

Issues Arising in Psychotherapy With Lesbian, Gay, Bisexual, and Transgender Patients

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In many ways, psychotherapy with lesbian, gay, bisexual, and transgender (LGBT) patients does not differ from psychotherapy for heterosexual, gender conforming, and cisgender patients. Additionally, concepts and considerations that arise in psychotherapy with LGBT patients can parallel issues that arise in psychotherapy with patients of other stigmatized minority groups. In this article, the authors discuss the concept of minority stress and its relationship with mental

health conditions and review specific issues that may arise with this heterogeneous patient population, including being in the closet, coming out of the closet, the psychotherapeutic search for “causes” of sexual orientation and gender identity, and therapist self-disclosure.

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In many ways, the practice of psychotherapy with lesbian, gay, bisexual, and transgender (LGBT) patients does not differ from treatments used with heterosexual, gender conforming, and cisgender patients. In this article, the abbreviation LGBT is used as shorthand for a wide range of identities, sometimes written as LGBTQQI+, meaning lesbian, gay, bisexual, transgender, queer, questioning, and intersex, with the + indicating that the list does not delineate all possible sexual and gender identities. That being said, LGBT patients, like other patients, most commonly enter psychotherapy needing discussion and help to better understand interpersonal relationships as well as how to navigate stressors related to work, family, and social circumstances.

Although a patient’s identity as a sexual or gender minority will undoubtedly come up during psychotherapy, it is unlikely to be the only issue discussed. It bears underscoring that one aspect of a person’s identity should never be conflated with the entire individual. A lesbian, gay, bisexual, or transgender identity is inevitably linked to multiple identities: child, parent, spouse and/or partner, sibling, professional, employer, employee, congregant, patient, or citizen.

Even if a patient’s LGBT identity is not the primary focus of treatment, its impact on the course of treatment should not be underestimated or overlooked. Some therapists may believe treating LGBT patients requires no specialized knowledge. “I treat my LGBT patients like everyone else” is a laudable attitude. However, this attitude may overlook the fact that growing up lesbian, gay, bisexual, or transgender is a different cultural experience than growing up heterosexual and cisgender.

Specific issues invariably arise with patients belonging to a sexual or gender minority. For example, LGBT patients often enter treatment after a long period of trying to make sense of feelings they have had that may be considered unacceptable by themselves and by those around them. LGBT patients’ adaptations may range across a spectrum that includes living openly within an LGBT-friendly environment or belonging to communities where people must hide their identities from friends, family, and even themselves.

Consequently, to facilitate the treatment of LGBT patients, it is worth outlining some issues that do not typically arise in the treatment of most heterosexual, cisgender patients. Additionally, concepts and considerations that arise during psychotherapy with LGBT patients may parallel issues that arise during psychotherapy with patients who belong to other stigmatized minority groups. In this article, we discuss the concept of minority stress and review issues that often arise with this heterogeneous patient population, including being in the closet, coming out of the closet, the psychotherapeutic search for “causes” of sexual orientation and gender identity, and therapist self-disclosure.

MINORITY STRESS

The LGBT community is not a homogenous group. Members of the community represent a diversity of racial, ethnic, cultural, and socioeconomic backgrounds. However, all of the members of the LGBT community are unified in that they belong to a stigmatized minority group. The minority stress model (1) has shown that individuals in a minority

group may be at higher risk for mental health disorders as a result of being subjected to stigmatizing attitudes, discriminatory policies, and other social stressors imposed by members of a majority group. As a result, LGBT individuals, like members of other stigmatized minority groups, may be subject to significant stress, prejudice, hostility, and expectations of rejection, which can all contribute to a considerable and disparate mental health burden (1).

Studies have shown that cumulative, chronic stress among LGBT individuals can lead to increased risk of substance use disorders, depression, anxiety, suicide, and self-harm, among other mental health issues (2–4). Furthermore, these risks, including disparities in access to health care, may vary from one sexual minority group to another. In general, however, compared with heterosexual and cisgender individuals, members of the LGBT community have more than a twofold increased likelihood of attempting suicide, and their risk for depression and anxiety disorders is almost double that of individuals who do not identify as LGBT (5, 6). Substance use is also significantly more prevalent among the LGBT community, with rates of illicit substance use, such as use of cannabis, cocaine, methamphetamine, cigarettes, and opioids, twice as high among LGBT individuals (7).

Despite the significant mental health burden that many members of the LGBT community may experience, these patients often delay or forgo seeking treatment because of concerns about discrimination or because of previous mistreatment in a medical setting (8–10). In particular, they may avoid mental health treatment because of its not-so-distant history of pathologizing LGBT identities and behaviors as psychiatric abnormalities (11, 12). Knowledge of psychiatry's history and theorizing about LGBT individuals (11) may help clinicians understand the resentment and avoidance that some LGBT patients may have toward mental health practitioners.

THE CLOSET

“Closetedness” [is] a performance initiated as such by the speech act of a silence—not a particular silence, but a silence that accrues particularity by fits and starts, in relation to the discourse that surrounds and differentially constitutes it.

—Eve Kosofsky Sedgwick (13)

It is not unusual in the developmental histories of LGBT patients to have experienced some period of difficulty in acknowledging to others either their sexual orientation or gender identity. Colloquially, this state of mind is referred to as “being in the closet,” and those who hide their identities are referred to as “closeted.”

Having to hide an aspect of one's identity in such a way is not a typical experience for those with heterosexual orientations or cisgender identities. The experience can be analogous to members of other stigmatized groups whose differences from the majority's public expressions are not immediately apparent. For example, persecuted religious minorities may be forced to practice their faith in secret, or individuals of mixed race or ethnicity may need to hide their

family origins to “pass” as a member of some other religious, racial, or ethnic majority.

However, there is an important difference between the latter minority groups and LGBT individuals. Members of most minority groups learn coping mechanisms from their families and communities to deal with the majority's prejudices. However, only until relatively recently have the children who grow up to be LGBT received family support to deal with anti-LGBT prejudices. All too often, their families of origin share the same prejudices of the heterosexual or cisgender majority. As one gay patient put it, “We are the only minority group born into the enemy camp” (14). Lending support to that observation is the fact that 30% of homeless youths are LGBT, most often resulting from being forced out of their home or feeling a need to run away from home because their sexual orientation, gender identity, and/or gender expression are not accepted (15).

Given the consequences of widespread negative attitudes toward LGBT individuals, it is not surprising that they may be unable to acknowledge to themselves, or reveal to others, any homoerotic feelings, attractions, or fantasies. Transgender individuals may experience a similar need to hide their gender dysphoria or any gender nonconforming feelings or behaviors. Individuals who find such thoughts and feelings unacceptable may not only hide them from others, they may keep them out of conscious awareness to themselves in a dissociative manner (16). Clinical presentations related to being in the closet can vary in severity, from the less intense case of a young adult man considering the possibility that he might be gay to more severe manifestations, in which any hint of same-sex feelings resides totally out of conscious awareness. By dissociating anxiety-provoking knowledge about the self, some individuals can live a whole double-life and yet, in some ways, not know it (14, 17).

From a clinical perspective, it should be noted that keeping aspects of the self hidden or separated is often difficult and harmful. Hiding creates difficulties, such as in accurately assessing other people's perceptions of oneself or recognizing one's own strengths. The impact of having to dissociate aspects of the self inevitably affects self-esteem, often making it difficult to recognize one's accomplishments as reflections of one's own abilities. Nevertheless, some individuals are able to maintain states of closetedness for long periods of time. Staying in the closet is sometimes done for religious reasons; at other times it is due to personal choice, such as an individual's efforts to maintain a stable, heterosexual, cisgender marriage.

COMING OUT OF THE CLOSET

Gay people in the pre-war years, then, did not speak of coming out of what we call the “gay closet” but rather of coming out into what they called “homosexual society” or the “gay world,” a world neither so small, nor so isolated, nor, often so hidden as “closet” implies.

—George Chauncey (18)

In contemporary usage, “coming out of the closet” means telling another person that one is lesbian, gay, bisexual, or transgender. A less commonly used term, but one with clinical significance is “coming out to oneself.” Patients often describe this occurrence as their first subjective experience of inner recognition. Coming out to oneself as lesbian, gay, or bisexual may precede any sexual contact or may occur during a sexual moment. Some describe the moment as a switch being turned on, “coming home,” or “discovering who I really am.” The experience may be charged with excitement or with trepidation. It is a realization that previously unacceptable feelings or desires are part of one’s self. It is, in part, a verbal process of putting into words what were previously inarticulate feelings and ideas. Coming out of the closet may also be conceptualized as a recapturing of disavowed experiences. From a psychological perspective, it means a reduction in dissociation and the possibility of integrating previously unacceptable aspects of the self (14, 19).

Coming out to oneself may precede coming out to others. Herdt and Boxer (20) have described coming out as a ritual process of passage requiring a lesbian, gay, or bisexual person to unlearn principles of essentialist heterosexuality, unlearn stereotypes of homosexuality, and learn the ways of LGBT culture. In coming out, LGBT individuals must decide, perhaps daily, whether to reveal and to whom they will reveal. Consequently, coming out is a process that never ends. Furthermore, such revelations are not always greeted in a welcoming manner. Fear of rejection often plays a significant role in an LGBT individual’s decision about whom to tell or whether to come out. A need to conceal their identity may be based on reasonable concerns, as in the case of LGBT individuals living and working in socially and politically conservative religious environments. Clinicians would be unwise to advise a patient to come out to anyone without knowing something about that person’s attitudes and opinions. Even with such knowledge, the psychiatrist cannot always predict accurately the consequences of making such a revelation on the relationship between the two people.

Given the social stigma and ubiquity of anti-LGBT attitudes, why come out at all? In most cases, coming out offers LGBT individuals the possibility of integrating a wider range of previously split-off affects, not just those having to do with sexuality and gender. Coming out can lead to greater ease in knowing oneself and expressing oneself to others, which in turn can lead to an enormous enrichment of work and relationships. Such activities constitute a reasonable definition of mental health.

OUTING

What came to be called outing—declaring closeted public figures to be gay—was . . . a by-product of a revolution [in which] everyone agreed that the closet was an ugly institution that had to be broken down.

—Michael Signorile (21)

The term “outing” refers to the involuntary revelation of an individual’s LGBT identity by another party. Some activists believe that deliberately exposing a closeted LGBT person to potential personal or public humiliation is justifiable, particularly if the closeted person is a public figure who espouses anti-LGBT beliefs and supports anti-LGBT public policies. This belief has accounted for revelations of, among others, a conservative U.S. congressman (22) and an influential megachurch pastor (23). Sometimes outing is done as an act of revenge by vindictive acquaintances or spurned lovers. Blackmailers may threaten to out an individual for financial or political remuneration. Historically, some politicians have tried to discredit an opponent by exposing them as LGBT (24).

A severe dissociative split between any LGBT identity and internalized anti-LGBT attitudes may account for the mental gymnastics of politically and religiously conservative individuals, allowing them to live with such stark contradictions. Such dissociation often serves as a defense against profound anxiety and shame. In the subjective experience of the outed individual, outing is experienced as a form of psychological violence.

THE SEARCH FOR CAUSES

Christ, how sick analysts must get of hearing how mommy and daddy made their darlin’ into a fairy.

—Mart Crowley (25)

It is not unusual for LGBT patients, when first beginning psychotherapy, to have a fantasy of discovering the causes of their sexual orientation or gender identity during the process. These fantasied beliefs are often enabled, sometimes even encouraged, by clinicians who believe that two people talking in a room have the necessary tools to discover the origins of either homosexual or transgender identities.

In reality, any “causes” remain unknown (26). This knowledge gap does not stop, and will probably never stop, continued theorizing by patients and therapists. A therapist’s own theories about gender and sexuality, however, may distract from therapeutic goals. Furthermore, patients’ etiological theories, when offered, provide insight into both positive and negative attitudes they may assign, consciously or unconsciously, to their own sexual or gender identity.

In contrast, heterosexual patients do not come seeking psychotherapeutic treatments to find out why they are straight. Nor do nontransgender patients expect to learn from a therapist why they are cisgender. Nor are most therapists likely to even raise the questions, “Do you ever wonder why you are heterosexual?” or “Do you ever wonder why you are cisgender?” with patients. The presumptions are that heterosexuality and cisgender identities are nature’s default setting.

Historically, however, it was not altogether unusual for heterosexual, cisgender therapists to bring up questions of etiology to their LGBT patients. Yet, if a therapist took the unusual step of doing so with heterosexual, cisgender

patients, it is unlikely that those patients would be interested in pursuing such a line of inquiry—or paying a therapist for any such insights. Sigmund Freud once remarked on the need to question the origins of heterosexuality, stating, “Thus from the point of view of psycho-analysis the exclusive sexual interest felt by men for women is also a problem that needs elucidating and is not a self-evident fact based upon an attraction that is ultimately of a chemical nature” (27). Yet, with a few exceptions (28, 29), psychoanalysts have not concerned themselves with the question nor have they typically offered treatment to find out why their patients are heterosexual or cisgender.

Why do some LGBT patients put up with such inquiries about the origins of their sexual identity or gender identity? One consequence of belonging to a stigmatized minority group is the desire to find a narrative to explain one’s “difference” from the majority. In the case of lesbian, gay, and bisexual people, these etiological narratives take three forms: theories of normal variation, theories of pathology, and theories of immaturity (14, 30). Transgender narratives take form as either normal variation or pathology.

Theories of pathology define a homosexual or bisexual orientation or a transgender identity as psychopathological, a disease or abnormal condition that deviates from biologically predetermined heterosexual, cisgender development. Such theories first gained prominence during the 19th century, most notably in Krafft-Ebing’s *Psychopathia Sexualis* (31). These etiological theories are based on the following assumptions: adult heterosexuality and being cisgender is the normal, nondiseased state; deviations from conventional gender role expectations are symptoms of disease; and some external, traumatizing pathogenic agent has prevented the individual from becoming heterosexual or cisgender. The external traumatizing event can occur pre- or postnatally and may include intrauterine hormonal exposure, excessive mothering, insufficient fathering, seduction, or a decadent lifestyle.

Theories of normal variation regard homosexuality and transgender presentations as phenomena that occur naturally and that are not signs of illness or psychopathology. Left-handedness is often used as an analogy in these narratives. Today, being in the left-handed minority is not defined as illness, although it may have disadvantages. In the past, being left-handed led to social opprobrium; the word “sinister” is derived from a Latin root connoting the left side. Historically, left-handed children were often treated as if they were abnormal and cured of their nonconforming behavior by being forced to write right-handed. The research of Alfred Kinsey et al. (32, 33) played a significant role in the eventual dissemination, among both health professionals and the general public, of theories of homosexuality as a normal variation. Today, the belief that one is born gay or transgender is the most common theory of normal variation.

Theories of immaturity regarding homosexuality are found in the field of psychoanalysis. Freud, for example, saw homosexuality as a developmental arrest or a psychosexual fixation (27). Immaturity theories are frequently confused

with theories of pathology. However, an inability to mature is not necessarily the same thing as being ill. Whereas pathologizing theories treat homosexuality as deviant and abnormal, immaturity theories regard homosexuality as a normal step, ideally a passing phase, to be outgrown on the road to adult heterosexuality. Harry Stack Sullivan hypothesized that children who ultimately became homosexual as adults were members of the “out-group, if only with respect to so-called mutual masturbation and other presumably homosexual activity which went on in this group of boys as preadolescent pals” (34). In maintaining that homosexuality could be a normal part of the heterosexual experience, theories of immaturity were more inclusive and compassionate than theories of pathology. They allowed for the possibility of a lesbian, gay, or bisexual person becoming sufficiently mature to become heterosexual, if they are motivated enough and have adequate adult (meaning heterosexual) guidance.

Yet etiological theories are not formulated in an objective vacuum. All of them contain underlying value judgments about the impact of being LGBT on the social order, on an individual’s worth within that order, or on the relationship between being LGBT and the intent of a higher force (14, 30). A higher force may include God, other deities, spiritual beings, nature, and even an anthropomorphized conceptualization of evolution. Among the key words in the morality tales underlying etiological theories are “social benefit” and “social harm,” “good and evil,” “health and illness,” “adaptive and maladaptive,” “holy and sinful,” or “mature and childish.”

For patients, their own etiological theory is likely to have a personal meaning and an affective charge. A therapist who authoritatively claims knowledge of the definitive etiology of being lesbian, gay, bisexual, or transgender would have difficulty appreciating how etiological narratives serve as vehicles for other issues. For example, a gay man asking, “What is the cause of homosexuality?” may simply be asking, “Why do I feel different from everybody else?” It is only by recognizing the often-irrational underpinnings of the psychotherapeutic search for origins that the focus of treatment may shift from trying to figure out *why* a patient is LGBT to helping a patient learn *how* to be LGBT.

THERAPIST SELF-DISCLOSURE

The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him.

—Sigmund Freud (35)

Today, it is not unusual for LGBT patients to seek out LGBT therapists, nor is it unusual for LGBT therapists to come out to patients about their own sexual or gender identity. Richard Isay (36) reported that the gay male patients he treated often sought him out as an openly gay psychoanalyst because they had concerns that heterosexual therapists would not treat them with appropriate empathy, respect, and neutrality.

One should not assume that therapists who identify as LGBT themselves will inherently have greater insight into the issues that bring LGBT patients into treatment. For example, being LGBT is not a substitute for being trained to do psychotherapy or for undergoing a personal psychoanalysis. Furthermore, the therapist's sexual or gender identity may not be the most meaningful way to gauge a therapy's efficacy. One does not need to be LGBT to treat LGBT patients any more than one needs a heterosexual and cisgender identity to treat heterosexual and cisgender patients. Psychotherapy's effectiveness is not necessarily determined by any presumed similarities between the patient and therapist. A better way to evaluate effectiveness is by how the similarities and differences between the two people are handled in the therapeutic relationship.

Nevertheless, most heterosexual, cisgender therapists are not in the habit of declaring their sexual or gender identities. In a world that naturalizes their sexual and gender identities, many are unaccustomed to the need for directly making such revelations. Most live in a world where everyone is considered heterosexual and cisgender until declared or labeled otherwise.

Historically, the question of whether therapists should disclose their own sexual or gender identities was rarely discussed for several reasons. These included the traditional psychoanalytic position that all therapists had to be heterosexual (37). If not, they had to pretend they were and hide their true sexual identities or risk professional ostracism and disgrace (38, 39). This practice began to change toward the end of the 20th century, which saw a growing literature by openly gay and lesbian therapists (38, 40–43). The new century saw the emergence of openly transgender therapists (44, 45).

There are practical reasons for therapists to eschew self-disclosure and to keep the primary focus of a therapeutic encounter on the patient's inner world. For example, some patients may feel burdened by knowledge of their therapist's sexual or gender identity or of other aspects of their therapist's personal life. Additionally, psychodynamic psychotherapy training programs, in teaching fledgling therapists how to set boundaries with patients, advise them to decline to offer any information about themselves and to elicit as much information as they can from their patients.

Coming out to patients is a form of self-disclosure. Whether one should do so is only a small part of the larger issue of therapist self-disclosure, a controversy dating back to technical disagreements between Freud and his close follower, Sándor Ferenczi (46). Yet for almost a century, the issue of self-disclosure has remained controversial, primarily because of unexamined beliefs, ideology, and allegiances to particular schools of thought. For example, there is little, if any, empirical evidence that supports nondisclosure as a superior therapeutic technique compared with self-disclosure. Also, no studies show head-to-head comparisons of the two approaches. Furthermore, although withholding information evokes therapeutic narratives from patients, so does disclosure.

Transferences will develop whether or not a patient knows a therapist is LGBT—or whether the patient knows anything else about a therapist for that matter (47).

Isay (36) noted that gay therapists living closeted, professional lives may have a countertransference need to hide, particularly if or when they experience their own homosexuality as something secretive and shameful. An unwillingness to self-disclose can lead to gaslighting patients, as in the example of the gay male therapist making naive inquiries about his gay patient's social milieu, which he knows very well. Such a therapist may consciously seek anonymity out of concerns about therapeutic technique. However, he may also not want the patient—or anyone else for that matter—to know that he, the therapist, has gone to the same gay club. In other words, one should also consider the possible harm of not disclosing. Therapists, regardless of their own sexual identity or gender, should evaluate the patient's need for them to come out, and should be prepared to do so when necessary.

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