

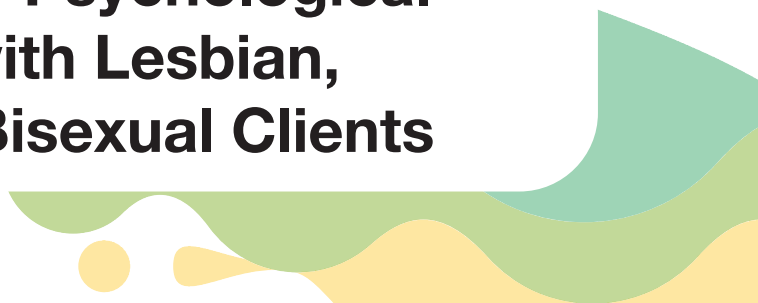


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Center for Equality and Liberty  
K O S O V A



# **Manual for Psychological Practice with Lesbian, Gay, and Bisexual Clients**



“This manual was made possible by the Engagement for Equality (E4E) Program, funded by the United States Agency for International Development - USAID and implemented by Advocacy Training and Resource Center- ATRC. The contents are the responsibility of Centre for Equality and Liberty of the LGBT community in Kosova (CEL) and do not necessarily reflect the views of ATRC, USAID or the United States Government.”



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**Manual for Psychological  
Practice with Lesbian, Gay,  
and Bisexual Clients**

# **Manual for Psychological Practice with Lesbian, Gay, and Bisexual Clients**

Year of Publication:

2017

Place of Publication:

Prishtina, Kosovo

A publication of:

Centre for Equality and Liberty of the LGBT community in  
Kosova (CEL)

Authors:

Ajete Kërqeli and Fortesa Kadriu

**Note:** *The original version of this manual was written in English.*

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## **Introduction**

The manual provides psychologists with basic information and tools in counselling of lesbian, gay and bisexual (LGB) people, in the areas of assessment, intervention, identity, and relationships. As such it serves psychologists when conducting of lesbian, gay, and bisexual affirmative practice.

Homosexuality is not a mental disorder. In 1973, the American Psychiatric Association (APA) removed the diagnosis of “homosexuality” from the second edition of its Diagnostic and Statistical Manual (DSM).<sup>1</sup> The removal of the diagnosis was a result of compelling theoretical and research evidence that reveals sexual orientation to be a normal variation of sexuality rather than pathology.<sup>2</sup> Although most LGB individuals grow up to lead satisfying and productive lives, similar to individuals in general, some LGB individuals may experience a range of mental health concerns.<sup>3</sup> Particularly LGB individuals with preexisting vulnerabilities and risk factors such as stigma are more prone for mental health problems.<sup>4</sup> LGB individuals in some cases might find it difficult to manage the stress associated with their sexual orientation, which as pointed out could be amplified by pre-existing vulnerabilities, such as dysfunctional or addicted parents, abuse and neglect, severe stress, and underlying emotional disorders. Furthermore, research reveals that LGB individuals experience disproportionately high rates of depression, anxiety, substance abuse and deliberate self-harm compared to heterosexual individuals.<sup>5</sup>

Systematic reviews of counselling practices with LGB

individuals, reveal that therapy is overall helpful. All the same, for the therapy to be helpful, it is imperative that the therapist comprehends LGB issues<sup>6</sup>. However, psychologists' relative lack of knowledge about LGB people and affirmative therapy, society stigma and discrimination that LGB people face and the significant mental health consequences that LGB people experience points to the need for psychological practice instructions for this population. Therefore the following manual aims to provide general instructions for psychologists working with LGB community.

## **Structure of the manual**

The purpose of this manual is to assist psychologists in provision of culturally competent counselling through adapting affirmative psychological approach as adjunct with their therapeutic approach for LGB people. The primary purpose of this manual is to provide an overview of best practices of counselling with LGB population. Therefore, it provides an introductory resource for psychologists who will work with LGB people, nonetheless it can also be useful for ones who are already working with LGB people.

The manual is focused solely in LGB population, rather than Trans gender/sexual people<sup>7</sup>, due to wide differences of psychological practice employed with these two groups. It includes a set of definitions for readers who may be less familiar with language used **when discussing LGB issues, most common issues and challenges faced in therapy** and specific instructions for different stages of therapy with LGB people.

The specific areas that this manual will cover are:

- Affirmative psychological approach
- Psychologist’s attitudes toward LGB people
- Relationships and Families
- Phase-specific psychotherapeutic interventions

The intended audience for this manual includes psychologists and counsellors who focus on LGB populations in their practice, research, or educational activities. Researchers, educators, social workers and trainers can use this manual to inform their work, even when not specifically focused on LGB populations.

### **Definition of Terms<sup>8</sup>**

Sex refers to a “person’s biological status and is typically categorized as male, female, or intersex (i.e., atypical combinations of features that usually distinguish male from female). There are a number of indicators of biological sex, including sex chromosomes, gonads, internal reproductive organs, and external genitalia”<sup>9</sup>.

Gender refers “to the attitudes, feelings, and behaviors that a given culture associates with a person’s biological sex. Behavior that is compatible with cultural expectations is referred to as gender normative; behaviors that are viewed as incompatible with these expectations constitute gender nonconformity”<sup>10</sup>.

Gender identity refers to “one’s sense of oneself as male, female, or transgender”<sup>11</sup>. When one’s gender identity and biological sex are not congruent, the individual may identify as transsexual or as another transgender category<sup>12</sup>.

Gender expression refers to the “way in which a person acts to communicate gender within a given culture; for example, in terms of clothing, communication patterns, and interests. A



person's gender expression may or may not be consistent with socially prescribed gender roles, and may or may not reflect his or her gender identity"<sup>13</sup>.

Sexual orientation "refers to the sex of those to whom one is sexually and romantically attracted. Categories of sexual orientation typically have included attraction to members of one's own sex (gay men or lesbians), attraction to members of the other sex (heterosexuals), and attraction to members of both sexes (bisexuals). Although these categories continue to be widely used, research has suggested that sexual orientation does not always appear in such definable categories and instead occurs on a continuum. In addition, some research indicates that sexual orientation is fluid for some people; this may be especially true for women"<sup>14</sup>.

Coming out "refers to the process in which one acknowledges and accepts one's own sexual orientation. It also encompasses the process in which one discloses one's sexual orientation to others. The term closeted refers to a state of secrecy or cautious privacy regarding one's sexual orientation".<sup>15</sup>

## **Background context regarding LGB community in Kosovo**

The legal framework of Kosovo for human rights is well developed. Anti-Discrimination Law is one of the most advanced anti-discrimination laws in the region. In national legislation, sexual orientation is included as a protected ground<sup>16</sup>. Nonetheless, the law enforcement related to discrimination based on sexual orientation remains weak. Research into the freedoms and protection for lesbians, gays, bisexual and transgender (LGBT) reveals that rights of the LGBT people are neglected by state institutions.<sup>17</sup> For instance,

81% of LGBT community has suffered threats or insults because of their sexual orientation or gender identity, making it the highest rate of discrimination in the Western Balkan.<sup>18</sup>

Thereby, a contrast between legal protection and conservative social attitudes can be observed. Discrimination against LGBT people is widely present, and is primarily perpetrated in the social context (e.g., by family and/or community) rather than official context<sup>19</sup>. Hence, coming out as LGBT can have detrimental consequences, including being rejected and ostracized by family and marginalized by their community. These effects are amplified in young LGBT people who are especially depended upon their families. Not surprisingly, some families insist that their LGBT family member be married off in order to control their sexuality. Further, there is low presence of the LGBT community in public life. Indeed, many in Kosovo believe that LGBT individuals are deviant or suffer from a mental disease, even though same-sex orientation is not a disorder.<sup>20</sup>

Despite this, some LGBT people are actively working to challenge these beliefs and promote the rights of the LGBT community. Among actions that have been conducted to promote the wellbeing of LGBT is provision of free counseling for LGBT people. Nonetheless, psychologists are not properly trained to work with LGBT people, because generally there is scarce number of available trainings for psychotherapy in Kosovo, and specifically needs of LGBT people are not included in any specialized training for psychotherapy format up to date.

To conclude, given the high rates of homophobia, increased vulnerability associated with sexual minority status, (such as of as increased suicide rates, depression, and experiences of stigmatization or victimization<sup>21</sup>), and lack of expertise of psychologists to work with LGBT people, a manual is imperative

to guide interested psychotherapists that work with LGBT.

## Work with LGB people in therapeutic setting

When working with LGB people, it is of outmost importance that psychologists have at least basic understanding and knowledge about the following topics:

- LGB situation and challenges in Kosovo
- Culturally sensitive language and practice models
- Heterosexism and its effects on mental health
- Concepts of sexual orientation and contemporary models of sexual orientation
- Appropriate Therapeutic Responses to Sexual Orientation
- Psychodiagnostic Considerations including: Heterosexist Bias in Diagnosis; Stigma, Stress, or Psychopathology?; Gender Dysphoria
- Psychotherapeutic Applications for Identity Formation: Phase-specific psychotherapeutic interventions
  - The Cass model
  - The Troiden model
  - The Coleman model
  - The Grace model
- Families of Origin and Coming-Out Issues
- Relationship stages and processes among LGB Couples
- Sex Therapy with Gay and Lesbian Couples
- Available affirmative LGB resources in Kosovo

## **Models of sexual orientation**

Human sexuality is the way in which human experience and

express themselves as sexual being, and as such it is an integral part of human personalities.<sup>22</sup> A person's sexual orientation is defined as “*a consistent and enduring pattern of sexual desire for individuals of the same sex, the other sex, or both sex*”.<sup>23</sup> Sexuality may be experienced and expressed through different means, such as thoughts, fantasies, desires, behaviors, practices, roles, or relationships. In general, several factors have an influence on sexuality, including physiology, cognition, and learning<sup>24</sup>. There is also evidence that sexuality is fluid and is dependent both in situation and context.<sup>25</sup>

Given that in counselling settings it is important to provide psychoeducation on sexual orientation theories, we present a brief overview of the most recent models that are used to conceptualize same-sex sexual and relational attraction - and that are grounded in research and most relevant to counselling settings. Other biological or psychological models on sexual orientation excluded here, encompass frameworks based on biological evidence for sexual orientation, social constructionism theory, lesbian and gay identity development theory etc.<sup>26</sup>

One of the first research based models of sexual orientation is single-continuum model by Kinsey and colleagues.<sup>27</sup> The work of Kinsey suggested that sexual behaviors can be placed in a continuum, from exclusively heterosexual to exclusively homosexual. Although the work of Kinsey revolutionized the ideas held on human sexuality, it has its limitations because it measures sexual orientation exclusively in terms of sexual behaviors. Many other theorists have expanded the model by proposing to measure sexuality in lines of two dimensions: physical-sexual and affective-emotional.<sup>28</sup> Further, other authors<sup>29</sup> have suggested multiple continua model of sexual and

relational orientations, based on mental, emotional and behavioral elements across a wide range of contexts. The latter model includes five components of measuring sexuality:

1. The desire of sex characteristics continuum. This continuum represents relative attraction to sex characteristics (genitalia or secondary sex features - such as, breasts or body hair): female body characteristics, male body characteristics, transsexual and/or intersexual characteristics.
2. The desire of gender expression continuum. This component measures the attraction of femininity and masculinity continuum. Masculinity and femininity represent the socially constructed roles and behaviors that have been culturally assigned to women and men in various modalities (e.g., speech, demeanor, patterns of relationships and personal adornment).
3. The sexual and relational interest continuum. It identifies attraction continuum in engaging in sexual and relational behaviors. For example, although one may be attracted to male characteristics and to masculinity, the curiosity and interest in engaging in sex with a male may be relatively low.
4. The relational orientation continuum. The emphasis here is in assessing the individual's relationship role congruence with those of the same gender, other gender or both.
5. The community identification continuum. It assesses the level of self-identification with the terms lesbian, gay or bisexual.

Multiple continua model of sexual and relational orientations:

Example<sup>30</sup>:

*“Sarah attended counseling to explore her emerging feelings for a man whom she was dating. Part of her struggle was embedded in the fact that, for all of her adult life, she had exclusively dated women. On the continua, Sarah’s experiences are as follows: (a) desire of sex characteristics—halfway between the female end of the continuum and the midpoint, (b) desire of secondary sex characteristics—halfway between the female end of the continuum and the midpoint, (c) desire of gender expression—feminine end of the continuum, (d) sexual and relational interest—between the midpoint and the high end of the continuum, (e) relational orientation—midpoint of the continuum, and (f) community identification—high end of the continuum. Through this exercise, Sarah was able to articulate that indeed she was primarily female-attracted to women and to femininity. In addition, her identity as a lesbian woman was important to her. Her attractions to her boyfriend were creating interest and curiosity that, as she identified, were moving her from the female end to the midpoint of the continuum.”*

## **Affirmative Therapy - A Therapeutic Approach Rather Than a Psychotherapy**

Homosexuality has been seen as a naturally occurring lifestyle only after it has been removed as a disorder from DSM. At this pointed, counselling of LGB individuals shifted from conversion type therapies to acceptance model therapies. In this line, APA has adopted 16 positive and affirming guidelines for

psychotherapy with LGB individuals<sup>31</sup>. Thus, the focus has altered in counselling toward a gay affirmative approach that attempts to understand the effects of discrimination, rejection, identity cover-up, and internalized homonegativity that often times many LGB individuals might experience<sup>32</sup>. In spite of the fact that it is not concluded on what actually makes up an effective psychotherapy with LGB clients to this day, many have recognized the importance of psychotherapists using gay affirmative therapy with their clients gay<sup>33</sup>.

Given that, there is no general agreement about what constitutes gay affirmative therapy; nor any theoretical framework or operational definitions- gay affirmative therapy is better described as a therapeutic approach rather than an actual psychotherapy. It is ‘the integration of knowledge and awareness by the therapist of the unique development and cultural aspect of LGBT individuals, the therapist’s own self-knowledge, and the translation of this knowledge and awareness into effective and helpful therapy skills at all stages of the therapeutic process.’<sup>34</sup> A gay affirmative approach to therapy is equivalent to culturally competent therapy. That being the case, affirmative therapy is used by psychotherapists to show understanding, to demonstrate cultural competence, and in this way to create a positive therapeutic alliance<sup>35</sup>.

In the sequel, applying a gay affirmative approach along with a philosophical school of psychotherapy helps to develop a positive therapeutic relationship<sup>36</sup>. This alignment of approaches is deemed as appropriate and adequate for working with LGB individuals. Undeniably, an integral part for creating an effective treatment design is to comprehend the specific challenges that LGB individuals face.

## **Attitudes toward LGB people**

### **Individual values and attitudes**

When providing therapy to LGB people, it becomes crucial for the psychologist to reflect on their personal views on this domain. In contrast, implicit and explicit personal biases and negative attitudes toward LGB culture may harbor self-hatred in the client and generally hamper the process of therapy.<sup>37</sup>

- Psychologists must consider and reflect on their personal perspectives on sex, gender, and sexual orientation and their own status of sexual identity development.<sup>38</sup>
- It is advised to employ appropriate methods of self-exploration and self-education in order to identify and ameliorate biases about homosexuality. Countering such bias in therapy (e.g., attempts to change clients' sexual orientation or attributing a client's problems to his or her sexual orientation without considering the influence of societal heterocentrism) is crucial to ensure ethical practices with LGB clients.<sup>39,40</sup> To accomplish this, psychologists may find it helpful to explore the societal and familial messages they had received on what constitutes a "normal" coupling practice.<sup>41</sup> Further, some authors have suggested several areas to explore that may be helpful for psychologists.<sup>42</sup> First, does one recognize that sexual orientation varieties are equally acceptable alternatives rather than one alternative (e.g., heterosexuality) being more acceptable or preferable. Second, to what extent does one limit homosexuals, including in terms of career options or parenting rights. Third, psychologists can ponder on the level they embrace the removal of homosexuality as mental illness,



and whether they view it as indicative of instability. And finally, psychologists can examine their religious beliefs that may deem homosexuality as shameful and sinful.

- Psychologists who believe that their own personal perspective on LGB issues is harmful to the assessment and treatment of their LGB clients, can seek consultations and make appropriate referrals when necessary.<sup>43</sup> Additionally, such biases may result from limited or inadequate experiences with LGB individuals, hence aside from consultations it may also be useful to increase personal contact with LGB individuals so the negative assumptions can be challenged.<sup>44</sup>
- It may also be helpful for psychologists to examine their own attitudes toward the nontraditional relationships that some bisexual people may have.<sup>45</sup>

## **Ethics in psychological practice with LGB people**

According to authorities in the field of psychology, including APA<sup>46</sup>, the following points are some of the many that psychologists ought to consider and practice when working with LGB population:

- Psychologists understand that lesbian, gay, and bisexual orientations are not mental illnesses<sup>47</sup>, as there is no established scientific basis for inferring a predisposition to psychopathology or other maladjustment as intrinsic to homosexuality or bisexuality.
- Psychologists understand that same-sex attractions, feelings, and behavior are normal variants of human

sexuality and that efforts to change sexual orientation have not been shown to be effective or safe.

- Psychologists are encouraged to avoid attributing a client's nonheterosexual orientation to psychosocial development or psychopathology.
- Conversion ("reparative") therapy is a controversial psychological treatment or spiritual counseling designed to helping LGB people to overcome same-sex attraction through the use of behavioral approaches and aversion techniques. Extensive research reveals that there is no scientific evidence that a homosexual sexual orientation can be changed by psychotherapy, and that conversion therapy can be harmful to the individual by increasing self-loathing, lowered self-esteem, hopelessness, and depression.<sup>48</sup> Psychologist are advised to not employ conversion therapy because they risk violating basic professional standard by providing an ineffective therapy modality, that is often harmful and that strengthens the client's false belief that homosexuality is a disorder that needs to be cured.<sup>49</sup> It must be noted though, that according to the APA Ethics Code clients hold the right to choose treatment and to be informed of available treatment modalities.<sup>50</sup> On the other hand, it is argued that LGB clients may be influenced in their choice (i.e., choosing conversion therapy) because of environmental stressors, oppression resulting from social norms and ingrained religious beliefs (religious morals denouncing homosexuality).<sup>51</sup> Again, such attempts have ethical implications, very often contribute negatively in mental health, and have not been proved to be successful over time<sup>52</sup>.
- When working with religious LGB, it is recommended

that psychologists first assess their client's religious values and sexual orientation, as well as the intersection between the two<sup>53</sup>. Furthermore, it is recommended that psychologists obtain competence in both domains of diversity, including appropriate training and self-reflection in both areas.<sup>54</sup>. Overall, psychologists must remember that “the greater the conflict between sexual and religious identities, the more difficult their integration and the greater the perceived loss in choosing one over the other”<sup>55</sup>. Cohering to one set of ethical recommendations and affirming religious values over sexual orientation or vice versa is not a solution to this problem, in place it aggravates the dispute between religious beliefs and LGB orientations. Instead, psychologists should aim to integrate them for the betterment of our clients and society<sup>56</sup>.

## **Understanding the effects of stigma**

Stigma is defined as “a negative social attitude or social disapproval directed toward a characteristic of a person that can lead to prejudice and discrimination against the individual”<sup>57</sup>. Psychologists strive to understand the effects of stigma and its impact in the lives of lesbian, gay, and bisexual people. Academic problems, running away, prostitution, substance abuse, and suicide are among the many problems that have been associated with experiencing stigma<sup>58</sup>. Further, bisexual women and men not only may experience negativity and stigmatization from heterosexual individuals, but also from lesbian and gay individuals<sup>59</sup>. As such, when working with LGB individuals who

have been exposed to notions homosexuality and bisexuality as mental illnesses, psychologists need to pay attention and look if the client exhibits internalized prejudicial attitudes<sup>60</sup>. Moreover, LGB individuals who are gender non-conforming, psychologist are advised to pay attention to the potential stigmatization that is aggravated due to gender nonconformity. Whereas, LGB individuals who experience stigma, psychologists are recommended to empower them to face social stigma and discrimination if appropriate, while supporting them to understand and manage stigma as well as develop positive coping skills and help-seeking behaviors.

## **Competences and skills to conduct therapy with LGB people**

Competences and skills are key to creating a culturally competent therapeutic environment for LGB people. As it is common in multicultural training, competency in the area of treating LGB people entails numerous significant areas. Psychologists need to be well informed of the most common presenting problems in psychotherapy that LGB individuals might bring (i.e., relationship distress, self-esteem, depression, anxiety, lack of support, etc.). Display of competency, use of appropriate terminology, ease of addressing sexuality and provision of a setting that is free of heteronormative bias are crucial when working with LGB individuals.

**Key competences and skills are:**

- Psychologists need to be informed about the historical context and sociocultural changes, both positive and negative<sup>61</sup>, so that to be able to address in therapy the unique and changing contextual conditions which LGB people might experience.
- Psychologists need to be aware of and apply LGB-specific culturally sensitive language across all forms of communication, (e.g., call screening, forms used, assessment) and have it as a standard practice.<sup>62</sup>
- In the initial contacts with LGB individuals, psychologists are urged to discuss the issue of confidentiality and documentation in great detail since they may have greater concern about being permanently labeled as LGB within medical records, and thus could be likely “outed” to others.<sup>63</sup>
- To better inform case conceptualization when working with LGB clients, psychologists ought to understand the societal context (e.g., legal, religious, regional sub-cultural differences) and explore family/personal context (e.g., internal and/or external sexual prejudice).<sup>64</sup>
- Psychologists should be informed and understand the distinctive ways that universal problems appear in the lives of LGB people (e.g., How is self-esteem impacted by experiences with discrimination?).<sup>65</sup>

**Table 1. *Questions that might be consulted to self-assess competence*<sup>66</sup>:**

- 1. Have my training and clinical experiences prepared me to see this client?**
- 2. Can I receive regular supervision or consultation with an expert in LGB issues and individuals if I accept this client**
- 3. What are my motivations to treat this client? Do my motivations conflict with or complement the client's?**
- 4. What are my own levels of sexual identity development? How well can I reflect on my counter-transferential reactions to this case?**
- 5. Are there other psychologists or mental health professionals in my local area who are competent and available to treat this client?**

## **LGB specific issues**

The following part of the manual focuses on specific issues pertaining to LGB people, such as: identity formation, coming out, coming out for parents, sexual orientation conflicts, heterosexisms, stigma and bias in diagnosis.

### **Phase-specific Psychotherapeutic Interventions for Identity Formation**

When working with LGB people, psychologists should have at least a working knowledge of sexual orientation identity development<sup>67</sup>, since the process of identity development for LGB people is complicated by the fact that, unlike other minority groups, LGB people do not have support from their

families during this developmental processes<sup>68</sup>. This process of identity formation not only includes the part of developing the identity as gay, lesbian or bisexual but also means that one is moving away from a heterosexual identity<sup>69</sup>, similar to the acculturation that occurs for transnational immigrants who must adapt to a new culture<sup>70</sup>.

To facilitate identity formation in gay, lesbian, and bisexual clients, psychotherapists must meet them at their level of development and intervene appropriately. Below are presented the five phases by Ritter and Terndrup<sup>71</sup> which are built on previous models of Cass, Troiden, Coleman, and Grace. The left-hand column represents a summary of the client behaviors described by these theorists. In the right-hand column, phase-specific, psychotherapeutic interventions are suggested for meeting the developmental needs of clients.

Accordingly, *in the first phase*<sup>72</sup> of this process, LGB people feel socially different, alienated, alone, and afraid, and their same-sex attractions are preconscious, if not unconscious. While in this phase, the LGB people most likely do not seek psychotherapy to address concerns about their sexual orientation. Instead, they might present with feelings of estrangement, isolation, loneliness, and fear. It is important for psychologist when meeting LGB people that are in this phase to look out for symptoms of depression, suicidal ideation or illnesses. Interventions in this phase include alleviation of isolation and depression, addressing behavioral problems such as school failure, drug activity and abuse, or physical aggression. LGB people might benefit also from learning anger management and decision making.

Table 2<sup>73</sup>. Gay and Lesbian Identity Formation: Phase 1- Specific

## Client Behaviors and Psychotherapeutic Interventions.

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**First phase:  
Sensitization (Troiden); Pre-Coming Out (Coleman);  
Emergence (Grace)**

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<b>Client behaviors</b>	<b>Psychotherapeutic interventions</b>
<ul style="list-style-type: none"><li>• <b>Feels socially different during childhood</b></li><li>• <b>Feels alienated and alone</b></li><li>• <b>Has ambiguous same-sex attractions</b></li><li>• <b>Senses strong heterosexist and gender specific Norms</b></li><li>• <b>Fears being noticed for both behaving incorrectly and for not trying</b></li><li>• <b>Keeps thoughts and feelings private</b></li><li>• <b>Protects self from awareness through various defense mechanisms</b></li><li>• <b>Feels depressed</b></li></ul>	<ul style="list-style-type: none"><li>• <b>Empathize with client's feelings of alienation and fear</b></li><li>• <b>Destigmatize feeling socially different</b></li><li>• <b>Treat client's depression</b></li><li>• <b>Address behavioral problems</b></li><li>• <b>Refer for medical consultation</b></li><li>• <b>Intervene to prevent suicide</b></li><li>• <b>Rule out serious psychopathology</b></li></ul>

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*In the second phase*<sup>74</sup>, LGB people usually have encountered information regarding homosexuality or bisexuality that could have had a personal meaning. Thus, they move to the second phase of identity formation. In this phase LGB people might start to challenge the heterosexist assumptions that others



might have for them, and this could lead them to start naming their feelings as lesbian, gay or bisexual. In this phase, many often time they might seek therapy to deal with their emotional turmoil.<sup>75</sup> It is of immense importance that psychologist empathize with their clients and use a slow pace in their intervention. Psychologists need to be careful not to encourage early self-labeling. Later on they can focus on providing information about homosexuality and work with their clients to be more accepting of themselves. Once the client reframes being gay, lesbian, or bisexual as positive they in a way might experience a sense of loss since they have socialized with a heterosexual image<sup>76</sup>. Hence psychologists can facilitate their client in this grieving process.<sup>77</sup>

**Table 3.<sup>78</sup> Gay and Lesbian Identity Formation: Phase 2 - Specific Behaviors and Psychotherapeutic Interventions**

<b>Second phase: Identity Confusion (Cass, Troiden); Identity Comparison (Cass); Coming Out (Coleman); Acknowledgment (Grace)</b>	
<b>Client behaviors</b>	<b>Psychotherapeutic interventions</b>
Feels sexually different during adolescence • Realizes homosexuality has personal meaning • Privately labels feelings as possibly gay or lesbian • Distances self from own homoerotic feelings	• Empathize with client’s confusion • Explore personal meaning of confusing information • Discourage premature self-labeling • Help client identify and acknowledge same-sex feelings

- Denies, rationalizes, or bargains to limit self awareness
  - Acknowledges but fears same-gender feelings
  - Maintains but questions a heterosexual identity
  - Asks self, “Am I gay (or lesbian)?”
  - Feels more alienated from others
  - Avoids information about homosexuality
  - Inhibits behaviors associated with being gay or lesbian and adopts those associated with being heterosexual
  - Assimilates into heterosexual peer groups
  - Limits exposure to members of the other sex process
  - Becomes an anti-gay/lesbian crusader
  - Immerses self in heterosexual relationships
  - Escapes homoerotic feelings through substances
  - Seeks professional help to change orientation
  - Seeks information to learn about being gay or lesbian
  - Initially self-discloses to others
  - Overvalues approval from heterosexuals
  - Realizes that heterosexual guidelines for behavior and expectations for future are no longer relevant
- Explore client’s fears and anxieties
  - Mirror client’s intrinsic worth
  - Provide accurate information upon client’s request
  - Dispel myths and stereotypes about lesbians/gay men
  - Affirm client’s ability to admit same-sex feelings
  - Challenge client’s critical and punitive superego
- Reframe being gay or lesbian as positive
  - Empathize with loss and facilitate grieving
  - Empathize with loss and facilitate grieving
  - Reflect and gently challenge inhibition strategies
  - Encourage and support client to move beyond fear
- Expose client to positive role models
  - Help client identify receptive supporters
  - Refer to affirming clergy, if necessary
  - Assess for substance abuse; intervene or refer

- Grieves the loss of heterosexual blueprint for life
- 

During *the third phase*<sup>79</sup>, LGB people start to acknowledge that they are gay, lesbian, or bisexual. They even might risk coming out to others. In this phase, LGB people are able to embrace their new identity and recognize their needs. Among the needs that they might recognize is seeing oneself as a member of sexual minority subculture, which enables them to experience belonging, thus not feeling as isolated as in previous phases. Since work in this phase mostly a continuation of the second phase, psychologists continue to provide information and specific education on human sexuality<sup>80</sup> as well as facilitate their decision making on self-disclosure. It is important that they pay attention if the client is experiencing an inconsistency between their chronological and developmental age.<sup>81</sup> In this phase they can intervene by helping the LGB individual define new values and standards, in emergence of a new sexual self and in development of a new social identity.<sup>82</sup> Adding to that, psychologists can help by providing information on identity formation and supporting them to develop interpersonal and social skills that help them to relate to individuals with the biological sex they are attracted to.<sup>83</sup>

Table 4<sup>84</sup>. Gay and Lesbian Identity Formation: Phase 3 - Specific Clients Behaviors and Psychotherapeutic Interventions

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<b>Third phase: Identity Tolerance (Cass); Identity Assumption (Troiden); Exploration (Coleman); Finding Community (Grace)</b>	
<b>Client behaviors</b>	<b>Psychotherapeutic interventions</b>

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- Admits probability of being lesbian or gay
  - Tolerates a new identity
  - Acknowledges social, emotional, and sexual needs
  - Seeks out gay and lesbian individuals and communities in order to overcome isolation
  - Explores the gay and lesbian subculture
  - Experiments sexually with same-sex partners (men)
  - Forms intense emotional relationships (women)
  - Attaches gay or lesbian meaning to sexual and social encounters with other members of the same sex
  - Selectively self-discloses or “crashes out”
  - Experiences a “developmental lag”
  - Experiences gay or lesbian adolescence
  - Feels inadequate about how to behave and how to manage new and unfamiliar feelings
  - Behaves in ways otherwise considered inappropriate
  - Judges self unfairly as immature or immoral
  - Develops interpersonal skills, sense of attractiveness, sexual competence, and positive self-concept
  - Finds peer group or community where private self can be publicly shared
  - Validate client’s self-perception of probable identity
  - Provide insight on identity formation
  - Offer community resource information and references
  - Facilitate decision making about self-disclosures
  - Rehearse self-disclosures in therapy
  - Foster interpersonal skill development
  - Provide human sexuality education
  - Offer perspectives on first relationships
  - Recast feelings and behaviors as “developmental lag”
  - Assist completion of adolescent tasks
  - Continue to facilitate individuation from parents
  - Facilitate further superego modification
  - Help client build new personal and social identity
  - Reframe potential rejection as external problem
-

*In the fourth phase*<sup>85</sup>, LGB individuals not only acknowledge their new identity and wish to socialize with people who are/ feel the same but even start to accept it. In this phase, psychologists not only motivate their clients to call themselves, but may even refer to them as gay, lesbian, or bisexual.<sup>86</sup> Given that one of the main development during this phase is formation of romantic relationships, one of the primary tasks for this phase is to support LGB clients to function more effectively in their intimate relationships.

Table 5<sup>87</sup>. Gay and Lesbian Identity Formation: Phase 4-Specific Clients Behaviors and Psychotherapeutic Interventions.

<b>Fourth phase: Identity Acceptance (Cass); Commitment (Troiden); First Relationships (Coleman, Grace)</b>	
<b>Client behaviors</b>	<b>Psychotherapeutic interventions</b>
Accepts rather than tolerates a gay or lesbian self-image • Increases the frequency and regularity of contacts with other lesbians and gay men • Discovers preferences for same-sex social contexts • Starts to make gay and lesbian friends • Clarifies sexual desires and emotional needs • Feels intense need for intimacy • Searches for an intimate relationship that includes	• Encourage client to adopt temporary identity label  • Refer to client as gay, lesbian, or bisexual • Support active involvement in gay and lesbian community • Reframe kinship concept to include intentional family • Refine client’s decision making about self-disclosures • Facilitate communication and relationship skill acquisition  • Provide couple counseling, if requested

emotional as well as physical attraction

- Enters a same-sex love relationship
- Frequently “couples” before consolidating identity
- Often has unrealistic expectations for first relationships
- Feels extremely vulnerable to partner, feelings, and emotional impact of relationship
- Learns to function in a same-sex love relationship
- Meets basic needs for affirmation, physical and sexual contact, and emotional nurturance
- Legitimizes the same sex as a source of love and romance as well as of sexual gratification
- Reconceptualizes identity as natural, normal, and valid
- Expresses satisfaction with being gay or lesbian and a reluctance to abandon new identity
- Increasingly desires to disclose to heterosexual others
- Applies passing strategies and selectively self discloses
- Adopts philosophy of full or partial legitimization

- Facilitate a balance between merger and individuation
- Clarify mindful choices for full and partial legitimization
- Assist with conscious selection of passing strategies
- Recast vocational goals, if necessary
- Enhance client’s discomfort with a dual identity

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*In this fifth phase, LGB people start communicating their dissatisfaction with heterosexism. Some even cut off relations*

with heterosexuals and engage entirely with LGB community, thus rejecting any identification with heterosexual community. Hence, some of the main tasks for psychologists include: validating anger at oppression and then support the client to see beyond their dichotomous thinking and isolation, and reframe their past<sup>88</sup>.

Table 6<sup>89</sup>. Gay and Lesbian Identity Formation: Phase 5-Specific Client Behaviors and Psychotherapeutic

**Interventions.**

<b>Fifth phase: Identity Pride/Synthesis (Cass); Integration (Coleman); Self-Definition and Reintegration (Grace)</b>	
<b>Client behaviors</b>	<b>Psychotherapeutic interventions</b>
<p>atomizes between people based on sexual tation and identification</p> <p>preciates the significance of heterosexuals</p> <p>ggerates the importance of other lesbians/gay</p> <p>fers the new identity to a heterosexual self-</p> <p>erxes self in gay and lesbian subculture</p> <p>enously consumes lesbian and gay media and ces</p> <p>omes an activist for gay and lesbian nunity</p> <p>ndons previously applied passing strategies</p> <p>ognizes potential similarities between self and osexual counterparts</p> <p>nowledges possible differences between self members of gay and lesbian community</p>	<ul style="list-style-type: none"> <li>• Validate client’s pride in being lesbian or gay</li> <li>• Encourage client to celebrate new identity</li> <li>• Legitimize the reality of heterosexist oppressi</li> <li>• Empathize with client’s rage</li> <li>• Explore negative outcomes of refusing to “pa</li> <li>• Address client conflicts with heterosexist environment</li> <li>• Discuss consequences of isolation in gay or lesbian ghetto</li> <li>• Challenge dichotomous thinking</li> <li>• Increase client’s identification with marginali others</li> <li>• Help client explore differences as well as similarities between self and gay and lesbian subculture</li> </ul>

condemns “them vs. us” philosophy  
is less overwhelmed by anger and pride  
maintain continuity of life  
discriminates not on the basis of sexual  
orientation but on the basis of perceived support  
receives greater trust in sensitive heterosexuals  
discloses almost automatically  
has greater security in integrated identity  
incorporates and integrates public and private  
activities into one self-image  
draws from reservoir of skills and resources from  
previous phases to meet situational demands of life  
proceeds with normal tasks of adult development

- Examine other dimensions of client’s personality
- Promote client’s integrated view of self
- Facilitate reintegration into dominant culture
- Assist client with reframing his or her past to meet current needs
- Help client redefine former relationships
- Resume superego modification when client regresses
- Advance to issues of authentic intimacy and generativity
- Address normal developmental issues of adulthood

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## **Understanding issues related to relationships and families**

It is critical for psychologists working with LGB clients to understand the impact of the sexual orientation on their family of origin and the relationship with that family of origin, especially concerning the coming out process. The coming out process and numerous suggestions on helping clients cope with its influence in family functioning will be discussed at length below (see: Coming out). Here, data on various family patterns and parental reactions toward their LGB family member will be discussed:

- There is evidence that families of LGB people are less likely to provide sufficient support for LGB members in terms of their sexuality, thus it has to be considered in therapy.<sup>90</sup> This may be given that, typically, family members of LGB people have internalized homophobic



attitudes similar to those reflected in society.<sup>91</sup> Furthermore, they may not be as well equipped with the knowledge of LGB challenges in order to provide advice, guidance or instrumental support.

Taking note of these data, several clinical implications can be drawn. First, it appears that interventions that boost provision of support regarding their sexuality can be very helpful (e.g., through developing a good therapeutic therapist-client relationship). Next, barriers in obtaining social support from family or social network can be discussed within therapy settings. It may also be helpful to assist LGB clients to disclose their sexuality to potential supportive family members and friends, in order to ensure a certain level of support and comfort in discussing their sexuality.<sup>92</sup>

- Psychologists need to take into account that most LGB people are very unlikely to disclose first their sexual orientation to family members before others.<sup>93</sup> One study reported that only 7.9% of LGB people disclosed their sexuality initially to their families.<sup>94</sup> Psychologists should consider that sometimes choosing not to disclose sexuality to family due to fear of rejection are based in reality.<sup>95</sup> Psychologists need to be aware that there are several patterns of family functioning with clients who are closeted <sup>96</sup>:
  1. LGB individuals maintain rigid geographical and emotional distance from the family. In such cases, the contact is reduced to the minimum and LGB people may lie (or avoid the topic altogether) about their sexual life. As a consequence, LGB people feel estranged from family members, while other family members may deal with the

loss of their loved one (i.e., LGB family member), without grasping the reasons behind.

2. The “I know you know” pattern. Here an unspoken agreement takes place between all family members, indicating the agreement to not talk about the personal lives of the LGB individual. A dominant feature within these families is the denial of same-sex orientation of their family member, and is reflected in treating their coupled LGB family member as single individual. For example, significant others may be referred to as “friends” and the LGB family member may be introduced to other sex individuals for dating.

3. The “don’t tell your father” pattern. In such scenarios, the LGB individual and other more supportive family members collude to hide this from another family member (e.g., father or grandmother) as it is believed it will cause immense pain.

- Research shows that family rejection has a serious impact on LGB young people’s health and mental health. LGB young people who were rejected by their families because of their identity have much lower self-esteem and have fewer people they can turn to for help. They are also more isolated and have less support than those who were accepted by their families.<sup>97</sup> Highly rejected LGB young people by families were more than 8 times as likely to have attempted suicide; nearly 6 times as likely to report high levels of depression; more than 3 times as likely to use illegal drugs; and more than 3 times as likely to be at high risk for HIV and STDs.<sup>98</sup> On the other hand, LGB young adults whose parents support them have

better overall health, and mental health, higher self-esteem, are much less likely to be depressed, to use illegal drugs, or to think about killing themselves or to attempt suicide.<sup>99</sup> Even if a family is a little less rejecting and a little more supportive it can reduce the child's risk for suicide. Taken together, the data suggests the importance of assessing suicidal ideation and risky behaviors when clients experience rejection from family members. Psychologists may also want to help their clients identify other sources of supports (e.g., friends, self-support groups etc). Evidence shows that using family based therapy could lead to improved treatment outcome rates of adolescents with high level of suicidal ideation.<sup>100</sup> Particularly, is it helpful if it focuses in working with adolescents and parents to identify and work through family conflicts that contribute to suicidal thinking; then engage the adolescent in treatment and building hope for change by helping them to become more autonomous and competent.<sup>101</sup> It is of outmost importance that this work is complemented by working with parents to reduce parental criticisms regarding sexuality and instead focus on the quality of the adolescent-parents attachment relationship; as well as initially working with parents to reduce parental distress and then improve parenting practices - so that they could become more empathetic of their child struggles.<sup>102</sup>

Another potential area of work with LGB clients is their romantic relationships. Again, apart from standard techniques applied when working with couples, additionally several points to be considered with this clientele are summarized:

- In many respects, LGB couples function much like and at least as well (e.g., are at least as cohesive, flexible, equal and satisfied) as heterosexual couples.<sup>103</sup> Nonetheless, it may be helpful for psychologists to take into account the influence of societal prejudice and discrimination toward LGB persons in the couple functioning.<sup>104</sup> A couple may not recognize the immense influence of prejudices on daily basis,<sup>105</sup> which is reflected through potential disagreements on public display of affection, where to spend the holidays when one is out and the other not etc.
- Psychologists need to be aware of the stereotypical presentations of lesbian couples as fused and gay couples as disengaged. This view is challenged, by some studies.<sup>106107</sup> Nonetheless, there is evidence that gay men are more prone to have non-monogamous relationships and be sex-driven compared to other individuals.<sup>108109</sup> This may be because some gay men, similar to heterosexual men, appear to not attach emotional meaning to the sex they may have out of their primary relationship.<sup>110</sup> As such, non-monogamous agreements in gay male couples do not negatively impact sexual relationship quality - unless there is discrepant impressions of relationship arrangements.<sup>111</sup> In the latter scenario, therapists may want to address this issue in couples in order to foster communication to reach a suitable agreement for both parties.
- Another issue that may be encountered in therapy with a LGB individual is when he or she is involved in opposite sex relationships. Research report that gay or bisexual men may choose to get married with opposite sex individuals because they believe it is natural and there is a desire for a traditional family.<sup>112</sup> The authors, however,

have postulated that such marriages reflect internalized homophobia; whereas eventual breakups reflect the cognitive dissonance. Other studies suggest that individuals in these marriages (i.e., when one partner identifies as non-heterosexual) report overall satisfaction with the relationship with the arrangement, when both spouses are religious and share a similar worldview.<sup>113</sup> In such cases, therapist should be aware of the research reports in such arrangement that associates honesty about sexuality with more positive relationships.<sup>114</sup>

### **The “Coming out” process**

Coming out is defined as the process in which the person discloses her or his sexual orientation and integrates this knowledge into their personal identity and social life.<sup>115</sup> The coming out process is usually not accomplished all at once, but it rather ranges in length from weeks to years.<sup>116</sup> Although most LGB people claim they were conscious of being different from others since childhood, the median age they claim to be aware of their sexual orientation is somewhere between 13 and 15.<sup>117</sup> To our knowledge, there is no data related to average age of coming out in Kosovar LGB community, however data on other countries suggest that the majority of LGB individuals start the process of coming out during their adolescent years.<sup>118</sup> Further, the average age at which LGB individuals reach the coming out milestone is decreasing over time, with younger generations reaching this phase earlier than older generations had.<sup>119</sup> The effects of coming out can be twofold: it may be encountered with hostility or discrimination and at the same time can be empowering.<sup>120</sup> Hence, it must be emphasized that it is of

utmost importance that therapists are cautious in examining unique life circumstances in their clients when discussing the coming out process. Further, the therapist needs to help clients guide the coming out process (e.g., in family, school, work, friends etc) in a manner that ensures minimum risks and maximum empowerment.

Coming out has two different features: (1) recognition (and potential acceptance) of one's homosexual identity and (2) disclosure of one's homosexual identity to others.<sup>121</sup> In addressing the first aspect, the therapist must foster the process toward self-acceptance. Furthermore, owing to the intense stress associated with the coming out process, other unrelated pathology might be triggered and /or exacerbated.<sup>122</sup> Therefore, therapists need to distinguish whether the individual who is coming out is experiencing adjustment problems related to coming out or whether is experiencing other psychopathological problems that are worsen at this phase.

Regarding to the second feature, the therapist needs to discuss the potential consequences of coming out to other people. Therapist must also take into account and inform the client that coming out process is likely to be a difficult time for both the LGB individual and his/her family.<sup>123</sup> Naturally, some LGB individuals fear being rejected or victimized by their family. The therapist may aid the client by exploring their families' typical reactions toward difficulties in order to hypothesize their potential reaction to this news as well.<sup>124</sup> For example, families who tend to be inflexible in general may be more prone to react negatively regarding their child's homosexuality. The therapist need also to be aware of research suggesting that young LGB individuals (still dependent emotionally and financially to their families) who come out to their families are four times more

likely than those who did not, to attempt suicide.<sup>125</sup>

Inferring from the research data in coming out, the therapist can help clients in several ways: (1) assess the potential risks and benefits before deciding to come out within their families and other settings, (2) help them cope with secretiveness of their sexual identity, (3) aid them develop healthy coping mechanisms that promote resiliency (e.g., help them connect to LGB community), (4) provide psycho-education that coming out is a process that can be lengthy and not necessarily all at once, (5) develop communication skills to express their thoughts, feelings and needs clearly if they decide to come out and, (5) lastly help them to empathize and provide time to their parents to adjust to the new situation.<sup>126</sup> There is also evidence to suggest that coming out process can be facilitated if parents are educated about homosexuality before the revelation.<sup>127</sup>

Another area where therapist could help LGB clients is coming out to peers. Again, it must be noted that disclosure to peers is often followed by harassment and victimization - emphasized in males and LGB individuals with gender atypical behaviors.<sup>128</sup> Thus, the therapist need to be mindful of symptoms associated with bullying related to sexual orientation, including post-traumatic stress disorder, depression or suicidal ideation.

In clinical settings, LGB individuals may not come out until they feel safe enough to trust the therapist. In such cases, it is helpful to let the clients decide the pace of disclosing and at the same time the therapist can provide understanding and support

throughout the process.<sup>129</sup> Additionally, Therapists may find it useful to have working knowledge of various stages of coming out (see Table 7 below), in order to employ appropriate intervention that accommodate the needs of the respective

Stage	Youth's experience	Practitioners' tasks
1	"Could I be homosexual?"	<ul style="list-style-type: none"> <li>• Encourage youth to explore feelings</li> <li>• Identify sources of accurate information on GLB identity</li> </ul>
2	"I might be gay/lesbian"	<ul style="list-style-type: none"> <li>• Provide accurate information and stress that a GLB identity can be a positive option</li> <li>• Recommend nonerotic novels with gay and lesbian characters</li> </ul>
3	"I probably am gay/lesbian"	<ul style="list-style-type: none"> <li>• Help youth identify and access gay affirmative role models and support groups</li> </ul>
4	"I know I am gay/lesbian"	<ul style="list-style-type: none"> <li>• Provide direct access to GLB youth organizations and/or service providers</li> <li>• Help youth identify ways to come out that will build self-esteem</li> <li>• Help youth identify ways for coping with negative social reactions</li> <li>• Educate adults and others in the general community about the importance and role of coming out and disclosure for GLB youth</li> </ul>
5	"I am gay/lesbian. So what?"	<ul style="list-style-type: none"> <li>• Most youth will not achieve this stage but should instead have it as a goal</li> </ul>

stage.

**Table 7. <sup>130</sup>Stages of LGB youth coming out and practitioner's tasks.**

### **“Coming out” for parents**

Like their children, parents endure a process of “coming out”



themselves which has four stages:

- a) Finding out: Emotional reaction; Cutoff; Conversion strategies; Denial; Acknowledgment
- b) Communicating with others: Telling friends; Getting help from gay or lesbian children; Listening to other gay men and lesbians; Learning from counselors; Receiving support from other parents
- c) Changing inner perceptions: Opening up to feelings; Moving toward acceptance; Taking the step beyond
- d) Taking a stand and telling others: Confronting homophobia; “Coming out” as parents; Speaking up and out in public; Educating critics ; Allying with other parents

These stages resemble the stages of sexual minority identity formation. In a way, parents of LGB members experience a cycle of attachment, separation, loss, and reattachment.<sup>131</sup> Hence it is crucial that during these phases psychologists supports these families to move through loss and facilitate adaptation to a disclosure. Through education and support families can start to see their lesbian, gay or bisexual member in a more positive light and thus accept this member in their family system.<sup>132</sup> Because if an LGB members is not integrated in the family’s definition of itself, the system will remain dysfunctional and fragmented.<sup>133</sup>

Stage-specific psychotherapeutic interventions for parents during these phases include: a) In the finding out phase, the psychologist can help parents to reflect on their emotional reactions, increase range of affective responses, avoid collusion with bargaining, and can gently challenge denial; b) in the communicating with others phase, the psychologist can support

parents by providing education about homosexuality, superego modification, role play and rehearse the “telling others”, and encourage parents to overcome fear; c) in the changing inner perceptions phase it is important to facilitate grieving of the loss of a heterosexual child, help parents recognize heterosexism in society and its effects on their children and assist mourning of personal losses; and d) in the taking a stand and telling others phase psychologists can facilitate selective and progressive disclosure, role play and rehearsal for handling situations, help parents move beyond fear, and refer parents to parents’ of LGB associations (if available).<sup>134</sup>

### **Psychotherapy focused on issues related to sexual orientation conflicts<sup>135</sup>**

While all LGB individual go through phases of some conflict in regards to their sexual orientation, for some this conflicts become more pronounced, due to contradictions with heterosexual society, cultural and religious beliefs. While some start experiencing such conflicts in other situational factors such as realizing that they have attractions towards the same sex when they are already in a heterosexual relationship such as being married. In such cases LGB people might present with secretiveness, liaisons, rationalizations, time away from home, guilt, desires for connection and to be known, and desire for stability with the family<sup>136</sup>, since they may be preoccupied with how their spouse, children or even themselves can be affected by this. In such cases, psychologists can focus on neutralizing the societal heteroseximim, by offering at the same time a wider view of reasonable lifestyle and identity choices, thus making sure to interconnect and integrate all aspects of the client’s multiple cultural identities.<sup>137</sup> Therapists may want to explore

reasons for marrying, and current level of intimacy and commitment toward their spouse. It is also useful to take into account cultural reasons for staying married, such as the norm implying to stay married at all costs or beliefs that homosexuality is wrong.<sup>138</sup>

Clients who are conflicted about their sexual orientation may require treatment goals that therapists find unjustified - such as changing one's sexual orientation.<sup>139</sup> An alternative treatment goal could be proposed, which conveys that is not necessary to decide on the outcome in the beginning of treatment. Instead of deciding in one specific treatment goal, several agreements and interventions could take place including: (1) agreeing to work consistently with the client's present values and simultaneously normalizing the desire to change sexual orientation (e.g., acknowledging cultural pressure) (2) psycho-educating the client on research evidence on the possibility of changing one's sexual orientation and at the same time assessing the pros and cons on using conversion therapy and (3) psycho-educating that homosexual and bisexual orientation are a normal form of human sexuality. Further, another alternative of tackling this issue would be by trying to resolve internal and external reasons that are causing homosexuality related distress - rather than treating the sexual orientation itself.<sup>140</sup>

## **Heterosexist Bias in Diagnosis**

Heterosexism has been defined as "the ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship, or community".<sup>141</sup> Numerous studies show that due to heterosexism psychologists might perceive clients as more disturbed (overpathologizing); attribute symptomatology to group membership rather than to

psychopathology (minimizing); and overdiagnose or underdiagnose as a function of group membership<sup>142</sup>. Hence, ethical practice urges psychologists to be aware of this likely bias, given that some of the diagnostic categories of DSM reflect the bias of the macroculture.<sup>143</sup>

Psychologists need to be aware that often times the coming-out process produces intricate symptoms that appropriately are perceived as frightening, ego alien, that could contribute to distress.<sup>144</sup> In such cases, clients sometimes may respond in dramatic way for a brief period of time. Thus, it is crucial that psychologists know the difference between LGB clients that have clinical psychiatric disorders; or those that have difficulties accepting their sexuality without presenting any serious psychopathology; and those whom the coming-out crisis precipitates serious underlying problems.

To this point psychologists are urged to utilize a systemic approach when assessing the presenting problems of gay, lesbian, and bisexual clients as well as evaluate the influence of heterosexually biased psychosocial stressors on symptomatology, personality structure, and current levels of functioning<sup>145</sup>. What's more, psychologists should ensure that they don't minimize nor overlook any intrapersonal or familial psychopathology, nor consider negative psychic effects living in an oppressive environment as inconsequential in the etiology of the presenting manifestations.<sup>146</sup>.

In order to lessen heterosexist assumptions and approaches psychologists need to be proactive and open-minded towards client's sexual orientation. Moreover, psychologists ought to communicate their openness by including materials that

address concerns that are unique to LGB population (e.g., coming out, coping with oppression). Particularly, psychologists should be careful to address sexual orientation during the intake even if it is not brought up by the client so that it serves as an invitation to discuss the meaning of that definition.<sup>147</sup> What's more, psychologists must be able, among other things, to identify psychological issues that could contribute to conflicts about sexual orientation.

Most common issues for which LGB people seek counselling

**The following is a list of most common issues that LGB people might present with when seeking counselling:**

Depression - Research shows that LGB people face a higher risk of suffering from depression.<sup>148 149</sup> It is thought that this might be due to the negative attitudes that LGBT people face and many LGB people might have negative thoughts and feelings about their own sexuality. In addition to this, the realization that they are LGB can cause some people to feel very anxious, down, and bad. LGB are more likely to have experienced bullying and victimization and more to have considered suicide than heterosexuals.

Anxiety - Like depression, anxiety is more prevalent in LGB population compared to heterosexuals.<sup>150</sup> Like with heterosexuals population, types of anxiety in LGB population including general anxiety disorder, obsessive-compulsive disorder, panic attacks, phobias, social anxiety, and health anxiety.

Alcohol abuse and harmful drinking - LGB individuals can use alcohol to deal with the stresses of being LGB.<sup>151 152</sup> Additionally, alcohol can be used as a way to help people manage difficult emotions.

Self-esteem/self-confidence- The effects of homophobia can have a negative impact on how people feel about themselves.<sup>153</sup> In addition to this, LGBT people often suffer from internalized homophobia. Many carry a great deal of shame.

Gay relationships/couples issues - Counselling for relationship issues covers a wide area. Among other issues, gay and lesbian couples can have their own particular stresses.<sup>154</sup> For example, what if one partner is out and the other is not; when one partner wants to have an open relationship, while the other person wants monogamy.

Sexual issues - Like many of the issues in this list, psychosexual issues faced by LGBT clients are no different to what other people experience.<sup>155</sup>

Body image issues- Gay men especially are subjected to various images in magazines and online, of how they are meant to look.<sup>156</sup> <sup>157</sup> Youth and beauty are held in high regard. This can lead many men to worry about the size and shape of their bodies. In extreme cases, people may develop an obsession with their body and go to great lengths to rectify what they perceive as imperfections.<sup>158</sup>

Religious, spiritual and cultural conflicts- If someone has been brought up in a religious faith, discovering that they are attracted to members of their own sex can cause inner conflict.<sup>159</sup> Counselling can help to understand the issues better and assist to move toward deciding what to do about the place of religion in one's life.

## **Annex 1. Definition of terms**

- *Ally* – a member of a majority group who works to end oppression

- Agender (Also Non-gender): not identifying with any gender, the feeling of having no gender.
- All-Gender: Descriptive phrase denoting inclusiveness of all gender expressions and identities.
- All-Gender Pronouns: Any of the multiple sets of pronouns which create gendered space beyond the he, him, and his/she, her, and hers binary. Sometimes referred to as gender neutral pronouns, but many prefer third gender as they do not consider themselves to have neutral genders. Examples: ze, hir, and hirs; ey, em, eirs; ze, zir, and zirs, or singular they.
- Ally: Someone who confronts heterosexism, homophobia, biphobia, transphobia, heterosexual and cisgender privilege in themselves and others; 2) A concern for the wellbeing of lesbian, gay, bisexual, trans\*, and intersex people; 3) A person who believes that heterosexism, homophobia, biphobia and transphobia are social justice issues; A person who identifies with the privileged group.
- Androgyne: 1) A person whose biological sex is not readily apparent; 2) A person who is intermediate between the two binary genders; 3) A person who rejects binary gender roles entirely.
- Androgynous: A person who may appear as and exhibit traits traditionally associated as both male and female, or as neither male nor female, or as in between male and female.
- Asexual: 1) A sexual orientation where a person does not experience sexual attraction or desire to partner for the purposes of sexual stimulation; 2) a spectrum of sexual orientations where a person may be

disinclined towards sexual behavior or sexual partnering. See also: Ace.

- Assigned Sex (Assigned Sex at Birth): The process of sex designation. See also: Designated Sex.
- Atypical Gender Role. A person who exhibits a gender role at odds with the norm for their assigned gender and social position.
- Bigender: To identify as both genders and/or to have a tendency to move between masculine and feminine gender-typed behavior depending on context; 2) Expressing a distinctly male persona and a distinctly female persona; 3) Two separate genders in one body.
- Bisexual: A person emotionally, physically, and/or sexually attracted to males/men and females/women. This attraction does not have to be equally split between genders, and there may be a preference for one gender over others.
- Bi-phobia: The fear, hatred, or intolerance of people who identify or are perceived as bisexual.
- Butch: A person, usually female identified, who identifies themselves as masculine, whether it be physically, mentally or emotionally. Most frequently claimed as an affirmative identity label among lesbian women, and gender non-conforming people designated female at birth.
- Cisgender: A person whose gender identity is aligned to what they were designated at birth, based on their physical sex; 2) A non-trans\* person.
- Closeted (In the Closet): Refers to a homosexual, bisexual, queer, Trans\* person, or intersex person who does not or cannot disclose their identity or identities to others.



- Coming Out: The process by which one accepts one's own sexuality, gender identity, or intersex status (to come out to oneself); 2) the process by which one shares one's sexuality, gender identity, or intersex status with others (to come out to friends, etc.). This can be a continual, life-long process for homosexual, bisexual, Trans\*, and intersex people.
- Crossdresser (CD): A person who wears clothes, makeup, etc. that is considered to be appropriate for another gender but not one's own (preferred term rather than "transvestite"). Considered part of the greater transgender umbrella community, cross-dressing may be considered "full time" or "part-time."
- Designated Sex (Designated Sex at Birth): The sex one is labeled at birth, generally by a medical or birthing professional, based on a cursory examination of external and/or physical sex characteristics such as genitalia and cultural concepts of male and female sexed bodies. Sex designation is used to label one's gender identity prior to self-identification. See also: Assigned Sex.
- Drag King: A person who identifies as a woman or female who dresses in masculine or gender-marked clothing, makeup, and mannerisms for the purpose of performance. Many drag kings perform by singing, dancing or lip-synching; 2) A person who feels connection to a male or masculine identity while wearing masculine clothing, either in a performance space or in everyday life; 3) A person of any gender identity that identifies with masculine drag "king" performance communities.
- Drag Queen: A person who identifies as a man or male

who dresses in feminine or gender-marked clothing, makeup, and mannerisms for the purpose of theater or performance. Many drag queens perform by singing, dancing or lip-synching; 2) A person who feels connection to a female or feminine identity while wearing feminine clothing, either in a performance space or in everyday life; 3) A person of any gender identity that identifies with feminine drag “queen” performance communities.

- **Femme:** A person who expresses and/or identifies with femininity; 2) A community label for people who identify with femininity specifically through a queer and/or politically radical and/or subversive context; 3) A feminine-identified person of any gender/sex.
- **Fluid:** A gender identity where a person identifies as 1) neither or both female and male; 2) Experiences a range of femaleness and maleness, with a denoted movement or flow between genders; 3) Consistently experiences their gender identity outside of the gender binary. See also: Genderqueer.
- **FTM or F2M (Female-to-Male):** Term used to identify a person who was designated a female sex at birth and currently identifies as male, lives as a man, or identifies predominantly as masculine. This includes a broad range of experiences, from those who identify as men or male to those who identify as transsexual, transgender men, transmen, female men, new men, or FTM. Some reject this terminology, arguing that they have always been male internally and are now making that identity visible, where others feel that such language reinforces an either/or gender system. Some individuals prefer the term MTM (male-to-

male) to underscore the fact that although they were assigned female at birth, they never had a female gender identity.

- Gay: Term used to refer to homosexual / same gender loving communities as a whole, or as an individual identity label for anyone who does not identify as heterosexual; 2) Term used in some cultural settings to specifically represent male identified people who are attracted to other male identified people in a romantic, erotic, and/or emotional sense.
- Gender: A social combination of identity, expression, and social elements related to masculinity and femininity. Includes gender identity (self-identification), gender expression (self-expression), social gender (social expectations), gender roles (socialized actions), and gender attribution (social perception).
- Gender Affirming Surgery: Surgical procedures that alter or change physical sex characteristics in order to better express a person's inner gender identity. May include removal of the breasts, augmentation of the chest, or alteration or reconstruction of genitals. Also called Gender Confirming Surgery or Sex Reassignment Surgery (SRS). Preferred term to "sex change surgery."
- Gender Bender: An individual who bends, changes, mixes, or combines society's gender conventions by expressing elements of masculinity and femininity together
- Gender Binary: The cultural insistence of two diametrically opposed, traditionally recognized genders - male and female; 2) The idea that there are

only two genders: male and female. May include a sensed requirement that a person must be strictly gendered as either/or.

- Gender Cues: Socially agreed upon traits used to identify the gender or sex of another person. i.e. hairstyle, clothing, gait, vocal inflection, body shape, facial hair, etc. Cues vary by culture.
- Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available<sup>160</sup>.
- Gender Expression: How one chooses to express one's gender identity to others through behavior, clothing, hairstyle, voice, body characteristics, etc. Gender expression may change over time and from day to day, and may or may not conform to an individual's gender identity.
- Gender Identity: An individual's internal sense of being male, female, both, neither, or something else. Since gender identity is internal, one's gender identity is not necessarily visible to others.
- Gender Identity and Expression: The most common phrase used in law and policy addressing gender-based needs, often in reference to violence and/or discrimination; encompasses both the inner sense (gender identity) and outer appearance (gender expression).
- Gender Non-Conforming: Gender expression or

identity that is outside or beyond a specific culture or society's gender expectations; 2) A term used to refer to individuals or communities who may not identify as transgender, but who do not conform to traditional gender norms. May be used in tandem with other identities. See also Gender Variant.

- Gender Neutral: Used to denote a unisex or all-gender inclusive space, language, etc. Ex: A gender neutral bathroom is a bathroom open to people of any gender identity and expression. Gender Neutral Pronouns: See All-Gender Pronouns.
- Gender Role: The behaviors, attitudes, values, beliefs etc. that a cultural group considers appropriate for males and females on the basis of their biological sex.
- Genderqueer: An umbrella term for people whose gender identity is outside of, not included within, or beyond the binary of female and male; 2) Gender non-conformity through expression, behavior, social roles, and/or identity; See also Fluid, Non-Binary.
- Gender Variant: People whose gender identity and/or expressions are different from the societal norms; 2) Broad term used to describe or denote people who are outside or beyond culturally expected or required identities or expressions.
- Heteronormativity: Lifestyle norm that insists that people fall into distinct genders (male and female), and naturalizes heterosexual coupling as the norm.
- Heterosexism: Prejudice against individuals and groups who display non-heterosexual behaviors or identities, combined with the majority power to impose such a prejudice.
- Heterosexual: A person emotionally, physically,

and/or sexually attracted to people of different sex or gender.

- Homosexual: A person emotionally, physically, and/or sexually attracted to the people of their same sex or gender.
- Hormone Therapy: Administration of hormones to affect the development of one's secondary sex characteristics.
- Intersex: One who is born with sex chromosomes, external genitalia, and/or an internal reproductive system that is not considered "standard" or normative for either the male or female sex. Preferred term to hermaphrodite.
- Intergender: A person whose gender identity is between genders or a combination of genders.
- LGBTQPIA: Acronym representing Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Pansexual, Intersex, Asexual, Ally. Often seen as LGBT or LGBTQ. Lesbian: Term used to describe female identified people attracted romantically, erotically, and/or emotionally to other female identified people.
- Metrosexual: A heterosexual male or masculine person who has a strong aesthetic sense or interest in personal fashion and appearance.
- Non-Binary: Describes a gender identity that is neither female nor male; 2) Gender identities that are outside of or beyond two traditional concepts of male or female. See also: Genderqueer, Fluid, Polygender.
- Outing (To Be Outed): The process where someone discloses a person's sexual orientation, gender identity, or intersex status without the concerned

person's permission. Directly associated with personal safety and consent.

- Packing: Wearing a phallic device or prosthesis on the groin and under clothing for any purpose.
- Pangender: A person whose gender identity is comprised of many gender identities and/or expressions.
- Pansexual: A sexual orientation where a person desires sexual partners based on personalized attraction to specific physical traits, bodies, identities, and/or personality features which may or may not be aligned to the gender and sex binary; 2) A sexual orientation signifying a person who has potential emotional, physical, and/or sexual attraction to any sex, gender identity or gender expression; 3) Sexual orientation associated with desiring/loving a person's personality primarily, and specific bodily features secondarily.
- Polygender: Identifying as more than one gender or a combination of genders.
- Pronouns: Grammatical element used to reference a person on the basis of gender. Traditionally he, him, his, himself and she, her, hers, herself. See also All Gender Pronouns.
- Queer: An umbrella term representative of the vast matrix of identities outside of the gender normative and heterosexual or monogamous majority. Reclaimed after a history of pejorative use, starting in the 1980s; 2) An umbrella term denoting a lack of normalcy in terms of one's sexuality, gender, or political ideologies in direct relation to sex, sexuality, and gender.

- Questioning: A person is in the process of questioning or analyzing their sexual orientation, gender identity, or gender expression.
- Sex Identity (Sex): The physical, biological, chromosomal, genetic, and anatomical make up of a body, classified as male, female, intersex, or (in some schools of thought) transsexual; 2) The categorization of a person's physiological status based on physical characteristics; 3) Label of bodies based on a socio-cultural concepts of physiology (e.g. what is a male vs. what is female).
- Sexual Orientation Identity: How a person self-identifies in regard to their sexual orientation. (I.e. identifying as Straight, Queer, Lesbian, Gay, Dyke (Dike), Homo, Hetero). Just like Sexual Orientation, Sexual Orientation Identity is not necessarily aligned to the sex or gender a person is attracted to or to whom they are partnered.
- Single Gender: Descriptive of a person whose gender consists of one identity, usually either male or female.
- Social Gender: The construction of masculinity and femininity in a specific culture, denoted by norms and expectations on behavior and appearance. See also: Gender.
- *Transphobia* – irrational fear or hatred of transpeople



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<sup>7</sup> Note: You can find useful manuals and/or tools to work with transgender/sexual people at the section of resources in this manual.

<sup>8</sup> Language is continuously changing. All the terms offered here are intended as flexible, working definitions. Culture, economic background, region, race, and age all influence how we talk about others and ourselves. Because of this, all language is subjective and culturally defined and most identity labels are dependent on personal interpretation and experience.

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