



## Ten common mistakes straight clinicians make when working with gays and lesbians

### 1. Not disclosing your sexual orientation when asked

Often gays and lesbians call a therapist for an initial appointment asking your sexual and romantic orientation. Many therapists believe that is a therapeutic question best left to the consulting room and do not answer.

You will most likely lose the referral if you are not open about your own orientation. While this may be a therapeutic issue, clients who make initial calls still want to know who they are entering treatment with.

### 2. Denying your own homophobia and heterosexism

We are all imprinted from childhood to be heterosexist and homophobic. To deny this is a form of covert homophobia. Checking your countertransference is imperative when working with gays and lesbians.

Without doing so you will inadvertently collude with their internalized homophobia (IH). For example a gay client might say, “I don’t know why they all have to act that way” and you might say, “Yes I don’t know why either” rather than assessing the IH within your client.

### 3. Lacking local resources for gays and lesbians

Every therapist working with gays and lesbians should have easy access to local resources for your clients. One of the most important tasks for these clients is homosocialization. Contact your local gay community center or get online to see what is in your area in terms of newsletters and local gay newspapers.

### 4. Using the wrong terminology

Appropriate terminology to use with gay clients no longer includes sexual preference or alternative lifestyle. Preference implies that it is a choice—which it is not—and heterosexuality is the alternative lifestyle for gays and lesbians. The correct word is sexual and romantic orientation. Homosexual is as offensive as would be the words negro and colored to an African-American today or crippled once was used to describe physically challenged individuals and would be offensive if used today. The correct word is gay and lesbian.

### 5. Lacking information about the stages of coming out

Knowing the stages of gay and lesbian identity development is essential for clinicians. Without this information therapists can misunderstand certain thoughts behaviors by a client. For example, stage five (identity pride) resembles an adolescent stage of development-so it is expected that short-term relationships with some sexual promiscuity would occur and be developmentally appropriate. In stages one and two clients prefer to be identified as homosexual and not gay or lesbian. The Cass Model of coming out is the most widely used in Gay Affirmative Therapy.

## **6. Misunderstanding Mixed Orientation Marriage (MOM)**

Countertransference is very high when it comes to working with couples with one straight partner and the other gay. Therapists often rush in to support divorce and move on with their lives or stay together—particularly if children are involved. The reality is these couples need to decide what is right for them—not the therapist. Knowing the stages of coming out as a MOM couple is important. The stages are 1) Humiliation; 2) Honeymoon; 3) Rage; and 4) Resolution.

## **7. Being a blank screen**

Therapists who favor a more psychoanalytic approach by being a blank screen to their clients and using little to no self-disclosure can do more damage and wounding to these clients than good. Lesbian and gay clients walk in with existing wounds of feeling and/or being shut out by others in their lives because of their sexual orientation. They need relational models in therapy. Appropriate self-disclosure by the therapist is essential and therapeutic in assisting these clients.

## **8. Neglecting to recognize that gay adults were once gay children**

I have a quote; “Would the small child you once were look up to the adult you have become?” Your lesbian and gay clients were once gay and lesbian children. This makes most people—including clinicians—uncomfortable as people do not like to think of children as being sexual. However, being gay does not equate to being only sexual. Heterosexual adults were once heterosexual children. While most gay and lesbian children did not self identify as gay or lesbian they will tell you they knew they were different. How they knew what made them different is important in helping them with in the consulting room.

## **9. Leaving your waiting room void of gay and lesbian literature and paperwork**

Waiting rooms say a lot to clients about you as a therapist and your work. Lacking lesbian and gay literature, magazines and newspapers communicates a heterosexist stance to your clients. Does your intake form ask about sexual and romantic identity? Does it include partner and significant other in addition to married and spouse? If you worry that some straight clients might have a negative reaction to this check your own heterosexist attitudes and homophobia.

## **10. Believing that a “couple is a couple”**

So often I hear well-intended therapists say, “A couple is a couple” in an effort to show they are non-judgmental toward gay and lesbian couples. However, gay and lesbian couples are very different than straight couples. While there are similarities, there are very different dynamics that two men or two women bring to a relationship than a man and woman do. The “Doubling” factor refers to intensified traditional gender role conditioning of both partners. Male couples are often disengaged having magnified issues around restricted emotional expression, achievement, competitiveness and sexual expression. Female couples typically are too engaged and struggle with enmeshment, lacking differentiation, and lack of sexual expression.