Conceptual and Ethical Issues in Therapy for the Psychological Problems of Gay Men, lesbians, and Bisexuals

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Reviewed here are a number of conceptual and ethical issues surrounding the study and treatment of gay men, lesbians, and bisexuals (GLB), with particular emphasis on the frequently overlooked political and ethical dimensions of what therapists choose to treat, indeed, on the goals patients themselves want to work towards. Several issues are discussed, including the relevance and irrelevance of sexual orientation and the role of therapist biases in assessment and treatment planning, the need for better understanding of how the problems of GLB patients are construed and the associated dangers of stereotyping, the challenges of coming out and the ways therapists can help patients make the decision and how to implement it, the extra effort required to be a GLB person in terms of the formation of an unconventional social and sexual identity, the trust issues that can arise when one partner in a committed relationship requests protected sex, the challenges and rewards of parents "coming out" as family members of a gay son or daughter, the social invisibility of lesbians and the deleterious effects this can have on them, social support issues for GLB youth, and the need for professionals to take a broad, institutional community psychology perspective to their study and treatment of GLB individuals. © 2001 John Wiley & Sons, Inc. J Clin Psychol/In Session 57: 695-704, 2001.

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The thesis of Halleck's (1971) important—and too seldom read—book, The Politics of Therapy, is that therapists never make ethically or politically neutral decisions. He argues that all psychological interventions, even those employed with voluntary patients, have
an impact on the distribution of power within the social systems in which the patient moves.

Consistent with Halleck, I believe that most of the time the very naturalness of and familiarity with our therapeutic practices blind us to the nonempirical biases that affect how we construe the patient’s problems and the goals we regard as acceptable to work towards. It is, though, better to be aware of and own up to our biases than to pretend that we have none.

Until the late 1970s, when working with gay or lesbian patients, psychotherapists spent nearly all of their time and effort trying to reduce homosexual and increase heterosexual attraction in homosexuals (and for the most part, the target population was men only.) Little if any time was spent by mainstream therapists, regardless of theoretical orientation, encouraging health professionals to change their biases against homosexuality and foster gay-affirmative attitudes and behavior in patients who happened to be homosexual, and to treat the problems that homosexual individuals have rather than the so-called problem of homosexuality. The question for me many years ago (Davison, 1974, 1976, 1978, 1991) was (and still is) the following: How can therapists honestly speak of nonprejudice when they participate in therapy regimens that, by their very existence and regardless of their effectiveness, condone a societal prejudice and perhaps also impede social change? The question of whether one can alter another’s sexual preference is separate from the political and ethical issue of whether one should, though this distinction often has gone unappreciated by critics of my position (e.g., Sturgis & Adams, 1978). (I don’t believe that one can make such changes, but that is beside the point. There are many things that therapists can do that they elect, for a variety of reasons, not to do.)

There has, however, been a sea change over the past 25 years. Instead of being focused almost entirely on how to alter sexual orientation from the homosexual to the heterosexual, articles and books have been published on the treatment of homosexuals for problems other than their sexual identity. This shift of focus away from sexual orientation change has, as predicted and encouraged earlier by some of us (Begelman, 1975; Davison, 1974; Silverstein, 1972), prompted therapists to examine the problems that beset people who prefer as sexual and love partners members of their own sex—without assuming that the only way to alleviate their distress is to work towards sexual reorientation. Many of these problems are the same as those for which heterosexuals seek treatment—for example, performance anxiety, depression, nonassertiveness, substance abuse. Sometimes these problems have little or nothing to do with sexual orientation. When they do relate to sexual identity, they generally do so, it seems to me, because being homosexual in our society continues to result in discrimination, hostility, and even physical violence.

As I argued in the aforementioned articles, people seldom go to mental health clinicians with problems as clearly delineated and independently verifiable as what patients often take to a physician. A person usually consults a therapist because he or she is unhappy, life is going badly, nothing is meaningful, sadness and despair are out of proportion to life circumstances, the mind wanders and unwanted thoughts intrude, and so on. The clinician transforms these often vague and complex complaints into a conceptualization of what is wrong, what the causes are, and what might be done to alleviate the suffering and maladaptation. The argument, then, is that psychological problems are for the most part constructions of the clinician. People come to us in pain, and they leave with a more clearly defined problem or set of problems that we assign to them.

My position in 1974 was that when a homosexual or bisexual person went to a therapist, he or she usually construed their psychological distress as caused entirely or primarily by their sexual orientation. This happened—and no doubt still happens for
many people—for two reasons: (a) their sexual orientation is usually the most salient part of their personhood, to the clinician and usually to the patients themselves (and their families), because of the negative salience homosexuality has been accorded by society; and (b) it is regarded as abnormal, regardless of the "liberal" stance that the clinician may adopt overtly. Even with the changes in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) over the past 25 years, the clinician’s perceptions and problem solving are, I believe, skewed in a direction that implicates homosexuality—no matter what the actual presenting problems are (see Davison & Friedman, 1981, for an experimental demonstration of this bias)—and, most importantly, imply the desirability of a change in sexual orientation.

None of this is to gainsay that being homosexual in our society is difficult psychologically, that it can cause considerable torment, and that it often can be downright dangerous to the person. This was particularly true a generation ago but remains so even now, given the disproportionate exposure to hate crimes and simple everyday prejudice that homosexuals are subject to (e.g., Herek Gillis, Kogan, & Glunt, 1996). The ethical and political point is that mental health professionals should not be co-opted by the societal pressures that, sometimes subtly, channel our clinical problem solving and decision making into narrowly defined domains that result in a maintenance of a status quo that, in official pronouncements, we say we do not support. The argument was and remains a political and moral one. *Whether* sexual orientation can be changed is a separate issue from whether it *should* be (cf. Davison, 1978, in an article entitled "Not Can But Ought").

The Relevance and Irrelevance of Sexual Orientation

Responsible cognitive–behavioral therapy rests on a specification of the situation in which the problem behaviors occur, what is going on within the person cognitively, emotionally, and physiologically, and what might be happening afterwards that maintains the problem—a functional analysis of the patient's problems (Goldfried & Davison, 1994). In an effort over the past couple of decades to respect same-sex attraction rather than attempt to alter it, some gay-positive therapists may run the risk of eschewing careful consideration of the role that a patient's gay, lesbian, or bisexual (GLB) sexual orientation can play in his or her life. This would be a mistake, and it is timely for us to be reminded of this possible omission (Safren & Rogers, 2001).

To be sure, one wants to avoid the extreme of always construing the psychological problems of a GLB patient in terms of their sexual orientation (Davison & Friedman, 1981). This erroneous penchant is seen in theorizing that implicates a homosexual orientation in virtually any problem the patient has—if he is drinking too much, it's because he is homosexual; if he is depressed, it is because he is homosexual; and true to psychoanalytic theory, if he is paranoid, it is because he is defending against his homosexuality. Consistent with the points made by Safren and Rogers (2001), the social stress arising from being homosexual in our society may indeed be part of the clinical picture of the substance abuser, the depressed person, and the paranoid individual. But this conceptualization is different from assigning direct etiological significance to the person’s GLB sexual orientation.

The relevance or irrelevance of a patient's sexual orientation brings to mind the challenges that clinicians and psychopathologists face when trying to understand the role of culture in psychological disorders. Cultural biases work in different and complex ways. They may cause clinicians either to over- or underestimate psychological problems in members of other cultures (Lopez, 1989, 1996). For example, African American children are overrepresented in special-education classes, which may be a result of subtle biases in
the tests used to determine such placement (Artiles & Trent, 1994). Yet, consider the example of an Asian American man who is emotionally withdrawn. Should the clinician be mindful of the tendency for lower levels of emotional expressiveness in men to be viewed more positively in Asian cultures than in European American culture? A clinician who, out of well-intentioned cultural sensitivity, attributes a man's withdrawn behavior to a cultural difference rather than to a psychological disorder risks overlooking an emotional disorder that he or she would be likely to diagnose if the patient were a White male. The effect of cultural bias in clinical assessment works both ways (Lopez, 1989).

Thus, although it is important to be aware of the potential of cultural differences to bias clinical assessment, it is not clear that attempting to include cultural differences in one's assessment work necessarily contributes to a helpful diagnosis. Consider the results of a survey of mental health practitioners in California (Lopez & Hernandez, 1986). One clinician reported attaching less psychopathological significance to the hallucinations of an African American woman because he believed that hallucinations were more prevalent among African Americans than among Whites. This clinician minimized the seriousness of the woman's problems by attributing them to a subcultural norm. As a result, he failed to consider a diagnosis of schizophrenia, a decision that may not have been in the woman's best interests.

Similar biases operate when assessing a person who happens to be GLB. It is a continuing challenge to clinicians to remain aware of their cultural, political, and personal biases and either to use them or set them aside in order to treat the patient as effectively and humanely as possible.

The Importance of Individualized Assessment

A noteworthy aspect of the case material in the Safren and Rogers article (2001) is their detailed assessment of the patient's depression, to wit: "...we discovered that [a patient's] depressed mood and occasional suicidal thoughts were due to his social anxiety and avoidance of social situations that he wanted to attend. Therefore, treatment was focused primarily on social phobia" (p. 633).

All too often in research on psychotherapy, problems of the same topography are assumed to be homogeneous. The requirement that federally funded psychotherapy outcome research employ the DSM for categorizing and then assigning people to various treatment conditions would seem to be the reason. This practice is standard in randomized clinical trials (cf. Haaga & Stiles, 2000), according to which patients judged to be, for example, depressed per the DSM are assigned randomly to different treatment or control conditions. This discourages, if not makes impossible, the kind of idiographic assessment and conceptualization (functional analysis) that are the lifeblood of responsible clinical practice as well as of sound experimental research (Goldfried & Davison, 1994). The assumption is made in contemporary psychotherapy research that patients diagnosed as, for example, "having" a major depressive disorder are homogeneous enough to be randomly assigned to different treatment conditions. But we know all too well that different people can be depressed for a wide variety of different reasons—from off-putting interpersonal behaviors (Coyne, 1976) to negative cognitive schemata and biases (Beck, 1967).

These considerations are relevant to the GLB theme. Think of the issue as one that involves stereotyping. Not all gay men and lesbians are alike. Just because they prefer members of their own sex as romantic/sexual partners should not blind us to differences among them. An idiographic assessment of, for example, depressed mood in Patient A may well reveal different controlling variables from what one might find for the depressed
mood of Patient B. Sophisticated clinicians know this, but the point is usually absent or buried in what has become the gold standard in the scientific study of psychotherapy, namely, the randomized clinical trial.

**Coming Out by GLB**

It is only with the growing acceptance of homosexuality as a legitimate lifestyle and sexual orientation that therapists have been focusing on issues surrounding the "whethers" and "hows" of coming out. A more supportive social context is certainly important in making the decision to be public about one's homosexuality (see discussion below on the critical role of social support in stress), but a positive context is not enough. Ultimately, individuals have to decide for themselves how open to be about their homosexuality. Once the decision is made, assistance in the challenges inherent to coming out—most especially disapproval from friends and family—may be amenable to cognitive–behavioral approaches. Examples are found in the cases reported by Safren and Rogers (2001), who bring to bear both Beck's cognitive therapy as well as behavior rehearsal and graduated exposure.

Noteworthy also are the special difficulties that Dworkin (2001) discusses for bisexual individuals, whose sexual preferences may even be more difficult for most people to understand and accept than is the case with people whose sexual identities are basically homosexual. These challenges, as Dworkin suggests, may be a function of bisexuality being considered nonexistent or as a transitional phase on the way to a lesbian or gay identity. For bisexuals, the issue is made even more complicated by the relative lack of acceptance that they encounter in both the heterosexual and gay/lesbian communities. Therefore, in an effort to feel a part of a community and to have places to meet potential partners, the bisexual person may feel constrained to select one of the dichotomous sexual identity labels. This forced identification can contribute to internalized biphobia. Dworkin also cautions us to be mindful of cultural factors in the decision to come out. As she points out, in some cultures, the healthiest choice may be not to come out, and such a decision does not signify internalized homophobia or biphobia (Smith, 1997).

**Extra Energy Expended to Being Gay**

A passing comment by Suarez and Kauth (2001) merits elaboration: "Maintaining multiple identities can be quite effortful; gay/bisexual men often expend more energy being gay or bisexual than heterosexuals expend being heterosexual" (p. 656).

On the face of it, this observation reflects the social and political realities of being gay in most segments of society. One must be on guard either against disclosure that could harm one's social standing or against prejudicial, even life-threatening, actions by others as a result of having revealed one's unconventional sexual orientation or as a result of suspicions that others have of one's sexual identity. A third source of tension derives from the everyday slights that minorities are subject to, for example, the "fag" and "dyke" jokes that are still prevalent in many people's casual conversations as well as in the media (though the frequency of these hurtful events is probably less than it was a generation ago).

But there is another dimension to the "extra energy" hypothesis, it seems to me, and that is the likelihood that GLB individuals spend more time examining the reasons for their homosexuality than heterosexuals devote to their heterosexuality. It may be that GLB people, even those who are comfortable with and open about their sexuality, consider more than do straights the origins of their sexuality for the simple reason that it is
judged by most of the general culture as deviant, a product of some psychobiological process gone wrong. We tend to take for granted behavior judged by society to be normative; we rarely look for reasons underlying behavior that is widely accepted and deemed to be normal.

The Issue of Trust in Protected Sex

Any conversation about sex has for the past couple of decades required consideration of the risk of HIV transmission. This is all the more important given that anal intercourse is the most risky of sexual practices (Kalichman, 1996) and given that this practice is most commonly found among gay men. Suarez and Kauth (2001) provide a frank and informative discussion of the challenges of dealing with HIV in men.

Much has been written on the barriers to people engaging in safer sex (e.g., Chernoff & Davison, 1999), but one variable that warrants particular consideration by psychotherapists is, I believe, the issue of trust. This is mentioned by Suarez and Kauth as one of the contextual relationship variables accounting for the difficulty many gay men have in using condoms.

The issue goes to the meaning of asking for or insisting upon condom use or other safer sex practice in the context of an intimate and assumedly monogamous relationship. In a study of gay male couples who had been in their relationship at least six months (the average length was almost four years), Appleby, Miller, and Rothspan (1999) found that engaging in risky sex symbolized trust, love, and commitment whereas safer sex was seen negatively by partners and considered a possible threat to a committed relationship. Suggestions by a partner that safer sex should be practiced were viewed with suspicion, as a sign of infidelity. If a couple has been together for several years with the understanding that each is monogamous and if both parties are seronegative, a request for condom use introduces a discordant note. Why use a condom under these relationship circumstances unless one has had unprotected sex outside of the relationship or unless one suspects this of his partner?

Parents and Families of Gay Men and Lesbians

Academic discussions of the issues surrounding GLB individuals certainly have their place, both in professional contexts and in laying the foundation for social action. But, the issues really come alive in the effects on the people themselves and on their families and friends. Personal reflections on these challenges are rarely published by health professionals. A welcome and engaging exception is the article by Goldfried and Goldfried (2001). They discuss the coming out of their younger son and of their own subsequent efforts to promote the open acceptance of homosexuality among the parents, families, and friends of lesbians and gays. In providing a parents' perception of the event, they themselves "come out" as the parents of a gay son, and by sharing their story with us within the context of a scholarly discussion, they provide a unique and valuable insight into the conflicts and liberation of the parents of a child who is not heterosexual.

The Goldfrieds agree with my proposition that therapists refrain from trying to change patients' sexual orientation even when asked by the patient to do so (Davison, 1974). This position underlies their proposing a vigorous and proactive campaign to encourage the parents of GLB individuals to "come out" in affirmative support of their sons and daughters. The position against sexual conversion therapy was from the outset intended to foster an atmosphere of acceptance of gay lifestyles, which is more in evidence today
than was the case 30 years ago. The Goldfrieds have taken a bold step in implementing that goal.

To review the core of my argument: I assume (and of course strongly believe) that homosexuals who ask for conversion therapy are almost always doing so for reasons of self-hate and a desire to escape from the hostility and discrimination of homophobic pressures in society. By condoning if not also offering sexual conversion therapy, mental health professionals (sometimes unwittingly) strengthen the societal bias against same-sex preferences. Goldfried and Goldfried cite several studies showing a negative relationship between low self-esteem and psychological distress among gays and lesbians. This low self-esteem almost surely stems from internalization of societal bias and discrimination against their sexual preferences. The argument against sexual conversion always has been aimed at the self-loathin\(^8\) that the Goldfrieds effectively document.

Identity Issues

The article by Saari (2001) sensitizes us to the "invisibility" experienced by lesbians—arguably more than that experienced by gay men, but probably not as acute as that felt by bisexuals (Dworkin, 2001)—and to the deleterious effects that the neglect of female sexuality has on women who prefer other women as sexual partners. She structures her argument around psychoanalytic and ego analytic notions of identity formation. Her main point, as I see it, is that by keeping their sexuality more hidden than male homosexuals do, lesbians deny themselves fulfilling opportunities to express their selves in ordinary social intercourse as well as to develop their individual identities to the fullest. Sexual identity is, as the phrase denotes, part of the way she organizes her sense of self and thereby her relationship to others. A more straightforward way to frame the issue is to remind ourselves that denial of or keeping secret one's sexual identity reduces the extent to which one can participate fully in human social intercourse. Also poorly developed is the range of meanings that one can construct for one's life.

Saari develops her thesis clearly and cogently, and her case illustrations bring things to life. What is less convincing to me is the degree to which the plight of male homosexuals who are uncomfortable with their sexuality is any less difficult than the situation for lesbians. Saari herself points out that male homosexuals are subject to considerably more physical violence than are lesbians. But she also acknowledges—and I agree—that a kind of violence is done to lesbians by the very fact that their sexual relationships tend to be overlooked, sometimes even by themselves. The resulting damage is more subtle and therefore all the more important for clinicians to be sensitive to. To be sure, the harm is different for it arises out of the differences between being male versus being female in our society (cf. Gagnon & Simon, 1973; Martin & Lyon, 1972). But the damage is similar, in my view, because of the secret and shame that many if not most homosexual individuals, both male and female, deal with in a society that generally continues to be homophobic.

Be that as it may, Saari describes in vivid and compelling detail some of the complex conflicts and struggles attendant on the decision of lesbians to come out and create a life with meaning and connection to their loved ones as well as to the society-at-large. And in her article, Dworkin (2001) illustrates that the challenges facing bisexual individuals are especially difficult, given the lack of attention in both the literature and in professional practice to the very concept of bisexuality.

Gay and Lesbian Youth and the Issue of Social Support

As in the developmental literature generally, problems of GLB adolescents have attracted less systematic attention from clinicians and researchers than have the challenges of
childhood and adulthood. The unique stresses experienced by homosexual young people are described in gripping detail by Hart and Heimberg (2001). That many psychotherapists increase the stress experienced by gay and lesbian young people is a situation that these authors are trying to rectify.

A theme in this article and, indeed, all the others is the lack of social support for GLB individuals and the stress that it occasions. There is a vast literature that attests to the relationship between social support and stress. For example, higher levels of social support were found to be related to lower rates of atherosclerosis (clogging of the arteries) (Seeman & Syme, 1987) and to the ability of women to adjust to chronic rheumatoid arthritis (Goodenow, Reisine, & Grady, 1989).

How does social support exert its beneficial effects? One possibility is that people who have higher levels of social support perform positive health behaviors more frequently, for example, eating a healthy diet, not smoking, and moderating alcohol intake. Alternatively, social support (or lack of it) could have a direct effect on biological processes. For example, low levels of social support are related to an increase in negative emotions (Kessler & McLeod, 1985), which may affect some hormone levels and the immune system (Kiecolt-Glaser et al., 1984).

Just as GLB individuals have to be included in theorizing about and research on human behavior and its disorders, so should the literature focused on homosexuality incorporate work that has been available for many years on general topics such as stress.

One of the challenges I see in the Hart and Heimberg article relates to a point made earlier, namely, the extent to which the problems one can find among GLB individuals are functionally different from those one finds in heterosexual groups. For example, in the case of "James," we are told that the patient was self-conscious about being too fat and therefore unattractive to other men, and that this led him to have anonymous sex with many partners. One has to ask how this problem is different from that of a heterosexual individual with a low opinion of his or her sexual attractiveness—except that, at least for a man, anonymous heterosexual sex is more difficult to engage in unless one pays for it. That the young man was depressed is not surprising. (Of course it would be naive to assume that this patient's same-sex preferences do not in and of themselves exacerbate the stresses of everyday living.)

Adolescents are particularly sensitive to the opinions of others. Little wonder, then, that, given the widespread prejudice against homosexuality among their peers (e.g., D'Augelli & Rose, 1990), GLB youth suffer a great deal of stress about being found out. Indeed, whether they remain in the closet or are open about their sexual preferences, their sense of being different from and vilified by their peers is bound to create anxiety, depression, and suicidality (Safren & Heimberg, 1999). The abuse that is visited upon GLB people when they come out is described vividly by Hart and Heimberg.

Conclusion

I believe there is one theme that ties these several articles together, namely, that the psychological stresses experienced by GLB individuals are due primarily to prejudice, discrimination, and abuse from most of society. The focus in these articles is heavily individualistic, and one certainly wants to develop approaches that will help ease the pain of individual patients. However, we should not neglect societal variables. We need, I believe, to address some questions that I tried to put to the field in 1974. namely, the pathologizing effects that the availability of sexual conversion programs have on how we view homosexuality. This requires that we operate at what Rappaport (1977) terms the institutional level, traditionally the domain of community psychology. An institutional
analysis of human problems examines those values and ideologies that guide the decision making of a society. My underlying assumption is that issues surrounding therapy for homosexuality should be addressed at an institutional level, and that greater societal acceptance of homosexuality as a normal variation of human sexuality rather than as a problem that needs to be fixed will, in fact, redound to the benefit of the individual. By reducing the discrimination and oppression described so well in the articles in this series, we can, I believe, mitigate the distress associated with homosexuality and ultimately the desire of some homosexual individuals to seek sexual reorientation. To repeat part of my earlier argument, mental health professionals usually do not try to change a pattern of thought, emotion, and behavior unless they believe there is something wrong with it.

Select References/Recommended Readings


