are commonly perceived to have a greater ability than their male colleagues to understand the consequences of sex-role conditioning. For female clients, the formation of a therapeutic relationship with a man may be impeded by the larger social context in which many women experience male victimizing behaviour. Sammy describes her past struggle to establish a sense of safety with male therapists in that it was not within her life

experience "to see men performing human duties....I had experienced some men in very inhumane ways." Given a shared social history, women who are consumers of therapeutic service may be more inclined to seek out female practitioners. All five lesbians who participated in the study identified such a tendency. Charlie declares that "as a woman my preference would be to go to a woman rather than a man." Jeff also states that she "would feel better with a female."

Women's choices in relation to selecting a counsellor have tended to be limited by the reality that a majority of mental health professionals have historically been male. In young adulthood, Sammy remembers having seen only male service providers. "I really didn't have a propensity for male counsellors....I truly didn't see any female counsellors anywhere. How many institutions did I go to and I did not see any female counsellors? They were never recommended to me." Given that women have come to have better representation in the counselling field, it is presently more likely that a worker's sex will provide an important initial criterion for determining the suitability of service. Sara recalls that she "...phoned an AIDS organization and asked them for a list of 'gay positive' doctors. I went through the list until I found a woman who was taking new clients." Her assertive approach to locating service is related to the discomfort she feels with the possibility that a generic agency may not present her with choice. "I'd have concern about whether it would be a male or female and how much control you would have over that, you know?" Other women may just presume that counselling will be provided by a female. Rose has not even considered that she could potentially be assigned to a male counsellor. "Whenever I thought of seeing somebody, I never thought of seeing a man. The thought never entered my brain."

Interestingly, male interviewees also identified a preference toward women practitioners. Paul assumes that the male drive to attain positions of social power would serve to compromise the capacity for empathy within a helping role. "I have a big issue myself with doctors who are just doctors because it's the male thing to do and they think 'we're in charge and we're so smart' but they are not that empathetic. Women might be more empathetic..." Male research participants anticipate a greater potential to develop emotional rapport with female counsellors. Melvin states that "I find women easier to talk to." In reflecting on his experience with a woman helper, Paul proposes that "women are more sensitive to certain issues....I knew that I related better to women....I could open up more to her. She was a warm person."

The actual measure of therapeutic compatibility may however, be less related to the sex of the counsellor than his/her ability to develop a relationship that reflects sensitivity to the client's feelings and concerns. The narratives reflect a willingness to see a male provided that he is able to inspire trust. Sky recalls seeing a woman practitioner. He concludes "I felt very comfortable with her but it all depends on the individual. Gender doesn't usually play into it for me." Other participants shared a similar perspective but maintained a preference for female service providers. Sammy advises that "today for the most part I would probably most always, go to a woman counsellor. But...my partner has gone to all female counsellors and they were disastrous. So I'm open. I would go according to whether it was someone I would know I could trust." Oscar also identifies trust as a primary requirement for discerning safety.

> I'd probably be more comfortable with a woman just because in general I am more comfortable with women. Although I am always on a search for men out there who I could trust. So if I found

someone, I would go to a man. I wouldn't not go to a man just cuz he's a man but most likely it would end up being a woman.

Although gay and lesbian consumers often have a preference to receive service through a female or male, the ultimate criterion for evaluating comfort may be more related to the practitioner's analytical framework and capacity to establish therapeutic rapport. In assessing the potential for conditions of trust and safety within the counselling relationship, clients are also likely to consider the worker's sexual orientation.

Sexual Orientation of Therapist

Given the numerical majority of heterosexual counselling professionals, individuals are more likely to receive service from heterosexual helpers than from lesbian or gay counselling professionals. Identifying comfort within the counselling setting may in part be determined by the meaning attributed by the client to the practitioner's sexual orientation. Given a social backdrop of homophobia and heterosexism, a consumer cannot necessarily assume 'gay/lesbian positivity'. In order to be perceived as accessible, clinicians need not be lesbian or gay themselves. However, the heterosexual clinician must devote special attention to addressing issues of emotional safety in order to facilitate the creation of a therapeutic alliance. The consumer commonly encounters the need to negotiate safety in relation to professionals with a dissimilar life experience, because of the lack of visible gay and lesbian service providers in many communities. Oscar states "I have heard of a few lesbian counsellors. I don't know if I have heard of any gay male counsellors who are doing private practice or doing counselling. I know some social workers and counsellors who are gay but they're not working with the gay community."

Research participants presented diverse positions in regard to their degree of comfort about receiving service from an heterosexual worker. Charlie outlines an order of preference that corresponds to her selection of counsellor. "I would probably prefer to see a lesbian counsellor. I suppose I would say further that I would be more comfortable seeing a gay man than a straight man....I think I would see a gay man before I would see a straight woman." Although Sara has clearly expressed an inclination towards female counsellors, she too claims "I might even prefer a gay man to some of the straight women that I can imagine." Rose's comments reflect a degree of surprise about the effectiveness of the service she received. "I ended up going to a straight woman who did remarkable work with me. So, go figure!" Jeff seems to advocate for a more integrated approach to practice as she equates gay and lesbian specific service with segregation. She concludes that given her positive experience with more generic helping agencies, effective counselling is possible regardless of one's differences with the service provider.

> ...when I was trying to get off drugs is when I found out about 'Pride Institute' in Minneapolis. It is a gay and lesbian 'detox'. It is all gay and lesbian counsellors for gays and lesbians getting off alcohol or drugs. Their whole approach is that "you wanna get in here because you are different and here it is different." It is a whole 'closet thing' I guess. I have often thought about that because going through the 'detox' service I went through really worked for me. Being in 'narcotics anonymous' although it is mostly white straight, middle class males has worked for me too. I wonder about the validity or the need for a 'Pride Institute'.

Paul advises of the need to avoid gay or lesbian practitioners. He suggests that they may themselves be struggling with the psychological consequences of homophobia and thus be unable to have the emotional distance necessary to affect an appropriate intervention.

> I think a gay or lesbian therapist is going to have to be a pretty together person. My theory is that being gay or lesbian is going to give you alot of problems in adjusting. I think it just comes with the territory, so if they haven't really come to terms with alot of things themselves, they wouldn't be much use to a client.... You might be better off seeking someone whose issues are so far away from that so that if they could be they'd be helpful.

In contrast to Paul's position, other lesbians and gays perceive the personal history of sexual minority counsellors to allow for a greater capacity to empathize. Mark states "I do have some slight residual distrust of heterosexuals." He implies that an heterosexual therapist may lack the experiential frame of reference that allows for identification with a gay or lesbian reality.

> "I did find myself feeling that some of the things he said were either heterosexist or really were reflective of the fact that he had not shared the experience of gays or lesbians. He couldn't quite see things the way they were. There were little jarring notes in what otherwise was very successful therapy."

Despite Sammy's satisfaction with her therapist, she similarly wonders if a gay practitioner would be better able to relate to her experience.

> I wish that we could find someone who would have all the qualities of this therapist we had been seeing but who would be gay. To me that would be almost a perfect combination. I have every love and respect for this counsellor we had seen but I do think it might make some difference if she were gay. Maybe she would understand a little more about what it does to people to have to be in the closet.

Melvin also values a gay counsellor's ability to relate with his experience.

> I would prefer to talk to a gay person, even if I was talking about family issues. That way that person knows about my stance in my family - as a gay person he had to deal with that same thing as where I am coming from, right? So, in a sense he would be able to identify things a lot quicker. Just who I was as a kid, I look back at how I was and so on and so forth. I could say this to a gay

> counsellor and they would be able to understand that a lot more. Ya know, like why I was withdrawn a bit in my teenage years. Ya know, things like that because a lot of us have to go through that because things aren't open to us like for our other brothers and sisters - ya know, like how you are supposed to progress in life and select a partner and do this and that. For us it always feels a little awkward. So having a gay counsellor would mean that he would be able to identify with that a lot more. Yah, so definitely it would be a bonus.

In receiving services from a sexual minority counsellor, individuals may experience anxiety with regard to issues of privacy and the maintenance of appropriate professional boundaries. Oscar voices a concern "...about confidentiality within the gay or lesbian community, particularly because Winnipeg seems so small." Jeff concludes that "...it is better that the counsellor is straight because the lesbian community is so small." In consideration of the insular nature of same-sex communities, the client faces the possibility of encountering their practitioner at lesbian or gay social events and meeting places. Rose describes this as a potential for professional boundaries to become blurred by more personal encounters. She portrays the community as "so darn incestuous. For all I know a counsellor I would be seeing could have slept with somebody that I have slept with. There's that kind of weird stuff that can feel really uncomfortable." The potential to engage in open dialogue may thus be hampered by fears about boundary violations. Jeff remembers a time when her counsellor asked her "...what is your girlfriend's name?' I was thinking 'why would you want to know her name?'... Of course I envisioned the women's bar and thought 'I don't want to get into that.'" The helper's visibility within a mutual social network may create an extreme sense of vulnerability given her or his knowledge of highly private details of the client's life. Mark advises that the gay or lesbian counsellor has the responsibility to consider the implications of their visibility within the community. "There is such an awkwardness in any

small community that I think maybe they have to be a little bit restricted in their social lives and have a circle of trusted friends...."Rose reflects back on how her experience in counselling was negatively effected by a lesbian worker's unclear delineation between professional and personal boundaries.

> I thought "oh man! Okay, so I'm going to a lesbian counsellor, so wow there won't be any homphobia." That was my hope, right? I thought "this is great. This is terrific but I'm seeing somebody who is like a year older that I am and who has friends who I am really good friends with. "Our social contacts were overlapping. It was starting to feel really uncomfortable and boundaries weren't really clear....What she asked was "well, if you see me in public do you think you'd want to talk to me or anything? How comfortable do you feel?" Well, I had never seen a counsellor before. All I could say was "well, whatever." Anyways, I ended up seeing her quite a bit. In fact, I think I saw her out in public more than I did in our sessions. Like, it was very weird - I mean I saw her at lots of different parties and functions, whatever. She would talk to me. So what ended up happening was that progressively the sessions became very strange. I mean it was almost like - I don't know how to really describe it but I felt as though she was being a little friendlier than she probably needed to be.

While many gays and lesbians are prepared to accept service from practitioners of any sexual orientation, the client may find circumstances intolerable where a clinician fails to directly communicate about sexual identity. While Sky has indicated a willingness to see an heterosexual helper, he is not prepared to participate in counselling where the worker fails to reveal his/her particular orientation. "I would have left....If they never said anything like that, I don't think I would be able to stay..." Charlie reports a similar perspective. She suggests that the ability to develop trust is compromised where the worker does not provide information as to their own identity. Given the client's own sense of vulnerability with disclosure, the worker's silence serves to maintain an imbalance of power.

> I would wonder why they felt the need to hide that from me. That would make me suspicious. I think that I would probably choose not to keep seeing them. The reason I would choose not to is because if I am in a position of being 'out', then I have established a certain level of trust and in order for the counselling relationship to work it seems to me that that trust would have to be reciprocal. So while the orientation would be a non-issue, someone who is being ambiguous to me - particularly if I had asked directly - would make me suspicious. It would make me uncomfortable within the counselling relationship.

Oscar imagines that he:

> would directly ask them and there would be no opportunity for them to be ambiguous. If they said they were 'bi' well then they are 'bi' but I'd be asking that so that I would know what I am dealing with so I could know the questions that I would need to ask them to find out if I felt comfortable with them.

Clinical training often tends to direct the helper away from sharing personal information with the client (Corey, 1991). More traditional models of therapy encourage a professional posture that is based on emotional distance and the rigid avoidance of self disclosure. That some gays and lesbians base accessibility on developing a sense of the counsellor outside of the therapeutic role creates demands that conflict with a conventional image of professional conduct. A feminist approach to counselling advises that an appropriate level of sharing is the level needed to build a therapeutic relationship. At no point is it ethical for such disclosure to be motivated by the social or psychological needs of the practitioner (Dworkin, 1992). Flexibility with regards to personal disclosure provides an opportunity to model the open expression of feelings and to spare the client from uncertainty about the counsellor's experience and perceptions. Melvin wonders "I don't know if counsellors talk about their own experiences - probably not, eh?....They should let me know....That would make me feel good.

That would make me feel that I could trust." Sky stresses that the openness of his therapist has helped him develop feelings of trust.

> I can't open up to someone who is very closed....We do talk about his children and his marriage - you know, things like that. If he wasn't to share things like that...I don't know if I could trust him. How am I supposed to open up to someone who can't open up to me for whatever professional reasons? I know they have to keep their boundaries, right - but they have to make a 'connection' as well.

In contrast to all other participants in the study, Rose objects to the worker's decision to 'come out' to her as she does not equate such disclosure with the development of trust. Rose perceives it as a distraction from her own issues.

> I thought like "okay, so now that she's told me she's a lesbian, this is supposed to validate her abilities to be able to work with me." I didn't need that. I just wanted to know that somebody wasn't going to be judgmental. That's all I wanted. I didn't want any kind of judgment coming through. If anything, the less that I had to know about her, the better I think in a situation like that. I was there for me. I wasn't there to find out about her life.

Although some individuals base the selection of a counsellor on sexual orientation, the demonstration of skill, competence and understanding are likely to be the primary factors influencing the formation of therapeutic rapport. Although these criteria apply to all helping professionals, the heterosexual worker begins the task of relationship building under a great degree of suspicion. Accessibility is enhanced if the heterosexual practitioner is knowledgeable about lesbian and gay issues. Oscar insists that "I wouldn't want to be wasting my time educating them." Charlie proposes that "...excellent counselling can be had regardless of the person's gender or sexual orientation if someone has done a lot of their own work with regards to male - female relationships and heterosexual -homosexual relationships." Sky describes how

his having gathered information prior to an initial meeting with his counsellor served to alleviate suspicion. The worker's practical experience with gay clients transcended perceived barriers related to heterosexual bias. "I was told that he is not gay but very 'gay positive' and that he has worked with other gay clients in regards to issues about being gay and being HIV positive and those kind of things."

Beyond specific clinical training and experience related to counselling sexual minorities, the worker's demonstration of compassion and empathy are paramount to establishing safety. Despite her stated preference to see a lesbian helper, Sara places ultimate value on the clinician's capacity to form an emotional bond. "My immediate answer would be 'yah, I'd be more comfortable with a lesbian', but that is not necessarily true. I'd be more comfortable with somebody who I connect with, which is a personal thing." Similarly, Melvin aims to determine "...that they are sincere and that somehow they care about what they are doing. Then the being gay or lesbian would be a bonus for me." A fundamental task in developing a therapeutic relationship involves communicating dedication to improving the life experience of lesbians and gays. Mark states "...I would either prefer someone who was gay or lesbian or really was what I would call an 'honorary gay or lesbian'. That would be someone who is very deeply immersed in and very committed to our community."

Professional Expertise

There is no uniform counselling model with which to approach all gay and lesbian clients. Determining suitability is complicated by the fact that service may be provided by a range of different counselling disciplines including psychiatrists, psychologists, social workers, general counsellors and peer

helpers. The selection of a helper commonly occurs without adequate information about the nature of specific disciplines. Paul indicates service location was based on the fact that "you knew psychiatrists existed, so you'd go to them." Consumers are left in a position of uncertainty when trying to evaluate which approach has the greatest relevance to their particular needs. Mark asks "how do you find out about who is good at this or that? There are so many specialized areas in which lesbians and gays potentially need counselling and psychological support." Sara advises the practitioner to maintain some degree of empathy for the position of potential consumers. She states that "when you are going through the process of learning to become a counsellor....you lose sight about how hard it is to be completely naive to the whole world of counselling....It's easy to forget what it is like to be standing outside."

Assessing the safety of a particular helping professional is based partially upon the meaning a client attributes to the individual's professional training. Respondents appear to place particular value on the counsellor's level of professionalism. Oscar indicates that:

> the very first thing that I would do is make sure that they have a background - that they have some sort of credentials. I'd ask about their background. I'd ask about whether they are supervised. I'd be suspicious because of my experience of being with these Christian flakes and people who aren't trained and people who are coming from a place where they have their own agenda.

Sammy expresses her concern about helpers that she perceives as having inadequate training. "I've been very disturbed by the hundreds of individuals who pass themselves off as counsellors but really they're not counsellors. They're not properly trained. Maybe they took a seminar here and there but really what they do is mind fucking." Despite suspicions about more conventional forms of

therapy, Sky frames his decision to see a psychiatrist as being based primarily on professional background. "I chose someone who I don't think that I would normally have chosen. I think their credentials were what sold me."

Although credible in relation to educational background, psychiatry and the medical model have historically promoted a pathological conceptualization of homosexuality. Research participants report a significant degree of suspicion toward the field of psychiatry. Paul perceives that "...in psychiatry you'll find stronger belief systems that it is probably basically pathological to be gay." Oscar describes a similar association. "I'd definitely prefer not to see a psychiatrist....I wouldn't want to go to someone that is coming from more of a medical model." Rose asserts that "...depending on how long they've practiced and when they studied, they still have some 'old school thought' going on. I don't agree with that model. It just doesn't fit for me."

While consumers tend to place value on a clinician's training credentials, they may interpret psychiatric professionalism as mechanical and impersonal. Paul states that "...with the normal path of medical school, a diploma of psychiatry, you're treating patients not people." The therapeutic style is characterized by emotional distance. "To be a therapy patient is to accommodate yourself to the lack of such contact, to the absence of any sense of relationship to the person to whom you are baring your soul" (Greenspan, 1983, p. 29). Sky expresses frustration with his therapist's detached style.

> I just don't see psychiatrists as counsellors....The guy I see, when I ask him "how do I handle this?" or "how do I deal with that?" his answer for everything is "hmm" or "okay." That is psychotherapy! What the hell does that mean. I challenge him when he's not listening I'll throw in " I hate my mother." Just those sort of things or say "are you listening?" or something, right? I've been going for two years.

Oscar also prefers a more interactional model of intervention.

> I wouldn't want someone who just goes, "mmm hmm" all the time and lets me do all the talking. I'd like someone who interacts with me. I can go to a friend for "mmm hmm." If I was going for counselling I'd want someone who could help me get to where I want to get to as fast as possible.

Paul suggests that for clients who have been marginalized due to a stigmatized sexual identity, the psychiatrist's emotional withholding is easily interpreted as heterosexual bias.

> In psychiatry, the approach most psychiatrists seem to feel is important is they keep a wall. They have to be totally neutral. I think that you are going to find automatically that with these kinds of people, you will interpret as homophobic whether they are or not. You immediately sense "oh, this is something they're not comfortable with." And you feel guilty and ashamed that you came to them with a problem dealing with sexuality of a homosexual nature. So you are never sure if they are homophobic. I assumed they were. That was easy for me to assume.

Of particular concern to many study participants was the long duration of psychiatric intervention. Sky states "I see what he is doing as a very long process. I don't think it needs to be that long for me in my situation." Paul is discouraged by the length of time he devoted to psychiatry without having achieved any noticeable changes. "I'm actually really upset about all the time I spent with that psychiatrist. I didn't realize that they left me with a terrible feeling.... I was on a long track." The narratives are consistent with a trend toward more practical kinds of therapies based on modifying behaviour as opposed to lengthy procedures associated with insight oriented counselling (Cade & Hudson O'Hanlon, 1993). While traditional psychodynamic approaches assume that change occurs through the consumer's evolving understanding of their presenting issues, models based on problem-solving argue that the

clinician's primary role is in generating expedient and creative solutions in order to facilitate change (Haley, 1991). Charlie states that her:

> ...perception of psychiatry is that it is not necessarily moving towards being more functional in society but that it in fact moves into dragging out your guts and examining them microscopically and I don't necessarily see it as something positive....It doesn't necessarily mean that counselling shouldn't involve some self examination but that shouldn't be the entire focus of it. I see counselling and therapy as something that ideally will make me or whoever's going to it, more functional within society. I see it as useless if it's not doing that. If it turns me into a blithering mass, then what's the point?

Sammy says:

> ...I would avoid psychiatry because psychiatrists like to muck around in places - first if you search into yourself it could be fathomless. There's no end to how fucked up we can be as human beings. If we really want to be fucked up there's no end to it. So you can muck around and dig around and do your archeology - I really don't think it solves anything.

While respondents assess the suitability of a practitioner through educational qualifications, models based on a generalized approach may be selected over more conventional approaches. Charlie considers both psychiatry and psychology to be inappropriate to her needs. "I would tend to say neither of those two disciplines would fit for me. I would look for someone who has had lots of experience but I still think that they should have some solid training." Sky's disenchantment with psychiatry stems from his desire for a more interactional approach. "I think looking back, I would probably see maybe just a counsellor or someone who is versed in counselling. I don't think psychiatrists are. I think they are more versed in drug therapy or psychotherapy."

As opposed to theories that isolate a presenting problem within the client, social work methods aim to attend to both the individual and the social environment. A foundation for intervention is based upon the client's efforts toward change and the worker's analysis of the problem within the context of an hostile social environment (Gunter, 1992). Sammy expresses concern that "counselling most often focuses on the individual or the couple and the onus is on the individual and on the couple. There is an inherent stress there because real life is sociological. We live in our society. We live in our social worlds." Rose describes a preference for a therapeutic framework that views individual experience within a larger social context.

> While psychology might be a route, I would go to someone with a social work background....The reason I say social work is just because of certain training pieces that take into account the bigger picture - that would probably be very important in how they apply it to their practice.

Lesbian and gay consumers may locate service based on factors such as the practitioner's particular counselling model, level of professional expertise and educational background. However, clients also evaluate the potential for therapeutic compatibility through observations of the helper's interpersonal style.

Therapeutic Style

Consumers are likely to be searching for any degree of homophobic bias that might underlie an introductory exchange with a counsellor. The nature of this first contact is pivotal in facilitating or hindering the creation of an ongoing therapeutic relationship. Trust may be cultivated through the degree of rapport the therapist is able to establish within the encounter. Clinical styles that incorporate such qualities as openness, empathy, acceptance and a general caring towards others facilitate the formation of a therapeutic alliance.

Respondents describe recognizing these elements through both empirical indicators of affirmation and intuitive means.

Interactions with people who are perceived to be in authority, typically involve a sense of risk. During the early stages of the counselling relationship, the lesbian or gay client is likely to be monitoring the helper's presentation in order to measure the potential consequences of self disclosure. Through carefully observing the manner in which a practitioner responds to information that relates specifically to homosexuality, the client derives information as to how they are being received. Rose asserts that "a 'gay/lesbian positive' counsellor wouldn't flinch when I say certain words. If I talk about any sexual behaviour or intimate behaviour, they wouldn't look uncomfortable." Charlie employs similar monitoring techniques to Rose. She contemplates the possibility of proceeding to expose herself in counselling or terminate the arrangement altogether.

> I would watch the counsellor's body language and I would probably after having done all of those things, then proceed to ask some leading questions to sort of get a sense of 'the lay of the land' and any preconceptions that this counsellor might have with regards to homosexuality. Then I would make a decision as to whether or not to 'come out' and continue with the counselling with that particular person.

A precondition in the formation of a helping relationship, is the worker's ability to transcend a client's ambivalence (Shulman, 1984). Although the individual has voiced a request for service, this phase in counselling is marked by concerns that the clinician will present as impersonal and artificial and be unable to empathize with the lesbian or gay experience. Sammy's sense of safety is established through an initial telephone encounter with her therapist. Her comfort is based upon the practitioner's capacity to communicate receptiveness through qualities of gentleness and humour.

> ...she has such a great sense of humour. The first time I phoned her, she made me laugh on the phone and she has this most wonderful voice - soft, welcoming and I could tell she had a great sense of humour. I felt safe almost right away. I felt safe even before I met her. Overall she made us feel safe....I would recommend her to any gay person.

Concrete examples of practitioner bias involve statements that convey value judgments, stereotypes and generalizations as creating greater personal distance with lesbian or gay clients (Read, 1988). Within her research on the attitudes of counselling professionals towards homosexuality, Teresa DeCresecenzo (1985) cites other overt indicators of counter-therapeutic behaviours. These include:

> ...making comparisons in conversation between homosexuals and cripples as reflected in psychotherapy aimed at helping homosexuals 'adjust to their condition'; being condescending toward homosexual clients, frequently characterized by pointing out all of the lost life opportunities being homosexual carries (such as children and marriage);...discouraging homosexual clients from disclosing their sexual orientation to family, friends and co-workers (an attitude which imposes tremendous psychic stress on a client leading a 'double life'); and in any other way disconfirming or devaluing homosexual identity (DeCresenzo, 1985, p.121).

The use of verbal communication is one of a helper's primary clinical tools. The manner in which language is used serves as an expression of one's knowledge base and value system. As marginalized populations are commonly rendered invisible through language that represents the majority experience, the use of inclusive terminology promotes a sense of accessibility. Sara determines the relevance of service through the helper's selection of words that extend beyond the heterosexual experience.

> I mean, you walk in to see someone and they ask you if you have a boyfriend. You know right away there is that barrier that you have

> to cross. It's really uncomfortable....I mean you should be able to word a sentence so that you aren't offending anyone. If I am on the edge of 'coming out' and really nervous about it and really sensitive about it, there are probably a number of ways that you can ask me a question that isn't going to offend me.

Oscar states:

> If I heard the terms 'partnership counselling' or 'relationship counselling', I'd go, "oh, maybe they're open minded there." If I see something that says 'marriage counselling', I know right away that that place is just dealing with heterosexuals. They don't even see me as part of their world. And that's such a simple thing to change, too.

As a lesbian, Rose experiences a sense of social exclusion in comparison to the greater attention given to issues associated with heterosexuals and gays. She advises that it would be important that a counsellor's manner of speech be reflective of her reality. "I would like to hear the word lesbian. It just is so often that it is never there. The invisibility makes me ill....So yah, mentioning the word would be really nice."

Determining practitioner bias also may be based partly on perceptions formed through intuition. Jeff shares how the identification of bias is influenced by her interpretations of the counsellor's presentation. She states that "it would just be a general feeling or vibe, if you know what I mean?...It could be their body language or even their smell or just the way they look. It just triggers this feeling of 'Oh, my God! I had that before and I hate it'." Her description implies an instinctive method of assessing safety that is informed by past experiences with homophobia. The client's evaluations may be founded upon a combination of both empirical indicators of prejudice and more intuitive interpretations of the client. While Sara makes reference to the counsellor's changing facial expression her primary measure of intolerance is based upon intuition.

> I don't know if I can put it into words. It's a look. I mean every gay person that has 'come out' to someone and has had disfavourable reactions knows 'the look.' I don't know if it is the roll of the eyes or a dismissal in the face but there is some kind of change of behaviour that makes you realize that this person is not accepting...you can tell. You can feel it more than anything.

Sara describes her sensitivity to bias as an understanding that is shared by all people who have undergone the experience of 'coming out'. While this means of assessing safety may be common to lesbians and gays, clients frequently evaluate service through the employment of more direct forms of inquiry.

Interviewing the Practitioner

Gays and lesbians face enormous challenges in adopting the role of consumer within a therapeutic setting. Consumerism requires the assertiveness to assume a position of expertise about one's own best interests. For sexual minorities, this may be complicated by the experience of growing up amidst a public debate amongst heterosexuals that has assumed the right to define an homosexual existence. Furthermore, the counselling relationship has long been characterized by a power imbalance that discourages open dialogue between the professional and the client. Paul asks:

> Now would a gay person have the 'chutzpa' to go to a therapist and say "look I wanna know where you stand on a gay issue? Can you deal with gay people and their sexuality and their problems? I mean, is this something you can work with?" I don't know. I mean that takes a fair bit of courage.

The dynamic he describes is upheld by a mystique that typically surrounds psychological theory and the myth that a trained professional somehow holds the capacity to function as the authority on another's life.

Informed decision-making about participation in therapy is dependent on creating an opportunity to interview the helper. Charlie outlines a process of information gathering in order to evaluate counsellor suitability. She states "I would set up appointments with the counsellor and based on my feelings about how they answered some questions, I would decide whether or not I was comfortable." As though in reply to Paul's skeptical questioning of the reality of gay consumerism, Oscar proposes an extremely assertive approach to assessing safety.

> I'd ask them directly, "is my homosexuality going to be a barrier between you and me? Are you going to see my sexuality as something pathological? Are you going to be asking me all kinds of questions about what it's like to be gay and stuff like this? That's not why I am here."

Rose refers to her strategy for assessing the suitability of a counsellor as research. She describes this procedure in great detail. Her criteria include factors such as the helper's theoretical orientation, professional training, direct experience in serving gays and lesbians, and the nature of clinical supervision. Rose acknowledges that adopting a consumer role may be stifled by financial constraints. The selection of a clinician in many circumstances may be dictated by issues of affordability rather than the criteria she has outlined.

> I'd want to explore what kind of practice they have and what kind of work they do. I'd do a lot of research. I would interview them very carefully. I would interview. I would be very, very selective and I would find out how they practice. I would find out what kind of model they use. I would find out about their educational background. Have they ever done any research? What kinds of 'hands on' work have they had? What kind of real work experience have they had with gays and lesbians? What kind of supervision do they get?...I'd be really careful. Hopefully I wouldn't be in that vulnerable of a position where I couldn't afford the counsellor so I could have the selection of my choice. That was part of the problem I think when I was going to that community health centre. I

> couldn't afford going anywhere else primarily. So I didn't feel like I had the power to sit and interview somebody to figure out whether or not the fit was okay and that's an issue.

Within the early sessions, the client who is not fully trusting of the worker will often risk exposing only peripheral aspects of a larger problem. However, ascertaining the helper's perspective on homosexuality demands a degree of self disclosure on the part of the client. Openness about one's sexual identity within a counselling context is commonly associated with a sense of vulnerability, given the common presupposition of the counsellor role as that of 'expert' who holds the power to pathologize. Yet the effectiveness of clinical intervention is ultimately dependent upon the client's freedom to openly explore all aspects of his/her life.

'Coming Out' Within the Counselling Setting

The demand to 'come out' to a professional presents significant concerns for consumers of counselling services. For many lesbians and gays, the most stressful and threatening aspect of a same-sex orientation is experienced in the process of 'coming out'. Such self disclosure acts as a stimulus for the redefinition of relationships as the individual exposes her or his authentic self to the possibility of either acceptance or rejection. The degree of vulnerability 'coming out' arouses is likely to be commensurate with the level of intimacy that is jeopardized by disclosure. While helping professionals represent a more emotionally distant relationship than that of friends or family, they have the authority to offer either validation and affirmation or to pathologize through the application of a medical model. Paul equates exposing his sexual identity to a clinician with being labeled. "I think that we grow up with so much shame about it that to admit it to a therapist, you almost feel that you have branded yourself."

'Coming out' has historically been associated with a potential for negative outcomes. Mark recalls that in his younger adulthood "I was admitting that I was a person who wished to do criminal acts." Similarly, Sammy reflects back on the risks she took in 'coming out' to a college counsellor. "You know looking back, I am really lucky I didn't get kicked out of that place because years later I actually met other people who went to that place who had been sent to a mental institution because the system found out they were gay." Research participants described a high degree of anticipatory anxiety in relation to speaking openly with a practitioner about their sexual orientation. Sara explains that "you don't know how they are going to react....Fear would be the biggest thing - about disclosing information and uncloaking myself to another person. I'd have fear about talking to the receptionist. Like what is she gonna think?" Preparing for this discussion typically entails devoting a tremendous amount of attention to monitoring emotional safety in order to predict possible consequences. Fearing social repercussions, Oscar is careful to ensure his privacy before 'coming out'. "First of all I made her promise. I said that 'I don't want to tell you, I want to get a promise from you first that you won't tell another person in the whole world'." Mark recalls having similar fears about possible consequences. He states:

> I certainly remember agonizing over the decision to talk to a counsellor and of course there was a fear of disclosure. There was a fear that contemporaries would ask me what I had been going into that building for or that my parents would find out that I had been seeing a therapist or that it would surface later in my career. All these fears were very major barriers.

The notion of presenting as openly gay or lesbian is determined by the client's current emotional state. 'Coming out' may be impeded by the degree of discomfort that individuals feel toward their sexuality. If the client is still grappling

with the earlier stages of forming an homosexual identity, the prospect of 'coming out' to a therapist may be daunting. Sky says "I remember when I was younger, when you get all this fear even mentioning it to someone you don't know." While Sara promotes an assertive approach to self disclosure, she is cognizant of the obstacles for those who are in a position of emotional fragility.

> I would rather be proactive and say "look, I am gay..." It is easy to say that now, though. I am not in a state of crisis. I am not in a state of distress. If I were really upset and needing to see someone, I might not have that strength...When you do go see a therapist you are weak and vulnerable and you are not feeling good about who you are. So you are not going to be proactive.

Despite the intense level of discomfort associated with 'coming out' in therapy, interviewees suggest that the issue should be addressed at the very beginning of the counselling relationship. The concern appears to involve the perception that if the issue does not surface immediately, it may never come up. Paul identifies that "for me it took alot of bravery but I always knew you just have to say it up front." He later discusses that without openness about one's sexual identity, the therapeutic process is stifled. "I knew a very troubled person. He was seeing a psychiatrist. He said 'the one thing I won't tell that doctor is that I am gay.'...He was so afraid to say this...but I mean if you don't say that, you're not able to get any help." Sara describes the internal dialogue that accompanies her decision-making. "Do I take the easy route and say 'no' or do I jump through that whole fuckin' hurdle on day one? You know, are you gonna be proactive or are you gonna sit back and wait until it comes up - are you never gonna tell them?" Mark attends counselling with a 'coming out' strategy that is guided by the gradual development of his emotional comfort. However, fear that the issue might never arise outweighs his instincts for safety and propels him toward spontaneous self disclosure.

> My initial presenting complaint was being unable to sleep and needing help with that. I thought that I would start out with that and see if I felt comfortable with whoever the clinician might turn out to be. Then I thought I might talk later about my homosexuality and what a problem it was for me. In actual fact, although the interview was very, very brief, I realized that I had better just open up about it or else nothing was ever going to get said or done. I didn't really have an opportunity to decide whether I trusted this individual. I just sort of blurted it out and he was terribly embarrassed and immediately referred me to a psychiatrist who worked in the same institution.

Strategies for revealing sexual identity may employ indirect methods of communication in the hopes that the helper will initiate more open discussion. Oscar remembers a time in his adolescence when he felt too unsafe to speak openly with a counsellor about his sexuality. "I gave him all kinds of hints because I didn't want to say it. I wanted him to get it out of me. I gave him all kinds of hints and all he did was career counsel me. ...when he didn't pick it up I just felt all the more alone." Other clients may avoid making a declaration in favour of subtly introducing their orientation within the course of conversation. Sky states "I guess I did say my partner is a male. That is always a little nerve-racking." While such an approach might imply that the topic represents a mere routine detail, the client is likely to be anxiously monitoring the practitioner's reaction.

Research participants report having experienced a vast range of reactions from service providers. Each scenario is characterized by a degree of uncertainty that leaves the client attempting to decipher the deeper meaning behind the helper's response. Sara appears to feel confused and judged by the clinician's opinions. She challenges the counsellor's authority to offer pronouncements regarding her process of 'coming out'. "She made a comment

that I 'came out' very late. It upset me. 'Who the hell are you to judge when I can or can't 'come out'?' Rose is left questioning the implications of having declared her motivation for attending counselling. '"I'm here to talk to somebody about 'coming out' issues.' She looked at me and then said 'I'll be right back' and then she left the room. It was classic. It really was. Then I thought to myself 'wow, what did I say?'" Sammy describes a situation where the counsellor appears to doubt the reality of her same-sex attraction. She states "he asked me questions that really embarrassed me. I guess he was trying to determine whether I really was attracted to the same sex or not." Jeff voices her frustration with a practitioner who reacts defensively to her needing to present her lesbianism as an issue." "It bothered me... She seemed to become offended that I didn't think that she was going to be professional." The narratives suggest a high potential for clients to feel misunderstood upon 'coming out' within the counselling setting.

Although consumers are likely to have made a thorough assessment of safety issues in relation to disclosing sexual identity, practitioners have an important role to play in diminishing anxiety. Sara advises that counsellors be sensitive to the fact that "you've exposed yourself. You have made yourself vulnerable. You're scared....You are feeling shitty about a bunch of stuff. You don't need that extra weight. If a counsellor can take that on somehow, it would make life alot easier." The premise of a 'lesbian/gay positive' intervention emphasizes that while homosexuality creates the context in which problems may occur, being gay is not the issue. Assessing safety involves verifying that the clinician has not become fixated on targeting sexual orientation as the point of intervention. Jeff describes how the helper's confirmation of an unbiased perspective served as a precondition for proceeding to address actual issues. "She just said she didn't think it was wrong and didn't have a problem with it.

Then she asked if anything I wanted to see her about had anything to do with my homosexuality. It wasn't, so my homosexuality wasn't really an issue after that."

Where the worker is perceived to exhibit an invalidating response to a same-sex orientation, the client may choose to terminate the counselling relationship. Without evidence for the safety of open dialogue, the utility of proceeding in therapy becomes questionable. Sara recalls such a scenario. "I didn't like her. I wasn't secure enough with myself to open up to her. I didn't trust her enough to do so. So I just stopped seeing her. I didn't call. I didn't do anything."

Terminating Service

For the helping professional, the ideal ending phase of therapy is marked by the attainment of the client's particular goals (Carl, 1990). However, termination of the counselling contract is often initiated by a consumer determining service to be ineffective in facilitating change. Discontinuing therapeutic involvement is sometimes based on conclusions that the nature of practice reflects an homophobic bias or simply lacks relevance to a gay or lesbian reality. Jeff insists that "...if you find a counsellor who is homophobic, leave the office - run don't walk! I've always kept that in mind." Despite the worker's efforts to communicate safety, the client's assessment is likely to take precedence in decisions regarding termination. Jeff advises "I would have to make a judgment about whether she was telling me the truth or not. She is more than likely to say 'you are safe here'. Then I would have to make a decision about if she is lying or bullshitting or am I leaving right now and never coming back." While such decisions are often disconcerting for the professional they provide a clear statement of client self determination.

While termination presents a valuable opportunity for clinical growth through direct feedback to the service provider, the ultimate priority is the well-being of the client. Removing oneself from an unhelpful situation may occur through indirect means as a way to bypass open dialogue with the clinician. Paul portrays his withdrawal from a biased counselling relationship as fleeing. "I ran away. I just didn't go back to those people." Jeff imagines that her "counsellor would probably wonder why I didn't come back - they would probably never know." Oscar describes how in young adulthood, his sense of being emotionally unsafe led him to falsify 'progress' as a strategy for discontinuing counselling. He suggests to his therapist that "'the desires are going away' and stuff like this and 'this is really helpful'. I just totally snowed her because I just didn't want to go any longer."

Some research participants described employing more direct methods of communication with service providers. In contrast to Oscar's earlier strategies of terminating service, he suggests that with time he has been able to adopt a more assertive stance. "Five years ago, if I had thought a counsellor was homophobic, I would have left and never come back. Now, I would say to them, 'I don't think that this is going to work out. My assessment of the situation is that you have issues here.'" Sara describes a similar approach."...if I were to walk into a situation and I 'came out' to them and they didn't respond favourably I'd leave and I would tell them why I was leaving." After experiencing sexual advances from her counsellor, Rose moved to terminate service in a manner that advanced her rights as a consumer.

> I ended up coming back to her at the end of that month and I just said 'I can't do this anymore. I'm needing to just stop.' And so I ended up going to the clinical director of that place and I said 'I'm uncomfortable with this. This is what's going on. I don't know what

you can suggest.' I made an appointment to see my clinical records because I thought 'what the hell 's been happening?'"

Respondents emphasized that the responsibility to be informed about lesbian and gay issues lies with the counsellor. The therapeutic benefits of service may be compromised if clients must endure the emotional demands associated with self exploration while attending to the education of their worker. Paul describes confronting his psychiatrist. "I just blew up and said 'I'm out of here!' I kept saying to him 'I'm working really hard because I want you to be a better therapist.' Those are not good things to be working on. You are supposed to be there to be a better person." Oscar insists that "I've educated enough people in my life and lived through enough garbage. I don't need to do that any more. They can go away and do their own work on their own time. I'm not gonna do it for them."

While a client's decision to discontinue counselling may be seen to represent self determination, many interviewees expressed a high degree of anger and frustration related to their experience. Unfortunately, abrupt endings to the therapeutic relationship provide no process for the resolution of negative feelings. Future attempts to locate an appropriate service may be tainted by an individual's unresolved issues related to past experiences with termination.

Conclusion

Like all consumers of counselling, gay and lesbian clients have a right to receive the most effective services they can possibly access. Given the prevalence of heterosexual bias, individuals cannot assume mainstream institutions to be informed and sensitive to their particular experience. However, as members of a minority community, lesbians and gays are likely to be familiar with demands related to assessing relevance and inclusivity. Through the

experience of growing up in an intolerant environment one becomes finely attuned to assessing safety. Oscar says:

> As gay and lesbian people, we have learned how to assess situations. We have learned how to assess people. We have learned how to assess safety. We have learned how to build up a support network around us because there was nothing there. We've developed these resources and are quite suspect of things outside of that.

As there are few situations where one can comfortably reveal their lesbian or gay identity, specific skills related to self preservation are acquired. These adaptive tools come to be applied to the complex task of determining comfort with helping professionals. Evaluating one's emotional safety within a counselling setting may be based on intuition as well as more concrete indicators of the practitioner's therapeutic approach and value base. The client's assessment process occurs through vigilant efforts to monitor the worker's general manner. Self protective measures are utilized in the location of a suitably trained clinician, risking self disclosure with regard to sexual identity and decisions related to the termination of service.

Chapter Six

Recommendations for Developing an Accessible Approach to Service

Although homosexuality has been officially removed from the diagnostic list of psychological illnesses for more than twenty years, service providers have been slow to advance a therapeutic approach that is informed by the experiences of lesbians and gays. While helping professionals may be assumed to provide service to diverse populations, the interests of sexual minorities have long been excluded and misunderstood within mainstream social institutions. Despite the reality that lesbians and gays represent a sizable portion of the overall population, counselling disciplines often fail to incorporate practice skills that relate specifically to the needs of those outside of the sexual majority. Research participants proposed a variety of recommendations for the creation of a more accessible and culturally relevant service. This chapter aims to explore reeducation of the helper, conditions that reflect accessibility, strategies for ensuring visibility within the communities and issues related to advocacy.

Reeducation

The development of an accessible approach to counselling is dependent upon helpers acquiring familiarity with sexual minority issues and addressing their own internalized heterosexual bias. Clinicians are generally expected to practice with a variety of clients whose life experience may differ from their own. They must be prepared to employ intervention tools to a range of problems that they have not personally encountered. Counsellors' professional values may hold them responsible to provide service equitably to all clients, but a lack of information and experience may prevent the application of these principles to lesbians and gays (Forrister, 1992).

Where biased beliefs about sexual minorities go undetected and unchallenged by practitioners, gay and lesbian consumers will continue to face obstacles to accessing service. DeCrescenzo (1985), posits that "if it is demonstrated that homophobic attitudes do exist among mental health professionals, we must address the question of how effectively workers suffering from homophobia are able to serve their clients" (DeCrescenzo, 1985, p.120). Sara illustrates how her concerns about a counsellor's biased belief system creates an immediate barrier to the formation of a therapeutic relationship. "I am not going in worried because I like women. I am going in worried because of how you might feel about that. It puts shit on it that shouldn't be there."

Dahlheimer and Feigal (1991), assert that training for an effective and accessible counselling practice must include efforts to gain familiarity with sexual minority issues, communities and cultures. Such an approach involves incorporating a perspective in which a lesbian or gay orientation is equally valid to heterosexuality. To modify homophobic indoctrination is to embrace bisexual, heterosexual and homosexual orientations as being morally neutral (Pharr, 1988). Similarly, an affirmative approach to service validates same-sex couples with or without children as having a legitimate status as a family (Carl, 1990). Sara portrays an informed service provider as:

> completely accepting of homosexuality as a healthy, normal aspect of human sexuality. That is the bottom line. You don't want to deal with people who say 'I think they have a right to live' or 'as long as they do what they do out of my space.' That to me isn't 'gay positive'. That is tolerance. I don't need to be tolerated.

Seeking out opportunities for clinical upgrading is essential to responsible practice. "The educational experiences provided by the profession generally are

expected to be responsible for the dual functions of transmitting a theoretical base of knowledge and applied skills and inculcating the values and norms of that particular profession's culture" (Nichols & Everett, 1986, p. 383). Research by Teresa DeCresenzo (1985), supports the expectation that homophobic bias would be eroded through the worker's exposure to professional literature and specialized clinical training. She developed and administered an 'homophobia scale' to a variety of social service agencies. Her sample was representative of a range of different counselling disciplines. Social workers were found to have the highest level of homophobic bias while psychologists appeared to be the least homophobic. DeCresenzo attributed these differences to greater attention paid to gay and lesbian issues within the curriculum of psychological education programs and journals.

While current trends in clinical training increasingly include attention to counselling issues associated with service provision to ethnic and racial minority groups, practitioners are less likely to receive specific instruction related to the lesbian or gay client. Even if opportunities for specialized education exist, the individual worker may be hesitant to participate. Social work educator, Harvey Gochros advises that clinicians "may fear that showing acceptance and understanding of homosexuality or even interest in problems that relate to homosexuality may call into question their own sexual orientation" (Gochros, 1985, P.140). This is likely to be especially complicated if counsellors do not identify as lesbian or gay, but have themselves had same-sex erotic experiences or fantasies. As encounters with a gay or lesbian client may awaken unresolved feelings, such practitioners may be invested in efforts to disassociate themselves from sexual minorities, so as to reinforce an heterosexual identity.

Since an affirmative stance toward homosexuality is in opposition to prevalent social attitudes, clients cannot presume that helpers have embarked upon reeducation efforts. Oscar says that he requires reassurance about what specific training a practitioner has sought out in relation to sexual minority issues. "I'd make sure they had training about gay issues. I'd feel okay if they said, 'I do have something to offer you because I've gone to workshops and done some reading.' They've got to read books, get journals, talk to gay and lesbian colleagues - do something." While lesbians and gays commonly present issues in counselling that are similar to those of heterosexual clients, specialized training facilitates an analysis of the individual's problem within a wider social context. Effective practice thus includes assessments that are informed by both traditional diagnostic concepts and the larger political issues (Dworkin, 1992). Intervention is determined by assessing where symptoms are pathological and where they represent a reaction to oppression. House and Holloway contend that "...counsellors who down play the importance of societal homophobia may fail to maintain empathy with gays and lesbians" (House & Holloway, 1992, p. 309). Paul states:

> I am actually about to come to the theory that maybe in dealing with gay and lesbian people, one needs a special training. I actually think it would be better. One should really have at least workshops in understanding the nature of gay life - the nature of gay stresses and problems and be able to see that side of it. I think that would help people be therapists rather than just dealing with the individual all the time. I mean they have to understand really well about the world they are going to deal with.

Rose describes a need for specific information about the helper's professional expertise in working with lesbian issues.

> I'd really be concerned about the kind of work they've done - the kind of actual work - whether it's academic or whether it's research.

> "Have you read a book on what it means and what the issues are? What do you know about the 'coming out' process? Can you tell me what that is?"...What kind of professional development are they getting in that area? And what if they haven't worked through their own issues and then they bring those issues into the sessions somehow? If their buttons go off I 'd like to know that they have gone through some professional development. I just want to know that they have a knowledge base to do what they are doing. There's nothing worse than going to someone to work on stuff and they have no fucking clue what you are talking about.

DeCrescenzo (1985) outlines some of the essential elements to reeducation. She posits that a:

> ...well-designed training program would include three major components: *factual information, theoretical material and participative experience* for those attending such a program. Specific topics would include information about what homosexuality is, what is known about its cause and incidence; a discussion of why prejudice against the homosexual minority exists, and how the major sources of that prejudice have operated to perpetuate the problem; a description of the contemporary gay and lesbian world; and a presentation of myths and stereotypes regarding lesbians and gay men with accurate information regarding each point (DeCrescenzo, 1985, p.132-133).

Preparation for counselling members of sexual minorities may also involve developing an awareness of gay and lesbian history, community norms and culturally relevant terminology. The relevance of service is enhanced through the practitioner's knowledge of particular themes such as the developmental tasks associated with formation of a lesbian or gay identity; 'coming out'; same-sex coupling; legal issues; and chosen families. The direction of counselling is most appropriately guided by clinical research on adapting therapeutic intervention to a gay or lesbian context. The informed clinician is sensitive to the way in which conventional counselling theories may conflict with the actual needs and values of sexual minorities.

Provision of sensitive and non-judgmental counselling requires that workers look beyond formal training in order to evaluate their own stereotypes, fears and assumptions. True professional development is stifled where efforts to expand one's clinical knowledge base occur in isolation from an assessment of one's own personal value system. It is the responsibility of service providers to strive to understand the ways in which they personally have internalized prejudicial assumptions and to actively work to resolve these feelings. Paul questions whether a counsellor can be truly sensitive to the struggle inherent in the gay experience. He suggests however that the capacity to empathize may emerge through the helper's understanding of universal human themes and direct personal experience with emotionally challenging life events.

> "Do you understand enough about a gay person's dilemmas and problems that you can actually help?" There's a lot of questions that would be really good to have addressed as a therapist before you accepted a gay client. For me an issue was "has the other person actually gone through anything in their life?" I mean do they know what it is like to have suffered psychologically? Maybe then they would understand what a gay person goes through and they'd be able to help....They need to be at least secure enough in their own sexuality and their approach to it and their own morays and probably their own inner issues around all of this so that they would be able to help another person.

Charlie agrees that responsible practice involves service providers resolving "their own issues before they come in and try and deal with anybody else's because if they haven't dealt with their own, they'll be bringing their stuff into the counselling. If it is clouding what they're doing, then they will become useless."

Developing comfort with homosexuality is likely to involve a process of self reflection that challenges one's own internalized bias and relationship to sexuality. This entails counsellors monitoring their own values, attitudes and

personal histories relating to homosexuality, so as to reorganize beliefs that obstruct the development of a therapeutic relationship. Counsellors may need to guard against a tendency to identify with people similar to their own lives and view those who are different as less healthy and adjusted (DeCrescenzo, 1984). The avoidance of bias involves careful self examination for an unconscious assignment of a male or female role to the client (Markowitz, 1991). The more feminine male or masculine female may be viewed as unhealthy or dysfunctional (Dworkin, 1992). Messing, Schoenberg and Stephens (1985) advise that:

> social workers should think about their early attitudes towards lesbians and gay men; remember the first lesbian or gay man they saw/talked with/were friends with/loved. Social workers should ask themselves what labels they used for lesbians and gay men when they were growing up. Do they have any lesbian or gay friends now? They should get in touch with their feelings about same-sex affection and eroticism and begin to overcome their internal barriers. (Messing et al., 1985, p. 68).

For many service providers, the initial meeting with a sexual minority client may be the first occasion of knowingly encountering an individual with an homosexual orientation. Exposure to lesbian and gay people may have the effect of humanizing a population that is commonly portrayed through stereotypes and misinformation. Sky stresses that education should occur "...not just by reading but by going and meeting gay people - becoming friends with them - I mean a part of it is seeing who we are." Where the clinician has not undergone this process of sensitization, the consumer potentially inherits a role of instructing on specific issues. While it is the professional responsibility of the counsellor to acquire a general understanding of the experience of diverse populations, heterosexual practitioners may come to depend upon a client's instruction. Although in moderation this practice may serve to empower consumers "counsellors need to assess what is a reasonable amount of information to ask

their clients about their culture" (Corey, 1991, p. 27). Research participants reacted negatively to helpers' reliance on them for insight into the sexual minority experience. Oscar is adamant that he has no responsibility to educate the worker. "I've educated enough people in my life and lived through enough garbage. I don't need to do that any more. They can go away and do their own work on their own time. I'm not gonna do it for them." Furthermore, if the client is in the position of educator, the practitioner's competence may come into question. Paul describes such a situation. He states "I kept saying to him "I'm working really hard because I want you to be a better therapist." Consumers may feel skeptical about the uninformed helper's capacity to relate to their experience. Sammy equates the empathic service provider with "...someone I could feel safe with - someone I didn't have to educate."

Where the practitioner is able to identify an ongoing struggle to resolve internalized bias, reeducation may entail co-counselling or clinical guidance from a lesbian or gay colleague or supervisor (Dahlheimer & Feigal, 1971). Rose states that in determining the appropriateness of a counsellor's approach, she would ask "What kind of supervision do they get? Are they part of a clinical group that meets regularly and discusses lesbian and gay issues? I'd be really careful." House and Holloway (1992), assert that clinical supervisors have the ethical responsibility to introduce issues of heterosexism and homophobia; challenge inappropriate language, jokes and assumptions; make lesbian and gay positive literature available in the agency library; to include issues of homophobia and heterosexism in staff evaluations; and, be willing to remove a gay or lesbian client from a worker's caseload. Where the helper's personal bias is insurmountable, counselling should be terminated and the client provided with a referral to a more appropriate service. Sky states that "if there is anything

uncomfortable I don't think they should try to counsel gays and lesbians. I think they should try to be honest with their clients about where they are coming from."

Responsible practice requires that workers develop a degree of insight sufficient to recognize and challenge internalized prejudice, not only within themselves but within the client. Oscar contends that "with any person who has had to endure the kind of bullshit that gays and lesbians have to handle or deal with in their lives, they're the kind of person who might be coming in to get counselling to deal with self hatred." Family therapist, Douglas Carl (1990) advises that where the cause of homosexuality is of concern for the client, the clinician must be equipped to present the range of etiological theories but concentrate efforts toward the individual's need for determining cause so as to proceed to issues that are more related to enhancing well-being. Through the worker's efforts to model affirming attitudes and behaviours, counselling becomes a vehicle to challenge cultural myths about homosexuality (Harrison, 1987).

The process of reeducation commonly encompasses a larger social analysis than simply evaluating the relationship between the lesbian and gay experience and heterosexist ideology. The elimination of homophobia is likely to facilitate sensitivity to other systems of marginalization. "It is impossible to view one oppression, such as sexism or homophobia, in isolation because they are all connected...They are linked by...common methods of limiting, controlling, and destroying lives" (Pharr, 1988, p.53). Sara suggests that accessibility is measured not just by criteria related to sexual orientation but the worker's capacity for "an inner acceptance of everyone." Oscar urges practitioners to promote working within "... a non-sexist, non-homophobic, non-racist

organization. You know - bang - if you say it right up front and I'd be much more apt to walk in your door." Charlie perceives accessibility where a counsellor has internalized a feminist sensibility. She says that the inclusive helper:

> ...would understand the balance of power that exists between men and women and then by the same token they would also understand the balance of power that exists between heterosexuals and homosexuals. They would have an understanding of what it means to grow up hiding a major portion of your identity for a long period of time. They would have dealt with their own homophobia and racism and sexism. I'm bringing in outside issues but I think that all of those things are important to my mind with being 'gay positive' or 'lesbian positive' because I ultimately don't think that you can separate one kind of oppression from another kind of oppression. I see them all as being interactive and intertwined. So they would have dealt with their own preconceptions about what it means to be homosexual or to be a woman or to be a part of any minority.

Creating accessible practice entails a process of reevaluating the oppressive ideologies within our culture. Since deviancy is a socially defined concept it can be modified through social redefinition that resists associating negative value to diversity. Counsellors who aim to provide service to gays and lesbians have a responsibility to educate themselves through formal clinical training as well as evaluating the degree to which a biased conditioning has influenced their perception of sexual minorities. It is through this recognition and resistance to the worker's own internalized prejudice that an inclusive and affirmative approach to counselling is developed. The reeducation process facilitates the employment of particular practices to create a counselling environment that is sensitive to the experiences and needs of lesbian and gay clients.

Laying the Groundwork for Accessibility

An informed practice takes into account the range of obstacles that may prevent gays and lesbians from making full use of counselling services, and incorporates approaches that deliberately minimize the barriers to participation. The groundwork for developing a therapeutic relationship is facilitated through "the worker's efforts to get in touch with potential feelings and concerns which the client may bring to the helping encounter" (Shulman, 1984, p. 17). Sara theorizes that "...even counsellors must go through a first time too. You know, like every time a new client comes in, they've got some anxiety. They could calm things down if they could multiply that by ten - keep in touch with that and even let the client know."

Consumer comfort may be increased by direct and open communication at the onset of the counselling relationship. Lesbian or gay helpers who identify their sexual orientation early in the therapeutic relationship may provide an opportunity to quickly address the issue of trust and safety necessary to the development of rapport (Dahlheimer & Feigal, 1991). Conversely, heterosexual practitioners may ease distrust by beginning the initial session with an acknowledgment of their differences with the client and a prediction of times where misunderstanding is likely to occur. Sara describes a situation where a therapist explored her past experience with biased counselling in order to establish an agreement for addressing conflicting perspectives.

> She asked "what happened? Why did it end?" I told her. I said I didn't go back. She made a point of saying "well, that would make me really uncomfortable if you did that with me. Can we make some kind of agreement that if you ever feel uncomfortable that you'll let me know? You don't have to come back. You don't have to do anything but just that you'll let me know. I just want to know where you are at." She turned it around so that I saw that she was a person. And made it much more of "okay, she just wants to know

> where I am at so that she can help me." She set the stage for that, whereas my first counsellor didn't at all.

Charlie proposes that within an initial contact, the counsellor would do well to directly acknowledge a lesbian or gay client's high level of anxiety. She states that:

> there is just no reason not to just acknowledge it over the telephone by saying 'you might find yourself feeling anxious and uncomfortable when you're coming in' and asking them 'what can I do if this is going to be an issue for you just walking in? What can I do to make you more comfortable?' It's fine if I were to walk in to a counsellor's office and they were to say "look, I don't know you. You don't know me. Maybe we can set some ground rules." Just to acknowledge that it is new to both of you calms things right down.

Charlie's recommendation that a counsellor establish ground rules to govern the therapeutic relationship reflects the importance of individuals being informed about their rights as a consumer. Rose declares her expectation "that someone's gonna have some ethical guidelines by which they define and practice their service that is going to be 'gay/lesbian positive' or 'friendly' or 'open'." A fundamental step in facilitating comfort involves providing the client with a detailed account of the procedures which guide the clinician's management of personal information.

Ensuring Confidentiality

Comfortable self disclosure is facilitated by a consumer's ability to trust in the helper's commitment to uphold a confidential approach to practice. Policies protecting a client's right to privacy contribute to the development of a sense of safety within a therapeutic setting (Geldard, 1989). Concerns about confidentiality are accentuated for gays and lesbians, given the potential for discrimination based on sexual orientation. Individuals are well aware of the

need to protect their choices in regard to self disclosure and inclusion in the larger world. Options for social participation, employment and housing have historically been jeopardized by societal prejudice against sexual minorities. Mark recalls that attending counselling aroused "fear that the information that I was gay could ruin my career or might even fall into the hands of blackmailers."

Informing the client about the nature of agency confidentiality policies assists in the formation of trust. Sky remembers how within an initial counselling appointment his therapist "did all the confidentiality things and that really made me feel comfortable being there." Rose states that her psychologist "...was so good that at the outset her confidentiality boundaries were made so damn clear. She was really clear and I liked that. I needed that." Consumers should be informed that no helping professional can offer completely confidential services given the need to keep clinical records, ethical responsibilities to report when a third party needs to be protected and legal requirements to disclose information. Charlie voices concern that "there is some question about court liability - that counsellors can be called on and can be subpoenaed within court cases to give evidence and that would be the only place that I would have concerns." Open dialogue about the limits to confidentiality procedures conveys a respect for the client's right to accurate information in making decisions about self disclosure. Practitioners may however, be tempted to make unrealistic promises about confidentiality in order to encourage openness. Mark recalls:

> The psychiatrist saw me and he said 'it's absolutely essential that you are completely candid with me, so I won't write anything in your chart. You don't have to worry about anyone else ever knowing anything about this.'... Incidentally, the psychiatrist may have meant what he said and done what he said but it didn't seem that way to me because a number of years later I had a dental problem and I went to the dental department in this same institution and my chart was produced and I saw the dental

> instructor and the dental student greet me in a pleasant way and there was this very long pause and there was an attitudinal change. They went out of the room for awhile so I hopped out of the dental chair and went and looked at the chart and there was just a - a sort of a stamp - diagnostic stamp with the date and 'homosexuality' written in and the psychiatrist's signature. So actually it really hadn't helped me....I'd gone to him without expecting complete privacy in the first place but when he gave me that assurance it did make me feel very secure. It was a terrible breach of trust.

A monumental violation of the therapeutic agreement occurs where client rights to privacy are disregarded. Oscar reflects on a situation where his counsellor at bible college:

> ...had broken her promise and had told other people about me... I shouldn't have trusted her because ...she also told me that there was a young woman that was in the bible college who was also struggling with this same thing. She told me enough about this woman's life for me to figure out who it was....if she is talking about this woman to me, what is she talking to other people about?

Sammy warns that "people can be devastated if they give information and it's not held in safety. They can be devastated and certainly in my early experiences with counselling, nothing I said was held in trust." The potential for open participation in future therapeutic relationships may be compromised by violations of the counselling agreement. Considering how her rights to a confidential service were breached, Sammy states "today that I can still trust counsellors, is amazing. I don't know if that's an indication of stupidity or desperation or strength."

Participation in programs where clients potentially encounter other lesbian or gay consumers is likely create a sense of anxiety about private information becoming known in the sexual minority communities. Given the small and highly interconnected nature of these communities, individuals may be less inclined to

seek out group counselling services. Agencies may address this barrier by giving special emphasis to a clear set of guidelines by which clients are expected to respectfully manage information about other program participants. However, individuals may remain skeptical that such an arrangement will be honoured. Accessibility is likely to be enhanced by giving options for service to be provided on an individual basis. For Paul group therapy presents too many confidentiality risks.

> I went to a group for a couple of sessions but I am not a good group joiner. I'm always really nervous.... It's really hard for a gay person in my situation to form a suitable place where you can be 'out'. It's just hard to do anything without the fear that you are really setting yourself up for everybody to know your business.

Jeff recalls her sense of panic when another lesbian entered the women's domestic abuse shelter she was residing at.

> I remember when I went into the shelter that time. I went up front to get this little allowance they give you everyday. This woman walks in and she is talking to the front desk lady. I recognized her. She is one of those 'lezzies' I had seen around. I went frozen and thought "oh, no! I am caught! Now everyone is gonna know." I saw her but I didn't want to say 'hello' or anything. I just took my money and went in the back. I was freaking out and talking to one of the counsellors saying "Oh my god! This woman is here and she has seen me. She is gay and she is gonna tell everybody."

The lesbian and gay experience is characterized by a struggle to adapt to homophobia through strategies intended to conceal essential aspects to one's identity. An important element of the 'coming out' process is an emancipation from the shame of carrying a secret. While the counsellor associates the introduction of a discussion about confidentiality with ethical behaviour, some clients may equate such concepts with the psychological consequences of being 'closeted'. In exploring this topic with Melvin, he proclaims that he is

unconcerned with potential violations to his privacy. He states that "that doesn't scare me. It is not all that private. I don't feel like now in my life that I have anything that I have to hide from anyone anymore." Sara also indicates that confidentiality is "... not a concern of mine. I am not worried about being 'outed'. I am pretty 'out' to anyone and everyone that cares to pay attention."

Despite Sara and Melvin's apparent lack of concern about confidentiality issues, many lesbian and gay clients seek assurance about their privacy within a counselling setting. Given the trauma associated with homophobic prejudice, issues of confidentiality should be addressed in a thorough and direct manner (Dworkin, 1992). It is through the provision of information relating to one's rights as a consumer of counselling services, that the professional may begin to dismantle the imbalance of power that exists between him or herself and the client.

Minimizing the Power Differential

Lesbians and gays have long occupied a social position of diminished status based on a minority sexual orientation. Traditional models of therapy have tended to mirror this power dynamic. The use of coercive interventions and hidden agendas have historically served to maintain the clinician's role as absolute authority in defining the meaning of an individual's sexuality. A lack of recognition for the healthy homosexual has elevated the counselling professional to the powerful position of socializing agent in upholding an heterosexist ideology. The establishment of a trusting therapeutic alliance may be threatened by the assumption of the clinician's superior knowledge over the client's inner world and ability to make decisions in his or her own best interests. Charlie identifies the importance of an helper having sensitivity to the historic

context in which counselling has occurred. She states that "I want them to know about all the homophobic counselling that has gone on before. They should be aware of the kind of power that they have wielded over people's lives."

An accessible approach to service protects a consumer's self determination. Corey (1991) warns that all too often, practitioners"...are motivated to enter the counselling profession because of their needs for power, for feeling useful and significant, and for reinforcing their feelings of adequacy" (Corey, 1991, p.63). While a power differential is implicit in the helping relationship, a feminist approach to therapy aims to minimize inequality (Greenspan, 1983). Oscar prefers "someone who didn't set themselves up as that much above me...so that the balance is a little bit more equal. It has something to do with me seeing that they are human." Sara's narrative illustrates how a more egalitarian clinical posture stimulated her participation in the counselling process.

> This first woman that I was going to see was a god. I felt like she was an authority figure, which isn't conducive to therapy really. She was someone untouchable. I didn't connect with her at all. It wasn't until the second counsellor I was seeing said "look, I can't read your mind. I am not omnipotent. I am just a person trying to listen to your stuff.' She helped me alot in realizing that counselling is just people talking. A good counselling relationship isn't about power. If you as a counsellor are willing to accept that you are going to say the wrong thing and willing to admit that outright - you know, "I am a person here just to listen to you. I may not match who you are but hopefully I can help you with what you need help with." That can immediately demystify some of it and make it more accessible.

Research participants associate such efforts with accessibility. Charlie's statement suggests that a power imbalance may be minimized through even the physical arrangement of the counselling office.

> I would be looking for a dynamic that doesn't place a big, huge desk between myself and the counsellor and that doesn't place the counsellor on a higher level than me. If there is great huge leather couch in there, I am going to look at that and go, 'ooh - Freudian, run away.' If I am sitting in a low chair and I am being looked down on, that's going to create some discomfort and I think it creates a power dynamic that I don't think is appropriate in counselling.

Clinical approaches that minimize the imbalance of power between the client and the professional serve to honour individuals' capacity to assume responsibility for their own choices and ultimately contributes to the formation of a partnership in creating change. Given the social context in which gays and lesbians live their lives, the client is likely to be sensitive to relationship dynamics that discourage self determination. The development of therapeutic rapport is likely to be stifled by worker's use of language that reinforces the social power, interests and experience of the sexual majority.

Adopting Inclusive Language

As the social invisibility and subjugation of gays and lesbians has historically been reinforced through heterosexist language, service providers may quickly allay suspicions and establish accessibility through the adoption of inclusive terminology. If their experience is not reflected in the worker's choice of language, clients are left in a position of uncertainty about the knowledge base and level of acceptance that underlies service. Efforts to establish a trusting therapeutic environment are threatened if the counsellor communicates in a manner that parades privileges enjoyed solely by the heterosexual majority. Oscar expresses exasperation that there are "so many people who still don't use the word partner. If I had a counsellor who kept on saying 'my wife this, my wife that' it would drive me crazy. I can't have a husband. It's like throwing it in my face. Say 'my partner'!" Sara indicates that she is "immediately much more

comfortable with counsellors who use the terms 'partner' and 'lover' than 'husband' or 'wife'. I am much more comfortable with people who show that they are open to other types of families and don't use the words 'married', 'separated', 'divorced'."

In designing intake and admissions forms, social service agencies would do well to broaden demographic categories so as to accurately reflect the lives of sexual minorities. Beyond gathering statistical information relevant to the program development and funding of lesbian and gay oriented service, use of inclusive questionnaires communicates to the consumer that the agency is intended for a population that extends beyond the dominant culture. Sara suggests that "if they've got this initial questionnaire set up, they could include something 'gay positive' in it. If they could include something in an original set of questions we know that we are welcome and the counsellor knows already if the person coming in is gay."

Counselling that aims to be accessible to sexual minorities is commonly promoted through terminology that is intended to communicate an inclusive approach. This involves advertising services through the use of such labels as 'gay/lesbian affirmative', 'gay/lesbian friendly' or 'gay/lesbian positive'. Respondents do not express an immediate trust for agencies that adopt such terms. Sammy states:

> I've laughed at those words - that phrase 'gay positive.' I remember hearing a friend of mine who is in the field saying that and something made me question "...how would that sound? I am 'heterosexual positive'. Just the fact that we need to say it is indicative that something is amiss. I guess that they are trying to recognize that something is amiss. They are trying to reassure gay clients that it's okay but it's sad that it has to be said that way. I

> wouldn't necessarily go running to an outfit that uses the phrase 'gay positive'.

The mere use of inclusive labels does not necessarily ease the suspicions of a lesbian or gay consumer. The service provider is still left with the task of demonstrating their level of knowledge and creating a sense of safety. Rose claims that "it is not enough to say you are 'gay positive' or if you are going to say it, you need to define what you mean. That could make a difference...What the hell do those terms mean?" Oscar is inclined to disregard such labels in comparison to his direct experience within counselling. "I am somewhat suspect of people who use those terms. I would need to experience how they are in the sessions before I decided that I was comfortable." Charlie also voices her suspicion with regard to the choice of words a counsellor uses to communicate accessibility to sexual minority clients. In her perception such terms are associated with a condescending response to homosexuality.

> I think that those words can be really misused. I'm 'gay positive'. What does that mean? I have an immediate response to somebody saying "I'm 'gay positive'. First of all I immediately think that they are not gay or lesbian because if they were gay or lesbian, they would just say "I'm gay" or "I'm lesbian". So if somebody was to come to me and say "I am a 'gay positive, lesbian positive' counsellor, I would immediately be suspicious of them. There's something in 'gay positive' and 'lesbian positive' that perhaps suggest to me a lack of knowledge or something. Like 'gay aware' and 'lesbian aware' might be better rather than 'gay positive'. It sounds less like "hey, aren't we wonderful because we are dealing with lesbians and gays? Aren't we great? We deal with the downtrodden of society and we are doing this big wonderful thing". It immediately makes me think that there is a lack of knowledge and understanding there.

As the heterosexual experience is so entrenched in mainstream vocabulary, lesbian and gay consumers are highly attentive to the practitioner's choice of language in determining the relevance of service. This may be indicated through

the phrases the counsellor uses, administrative forms or the terminology that is employed to advance the philosophy of service as it relates to homosexuality. The client is likely to be similarly observant of an agency's physical environment for evidence of the worker's sensitivity to sexual minority concerns.

Creating Physical Indicators of Safety

The building in which a counselling service is housed functions as a public relations medium. The physical environment provides clues as to the nature of practice and may ultimately affect the degree to which a potential client is able to transcend obstacles to accessibility. The facility itself may serve as a barrier to entering into unfamiliar territory. Sara states that "That fucking building is scary. There is no way I am going to walk in there. I don't know anybody in there." Melvin stresses that "...the thought of going to look for a place that doesn't have no sign of whatever it is, is a scary thought. Why should I trust somebody that I have no idea could be of any benefit to me?"

Within a facility, the physical environment can clearly identify who the service is intended for. In seeking to access counselling services, the lesbian or gay consumer is likely to be investigating the physical environment for evidence of cultural sensitivity. Sara begins to form an assessment of safety prior to an encounter with the helper. "I'll get alot of vibes on my first visit from just sitting in the waiting room. If it's not friendly to me, I'm certainly not gonna be willing to open up." The majority of research participants discussed the importance of culturally relevant magazines. Charlie suggests that "if the counsellor is serious about being 'gay and lesbian positive' then I would like see to copies of 'Out Magazine' and 'The Advocate' in the waiting room." Rose suggests that the presence of lesbian and gay images within the facility is a clear demonstration of

a clinician's commitment to an inclusive practice. Her discussion serves to normalize the need for visibility by providing a comparison with other underrepresented populations.

> One thing that might be helpful in accessing services in going into a building is whether there are any posters or information that talked about gays and lesbians. Even posters that clearly identify things that can help me feel as though "oh this place doesn't just say in their words that they're 'gay/lesbian positive'. They also show that in a certain way and I can identify that. It is no different than any other population - like seniors walking in and wanting to see seniors magazines. You know, it is the same kind of thing. Even if it meant magazines. If they've got Time and Maclean's and all these stupid other magazines they can have The Advocate or X-tra or Swerve.

Members of sexual minority groups are likely to be accustomed to encountering portrayals based on stereotypes and prejudice. It is important for practitioners to avoid mirroring the distorted images of lesbian and gay lives that are commonly upheld in mainstream society. Jeff states "I guess I'd want to see pamphlets but not about safe sex. That would be like saying that homosexuality is just about having sex with other people." She also stresses the need for the counselling environment to specifically reflect lesbian concerns given the societal tendency to place greater significance on the experience of gay males. "It should be more like having some magazines....There should be lesbian oriented ones too. Just pure lesbian ones because alot of magazines, even the local gay and lesbian mag is mostly about men. That doesn't interest me." Mark describes a lesbian and gay facility that he perceives to have reinforced homophobia through its depiction of damaging stereotypes.

> It was just that a setting which was supposed to be providing help for lesbians and gay clients was actually presenting images of heterosexual couples. Young heterosexuals were being allowed to be the dominant theme there. There was a poster too - the only

> poster that was put in the waiting room was about the sexual abuse of children. It was like the only poster in this institution that was serving gays and lesbians. I thought that reflected a homophobic stereotype. I found it personally disturbing in thinking about the impact it might be having on clients.

Codes that identify an individual's same-sex orientation have historically served as a visual language for negotiating where and with whom one can risk openness. They represent an immediate avenue for communicating reassurance within environments where safety is uncertain. Such codes have come to be incorporated into conceptualizations of gay and lesbian cultures. The absence of symbols that communicate a gay/lesbian informed consciousness is in itself a statement that services are oriented solely toward the needs of the heterosexual majority. Clients are given insufficient information with which to negotiate comfortable interaction. They are left pondering the degree to which the practice is relevant to their reality. Sara says "if I don't see anything related to homosexuality at all, I am going to wonder. I might not consciously but you'll notice. If you see things you notice." Oscar discusses how these indicators can be used to reflect a coded message of inclusivity that is recognizable only to gay/lesbian or 'gay/lesbian positive' people. Like Sara, he suggests that the very absence of symbols creates an obstacle to accessibility.

> There are things that counsellors could do that only gays and lesbians would only catch on to. You know, like a pink triangle, so that we would know that we are included there. It would a be very fast, a very visible thing for us to pick up on. The freedom flag, the gay and lesbian flag, would be something that - ya know - showed us something about where the organization is coming from. Normally I would be very, very suspicious of anybody who doesn't do that. I'd be very suspicious of why they aren't doing that. If they aren't doing that, it communicates something to me. Absence speaks tons....Actually absence would make me not even bother. I can eliminate a lot of the hassle by rejecting an organization or a person by just walking up to their door and seeing their advertisement in the yellow pages or being in their foyer. I can go

> in there and sit for a half an hour and I know what I am going to discover already because there is an absence of my life being reflected - an absence of me being reflected in any way here or of me being included.

Like many lesbian and gay consumers, Oscar's assessment of counsellor suitability and inclusivity is based partially on interpretations of the physical environment in which counselling occurs. Practitioners may lend assistance in the minority clients' determination of safety through consciously integrating evidence of cultural sensitivity into the agency environment. Accessibility is advanced further through extending such efforts to create a profile that is publicly affirming of sexual minorities.

Creating Visibility

Counsellors typically promote their practice as a generic service. They are unlikely to advertise in a manner that communicates directly about their values and expertise in relation to gays and lesbians. In determining whether or not to enter into a therapeutic relationship, the individual needs information with regard to the clinician's perspective on homosexuality. Melvin asserts that "...information on that person would be a 'plus' for me as far as knowing who they were a little bit and where they are coming from."

While a practitioner's reputation may be established through the testimonial of friends, accessibility is aided by securing a favourable profile within the wider lesbian and gay communities. Given that a high degree of suspicion toward mainstream institutions is likely, attracting a sexual minority clientele may demand that practice make its accessibility visible to potential consumers. Credibility is suggested by the advancement of a professional image of responsibility, competence and knowledge about lesbian and gay issues. Melvin

portrays the decision to attend counselling as a slow exploration process that is dependent upon his familiarity with the service from within his community. He says:

> I would maybe progress to going but you have to have some of that confidence inside of you to even give it thought, right? If that kind of counselling was happening in the community, I could see that and I could find some literature and then I could let it happen in my mind for a time. Then I could make a decision of going or not.

Sara reminds helpers of the necessity to promote service through direct communication with sexual minorities. She urges practitioners "don't sit back and open your door and say 'okay, I'm here. Come on in. I'm gay positive.' That doesn't work in any form of social services - you know, opening your door and just waiting. You need outreach." The mere presence of a counselling agency, with no overt indicators of philosophy, does little to invite participation by those who have been socially marginalized. Through advertising in gay and lesbian media sources, the professional offers a public declaration of affirmation. Mark states:

> I have to admit that when I see an ad in a gay paper or newsletter and see that this counsellor is advertising in the context of the pink triangle or membership in some gay professional organization, it does give me a feeling that they are demonstrating some kind of commitment to the lesbian and gay community. So I think I am always looking for evidence of that kind of commitment to the community.

Ensuring accessibility may entail efforts to create visibility in physical settings that are particularly relevant to the lives of gay and lesbian community members. Charlie provides helpers with a range of culturally specific ideas for providing outreach to sexual minorities.

> Assuming then that...this is a person who is now educated and aware and knowledgeable, then they should get out there in the community and make themself known...If they are really serious about getting involved with problems in the gay and lesbian community, they can go to the bars and put up signs there. I remember seeing on the backs of the washroom stalls when the group that deals with lesbian battering were doing a research project. What they did was put up posters on the back of the washroom doors with little slips of paper that you could rip off with the phone number on it so that you could call. Also, recognizing that people that are going to be coming to the counsellor, may themselves be dealing with issues of comfort around being open, then...signs on the back of the washroom door are great because they don't require that you go down to the resource centre if you are a person who only ever goes out to the bars. Also if you know where the cruising areas are, those are also good places to put up signs that offer a little more privacy in terms of being able to get out there and find out where the counsellor is.

For sexual minorities, the determination of safety may be facilitated by evidence of the deliberate efforts of a professional to create visibility. However, supporting lesbians and gays in the effort to access the best possible service often occurs through less overt activities.

Advocacy

Beyond addressing one's own internalized bias, reeducation includes developing an awareness of potential resources that are specifically designed for lesbians and gays. "It is the social worker's responsibility to explore existing services and learn the extent of their usefulness, limits, competency and referral procedures" (Burnham, 1992, p. 150). The counsellor's knowledge of counselling services, recreational clubs and political or religious organizations allows for referral to culturally relevant social networks. Many individuals experience discomfort initially in regard to making social contacts within the sexual minority communities. The formation of supportive relationships with

other lesbian and gay people facilitates an important sense of belonging. Given the high level of anxiety that is common to those who have not yet achieved a sense of community, effective advocacy is likely to include assisting the individual to develop interactional skills that facilitate entrance into these systems. Oscar stresses how, as a youth, his sense of alienation might have been quelled if his counsellor had assisted him in locating support systems composed of other sexual minorities.

> When I watch daytime talk shows, I think, "if when I was a kid and I was home on my spares, if I could have seen a daytime talk show with gay and lesbian youth or lesbian avengers or all these different groups, I would have known that I wasn't alone." I would have known to keep on looking. I didn't know that when I saw my counsellor and didn't get any response so I didn't keep on looking.

Many clinical resources do not operate from within a value system that allows for effective service provision to lesbians and gays. The client may require a degree of professional competency that extends beyond the worker's particular expertise. Paul advises that the clinician should be "...willing to admit when they couldn't do this or that for you and then they would suggest a resource." Given the barriers to locating service, it is critical that the informed practitioner be prepared to function as a bridge to link sexual minorities with other more appropriate helping professionals. Paul suggests that the "...therapist has to know that for a gay person to come to terms with themselves they might need some guidance about where they could go, what they could do or who they could talk to to work it out." Sky recalls having approached his doctor for a counselling referral. "I asked if he knew of anyone. He is gay and gay positive and knew of other professionals who are gay or gay positive....He gave me a list of different people and told me who they were and what their involvement was and how he felt about them."

Research participants recommended the development of a more formal method for assisting sexual minorities to locate appropriate service. Paul suggests that "...maybe what we need to have is a brochure. 'If you're gay and you're looking for therapy, here's what you should do.' Maybe people...would be more empowered to find things that help them rather than just drift in to whatever is out there." Oscar envisions that a directory outlining 'lesbian and gay informed' services would promote accessibility. "...I would figure that there should be some sort of registry or something like that to help you find a 'gay positive' counsellor." Mark offers similar advice for identifying ethical and non-biased practice.

> I think it would be very good if there was some kind of umbrella organization for lesbian and gay counsellors and therapists. Membership could be dependent on certain professional standards and this sort of thing. In my experience as a care-giver, I have come across people who have been in counselling and where I think some very counter-productive things have been said because the therapist was either actively homophobic or was heterosexist. I can also think of situations where there has been unprofessional and inappropriate conduct in the area of a sexual liaison being allowed to develop with a therapist. I think it would be good to have an organization which made it very clear that that kind of thing is not acceptable to this organization.

It cannot be assumed that all professionals have the insight and experience to work effectively with lesbians and gays. Attending to consumer interests may thus occur through the clinician advocating on behalf of the consumer. For example the informed clinician may assume a powerful role in consulting within medical institutions, social assistance organizations, home-care agencies and other forms of social service. Messing, Schoenberg and Stephens (1985) recommended that the "...worker can help physicians who have a lack of experience with lesbians and gay men to use sensitive language, ask pertinent

questions, and overcome their initial discomfort with an unfamiliar patient group"(Messing et al., 1985, p.70). Advocacy may be especially pertinent where a number of different helping professionals become involved in supporting the same client. This is a common scenario for persons living with AIDS given the need for access to medical settings where the range of workers the individual is likely to encounter will have varying degrees of exposure to sexual minority issues.

Advocacy for the special needs of lesbians and gays may direct programming toward structuring operations in a manner that encourages greater accessibility. Established social service agencies may not easily integrate the sexual minority client. For example, group therapy related to domestic abuse typically fails to examine the dynamics of power and control outside of an heterosexual context. Incorporating lesbian or gay clients into such a setting may be further complicated by the homophobic attitudes of other group members. In such instances, an argument emerges for expanding programming to form a more segregated lesbian or gay service.

Statistical record keeping would document those counselling requests which the organization is not equipped to address. The informed helper may thus present evidence to program administrators and funders that argues for managing agency resources in a manner that reaches gay and lesbian clients. Such a proposal is likely to entail an increased financial commitment for the training of staff and the development of specialized service. Mark advises that professionals:

> ...should be making a push toward getting funding for some kind of counselling service for our community. This is an unfortunate time to be looking at that but we have such huge, huge needs related to

> 'coming out' and coping with so many aspects of our lives. We have not only the problems that heterosexuals do but there is a particular slant to our experience from sometimes having been deprived of family support or from suffering terribly at school and not being able to turn to one's parents. These are really psychological stresses that a person of colour or a Jewish person or an aboriginal, experience differently if they are lucky enough to have parents who are supportive. It doesn't matter if they are picked on for those things. They have family that they can go and talk to. Our issues are all right through the spectrum. You know - the lesbian whose lover of thirty years dies and she can't grieve about it publicly. So I think that we have got a real big need. There is just a huge great gap in our community.

This form of advocacy is likely to involve challenges, given the current economic cutbacks to social programs and the traditional lack of recognition within mainstream society of sexual minority issues. However, practitioners have an ethical responsibility to participate in the movement toward social change for gays and lesbians.

The possibilities for enriching the health of sexual minorities are limited where the social factors that uphold homophobia and heterosexism go unchallenged. Helping professionals who are concerned with the well-being of gays and lesbians must look beyond models of clinical intervention that target the individual, while disregarding the wider cultural environment. Oscar contends that such a singular focus for intervention represents a misunderstanding of the problem. "It just seems too limiting if they want to zero in on me. I'd be scared that they would just want to change me without understanding what goes on around me and where I've come from. I mean I'm not what needs to change." True social change is possible only through the erosion of mainstream beliefs that continue to impose social constraints on the lives of clients. "Mental health professionals must stand up and inform our lawmakers and government administrators setting public policy about the reality of gay, lesbian and bisexual

population in order to prevent decisions being based on fear or erroneous stereotypes" (Dworkin & Gutierrez, 1992 , p.336). Social work, with its dual focus on the individual and the environment, is in the position to offer a unique contribution to dismantling the effects of ongoing oppression.

Practitioners who advocate for greater social acceptance of sexual diversity assume a powerful role through enlisting their professional credibility. Open participation in activism reaps relatively few social consequences for helpers in comparison to the potential repercussions for the individual client. Sara states that while "... I would always call someone on a racist comment, there is enough personal investment in the gay stuff that I wouldn't always call someone on a homophobic comment." Sammy indicates that:

> I did experience very profound feelings about the oppression, the suppression of gay people in society because in every other part of my life I'm so open. I've stood up for human rights for so many different groups of people in our society but in this one area, the most private, the most personal, the most meaningful area of my life, strangely I have been the most silent.

Becoming informed about sexual minority issues equips counselling professionals to promote the health of gays and lesbians through indirect forms of practice. Addressing the particular needs and concerns of these populations may include linking the client to community resources, offering to consult with less aware helpers, modifying agency programming toward inclusivity and political lobbying for social change.

Conclusion

While sexual minorities have been historically isolated from counselling professionals, political efforts towards visibility and equality suggest that

clinicians are increasingly likely to receive service requests from lesbians and gays. It is the responsibility of clinicians from a range of helping disciplines to become familiar with the particular clinical needs and concerns of sexual minorities. Feminist approaches within these counselling disciplines have sought to incorporate many of the research participant's recommendations for enhancing accessibility. Greenspan (1983) and Lerner (1988) have written extensively about clinicians obligations to challenge their own social conditioning; the need to diminish the power differential within the therapeutic setting; adopting a non-judgmental perspective; the consumer's right to privacy and self determination; and, the use of inclusive language. Similarly, the field of social work may assume an important role in advancing an approach to intervention that is informed by the actual life experience of sexual minorities. As a profession that is committed to ensuring equitable services to under-served and oppressed populations, social work may assume an important role in directing counselling theory and practice toward an affirmative and accessible clinical response to the needs of gays and lesbians. Like feminism, social work methods aim to attend to both the individual and the social environment. Such an approach provides a foundation for intervention that is based upon the client's efforts toward change and the clinician's analysis of the problem within the context of an hostile social environment (Gunter, 1992). It is through such models for intervention that helping professionals are directed toward their responsibility to challenge assumptions about lesbian and gay clients and to attend to specific conditions that facilitate accessibility.

Chapter Seven

Summary of Findings

Western society has historically been organized around the social interests of the White, male, 'able bodied', Christian, heterosexual citizen. Regardless of the existence of a sizable portion of the population who do not meet this demographic criteria, all social institutions have been systematically designed to promote the values and norms of the dominant culture. Popular conceptualizations of healthy adulthood prescribe that all individuals must strive for participation in traditional heterosexual forms of kinship. Such demands for conformity have produced a profound level of intolerance and suspicion for diversity. The consequence for those who deviate from the homogeneous mold is relegation to a peripheral social status. Lesbian and gay minorities in particular have come to represent the standard for that which is defined as unacceptable.

Sexual uniformity has been rigorously enforced through efforts to punish, suppress, convert and ignore variant behaviours. Early proscriptions against homosexuality were upheld through religious threats of eternal damnation and legal prohibitions. As the governance of social behaviour came increasingly to be influenced by scientific conjecture, lesbians and gays were subjected to a range of biological and psychological interventions that sought to modify a 'pathological' orientation toward the heterosexual norm. Conventional clinical theories about homosexuality that were constructed by heterosexual counselling professionals have tended to reflect and perpetuate the subordination of those who do not conform to majority standards. It is only through the recent emergence of the lesbian/gay civil rights movement that the authority of such

institutions has been challenged. As sexual minorities assert the right to self definition, a more tolerant context for sexual diversity has begun to emerge.

Despite ongoing progress toward social visibility and acceptance, sexual minorities continue to face obstacles to participation in established counselling institutions. The 1973 decision by the American Psychiatric Association to remove homosexuality from its list of mental disorders represents a significant development in the struggle to create a non-biased clinical approach that is specific to meeting the psychological and social needs of gay and lesbian counselling consumers. However, barriers to accessibility are upheld by traditional approaches to practice that overlook the distinct needs of lesbian and gay clients, disregard the very existence of sexual minorities, reflect hostility for sexual diversity or seek to 'cure' homosexuality. The widespread adoption of a more relevant and affirmative counselling perspective is inhibited by a lack of attention given to gay and lesbian issues with the training programs of the various counselling disciplines.

Given a long history of reorientation strategies and the current lack of overtly affirmative social resources, gays and lesbians are likely to remain wary of mainstream helping professionals. While some specialized services have been developed that are visibly promoted as being delivered to and by sexual minorities, lesbian and gay consumers more typically must approach generic agencies for counselling. Unless directly identified as accessible, a therapeutic environment is commonly equated with an heterosexist context. Given that the experience of living as a minority demands that the individual interact with systems that are based on a heterosexual frame of reference, decisions about openness are founded upon assessments about the degree of relevance and

safety that is possible. Within the counselling setting such decisions may be made through interpretations about the counsellor's sex, sexual orientation or style of presentation. Clients are likely to be gauging accessibility on indicators of cultural relevance within the physical environment in which service is offered. Choice about participation may be informed by recommendations from trusted community members, directly interviewing practitioners with regards to knowledge base and experience as well as the individual's intuitive sense about emotional safety.

It has been beyond the scope of this study to provide an outline of counselling directives as they relate to specific presenting issues faced by gay and lesbian clients. Instead the practitioner is reminded that interventions are most appropriately developed in accordance with the norms of the clients' identified community. As problems are best defined with a recognition that sexual orientation represents just one factor in the individual's life, an affirmative therapeutic response aims for balance between honouring the client's distinctness while recognizing his/her commonality with the majority experience. Although gays and lesbians enter counselling with many of the same needs as the heterosexual client, therapeutic response is likely to be inadequate where one fails to analyze the presenting problem within the context of societal heterosexism and homophobia. The effective helper must be prepared to employ established counselling methods and diagnostic procedures within a framework that recognizes the impact of the client's marginalized social position. As with the population at large, members of sexual minorities encounter issues of domestic abuse, alcohol/drug dependency; HIV/AIDS; sexual assaults; partnership problems; and parenting challenges. However, these everyday struggles within the lives of lesbian and gay citizens have tended to be

suppressed in an effort to avoid reinforcing the stigma that is commonly associated with homosexuality. The clinician who seeks to provide accessible service would also do well to develop knowledge about issues that are more specific to the gay and lesbian experience such as anti-gay/lesbian violence; 'coming out'; alienation from biological family; and, internalized self-hatred.

The counsellor's efforts to gain familiarity with the sexual minority experience may be aided by professional literature and training. However, reeducation about homosexuality is likely to be enhanced by actual encounters with individuals and resources from within the lesbian and gay communities. Such interactions reflect accountability to the minority communities and may lend visibility to the service. Barriers to establishing a therapeutic relationship are challenged where professionals work to openly declare their knowledge base, experience and value systems as they relate to the minority client. As rapport may be stifled by the consumer's high degree of suspicion with regard to the helper's perspective, accessibility is facilitated through the use of inclusive language, realistic assurances about confidentiality and preparation for times when misunderstandings between the client and the counsellor may occur. Such an approach avoids the power differential that is upheld in more traditional counselling settings in favour of a therapeutic partnership that promotes client self-determination.

Recommendations for Future Research

This study has sought to explore the relationship between the lesbian and gay populations and counselling professionals, so as to advance ideas for establishing a more accessible approach to service provision. While my findings

may provide clinicians with some initial suggestions, there are persistent questions left to examine. Ideas for future research are as follows:

1. Given some of the limitations to the sample, it seems necessary to consider the issue of accessibility as it relates to individuals who identify as bisexual or transgendered. Due to the inadequate and discriminatory resources offered within mainstream society, many minority communities have gone on to develop their own more specialized counselling services.

2. While this study targeted the voice of individuals from the lesbian and gay communities, it may be illuminating to explore the perceptions and experiences of service providers who have sought to offer an inclusive practice.

3. Within this study I have outlined specific recommendations for the role of the clinical supervisor in ensuring non-biased service. Research may provide insight into the potential value of the supervisory relationship as a method of clinical preparation for working with sexual minorities.

4. The tasks associated with adapting practice to minority issues may be identified through a comparative investigation of more segregated services with those generic agencies that seek to integrate lesbian and gay client populations.

5. Within the professional literature and training programs, the more established tendency is to view multicultural counselling issues from a racial perspective. Research may provide valuable clinical information through investigating the applicability of these approaches to lesbian and gay populations.

6. Research has traditionally focused on issues of etiology and the deficits associated with the gay or lesbian experience. This approach tends to disregard

the strength and resilience that was evident in the narratives of this study. Many participants spoke of a sense of self reliance and the rich systems of support that they had developed in coping with problems. In the current climate of government cutbacks, studying the gay and lesbian experience may provide important information about how people adapt to an hostile environment with limited social resources.

The emergence of lesbians and gays as visible citizens who seek access to all of society's institutions is reflective of significant social change. It may now be assumed that all counselling professionals will at some time encounter service requests from sexual minority clients. As clinicians begin to prepare themselves to meet the challenge of creating accessibility, it must be remembered that the ability of counselling to enrich the lives of lesbians and gays will remain limited as long as societal bias against sexual diversity persists. The capacity for change within an individual is compromised where his or her life opportunities are continually restricted by a social structure that enforces a marginalized existence. Practitioners may play a powerful role in the movement toward social change, by lending professional weight to the enhancement of public awareness, challenging bias within the various counselling disciplines and lobbying for legislative change. Sammy's narrative expresses the importance of our continued struggle toward social change.

> I can handle being a visible minority 'cause I can always fight back. I know what that's about. I know where that's coming from. I know how to fight those battles but there's nothing worse than being oppressed for things that people can't see. It's a very, very strange place to be in - to have to always hold onto yourself. Even the most open people like me, I still have to hold onto myself so much of the time. Nobody should have to be stifled anymore as we are approaching the year two thousand.

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Appendix A

TABLE 1. SEX OF RESEARCH PARTICIPANTS

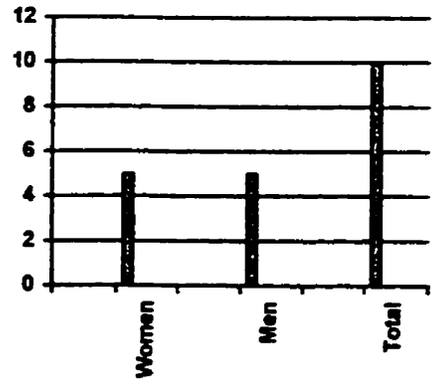
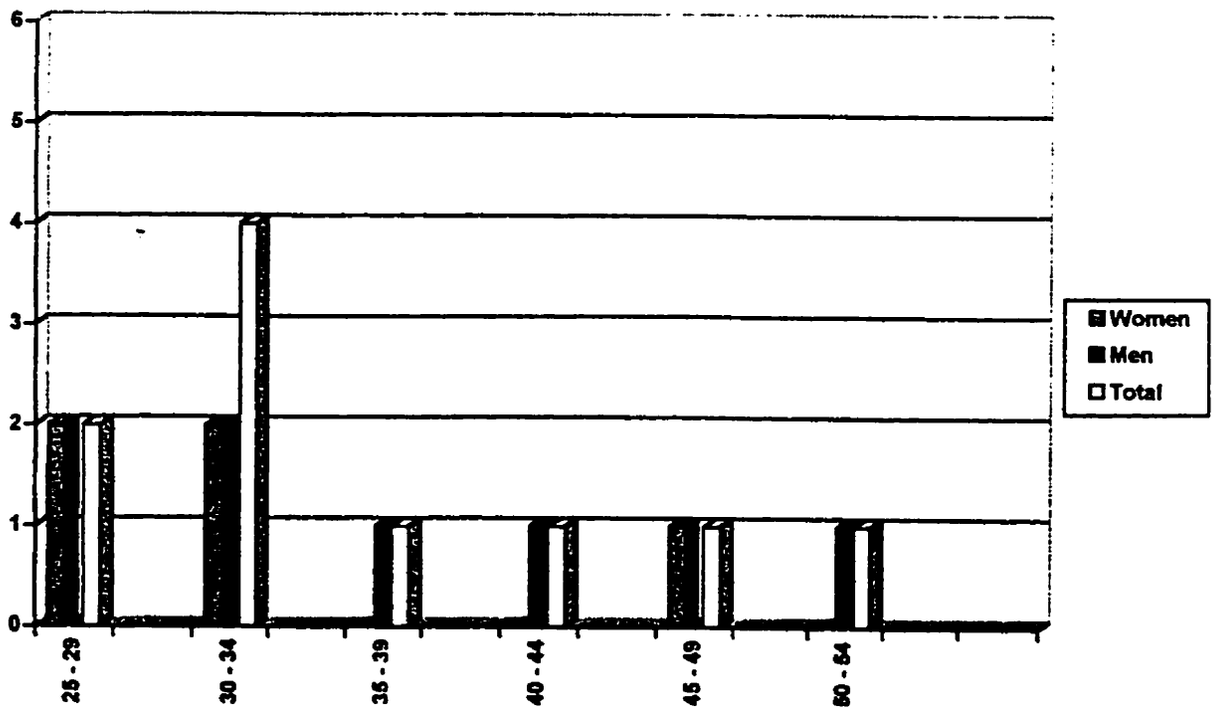


TABLE 2. AGE OF RESEARCH PARTICIPANTS



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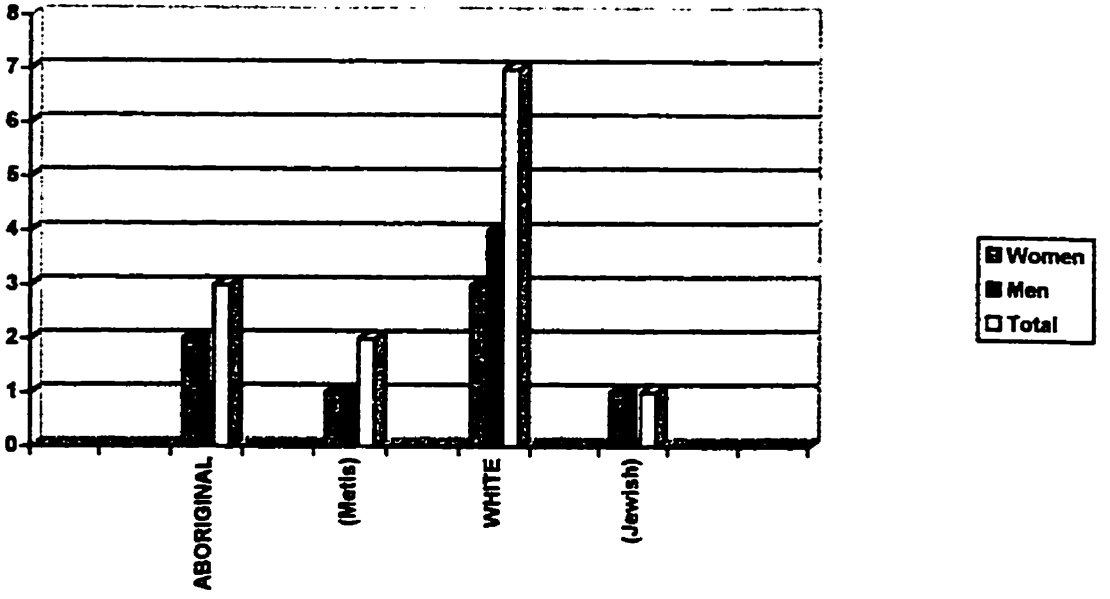


TABLE 4. CURRENT RELATIONSHIP STATUS

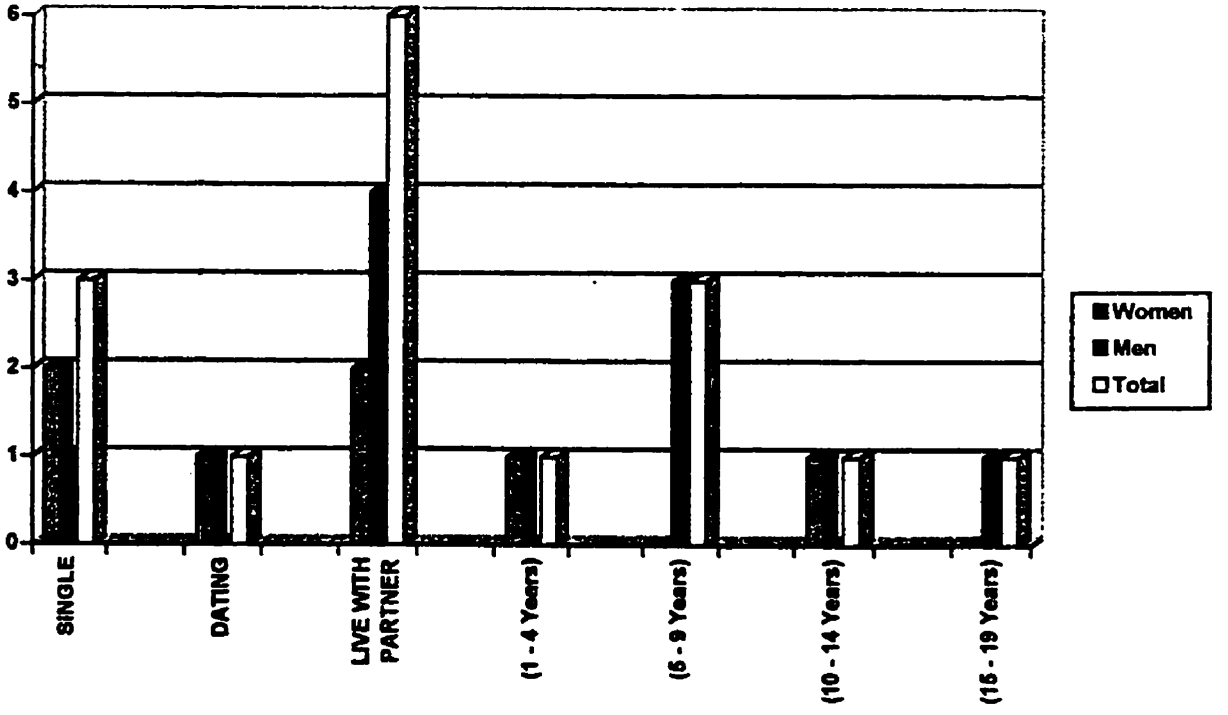


TABLE 5. HIGHEST EDUCATION LEVEL

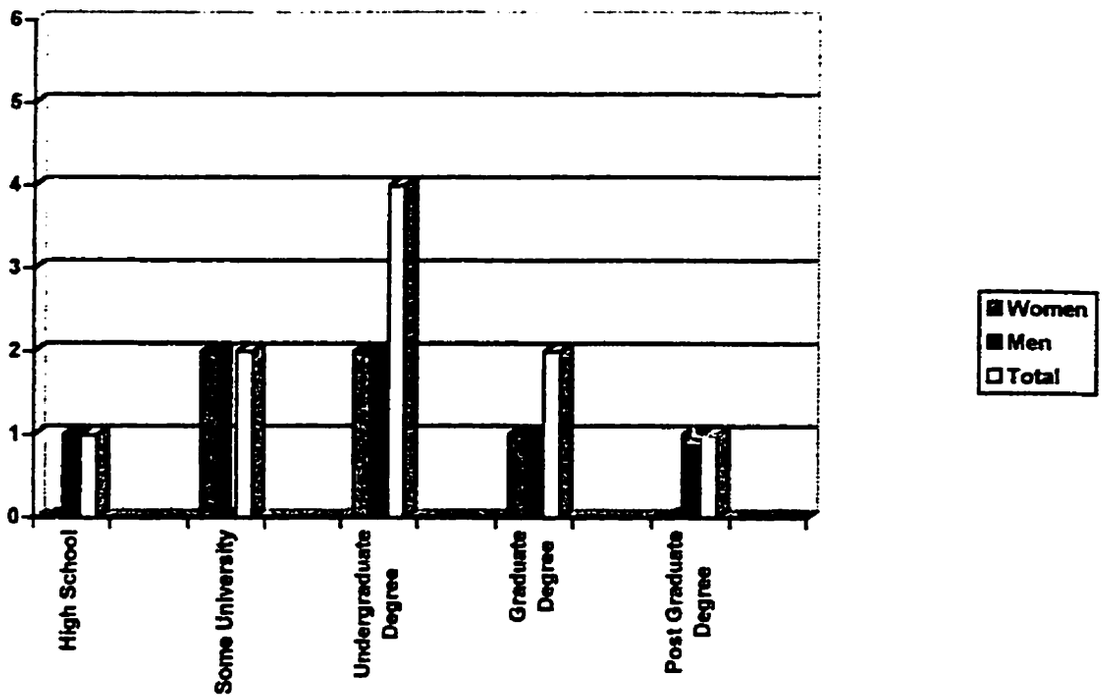


TABLE 6. CLASS BACKGROUND

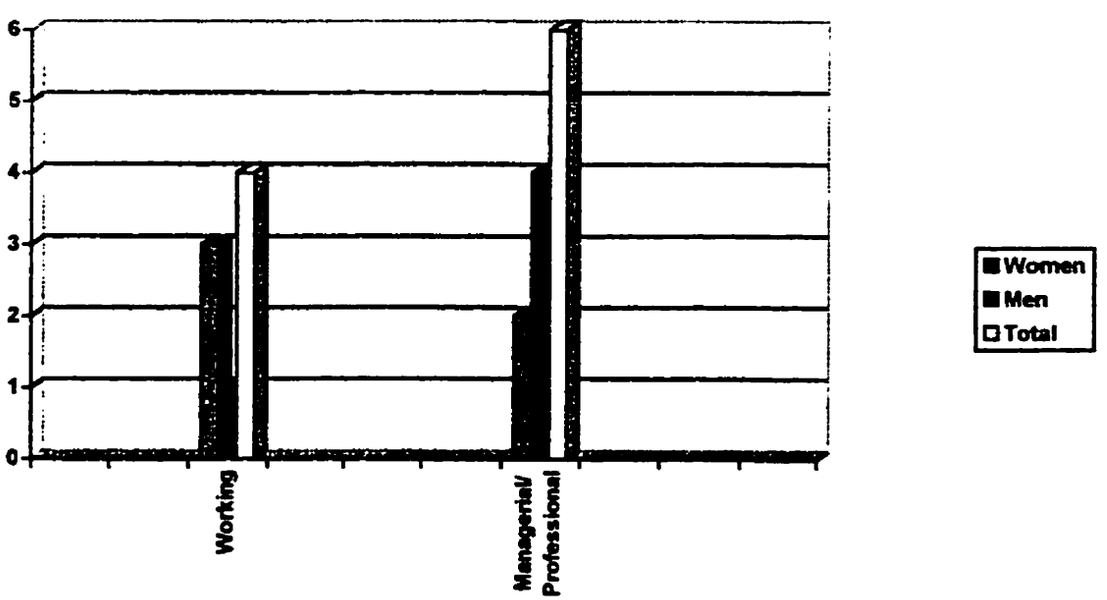


TABLE 7. PRESENT CLASS

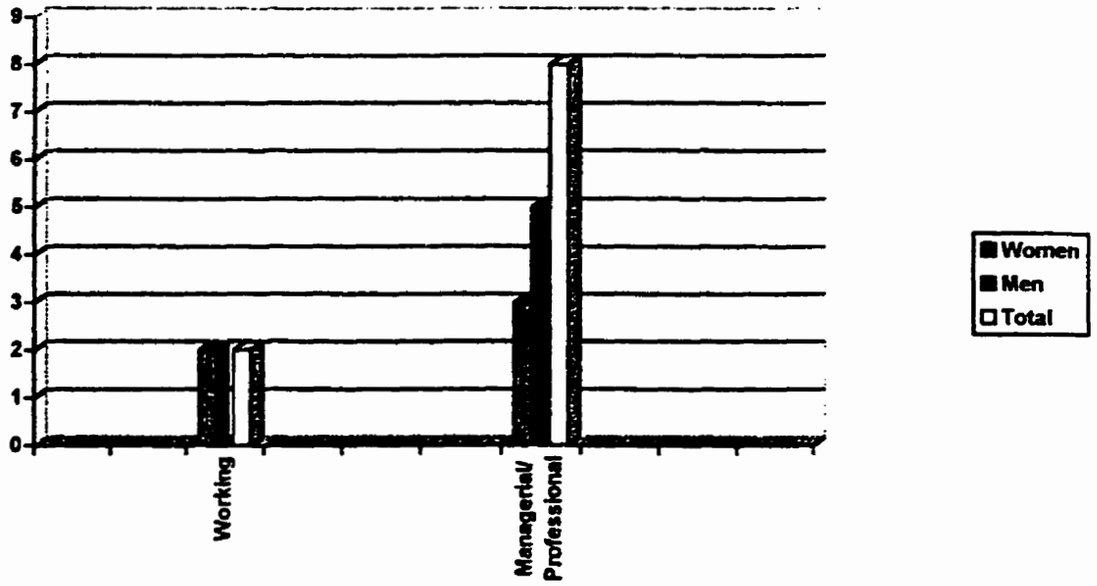
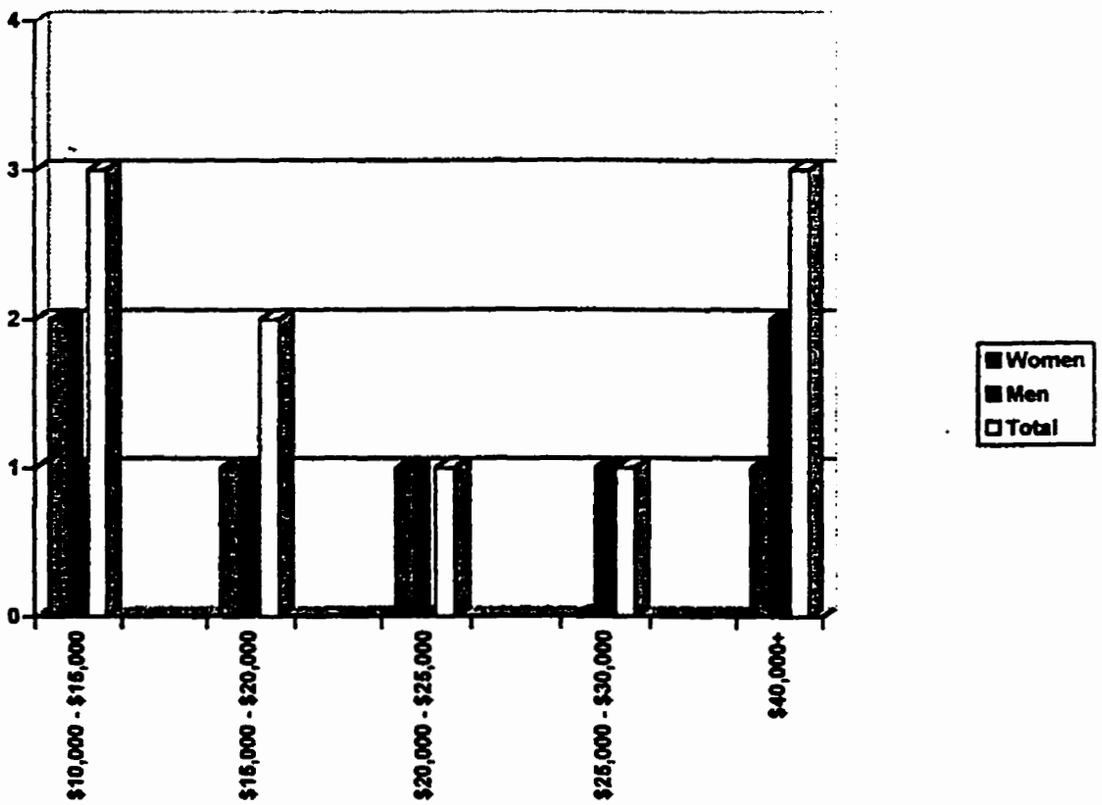


TABLE 8. ANNUAL INCOME (in dollars)



Appendix B

Consent Form

I _____, agree to participate in a research project that explores the relationship between the counselling profession and the lesbian and gay communities. Information obtained from my involvement is to be applied to a Masters of Social Work thesis. I will be interviewed for approximately one hour by Jaik Josephson (284-2642). We will discuss my experiences and perceptions as they relate to counselling professionals. The project will provide an opportunity for me to offer opinions on the development of an accessible, gay and lesbian positive approach to counselling services. While our discussion will be audiotaped, no one outside of the interviewer shall have access to the recorded interview or the transcripts. Both the content of the tapes and the transcripts will be stored in a locked cabinet and shall be erased at the end of the study. To protect my privacy, any reference to myself in the written report will be done through the use of a pseudonym. I have been informed that I have the right to withdraw my participation at any point during the course of the research. All participation in the study is voluntary. Any inquiries I may have regarding the research will be answered fully, providing that the questions do not compromise the confidentiality of other participants. Upon my request, a summary of the research results will be made available.

Participant signature _____

Interviewer signature _____

Date _____

Appendix C

Distribution of Themes in Relation to Main Categories:

1. Barriers to Accessing Service:

- historical approaches to practice
- current reparative therapies
- construction of identity
- internalized stereotypes
- bias in therapeutic approach
- community support
- self reliance

2. Assessing Safety:

- determining homophobic bias
- locating service
- sex of service provider
- sexual orientation of service provider
- professional expertise
- therapeutic style
- interviewing the practitioner
- 'coming out' within the counselling setting
- terminating service

3. Recommendations for Service Providers

- reeducation
- laying the groundwork for accessibility
- identifying qualities of 'gay and lesbian positivity'
- ensuring confidentiality
- group interventions
- creating physical indicators of safety

- creating visibility

- adopting inclusive language

- diminishing power imbalance

- advocacy

Discarded Categories

- fear

- financial constraints to accessing service

- Christian approaches to counselling

- boundaries

- comparison of past experiences with homophobia to present perceptions of accessibility