



Guidelines for Psychotherapy with Lesbian, Gay, & Bisexual Clients

Developed by the Division 44/ Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients.

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In 1975, the American Psychological Association (APA) adopted a resolution stating that "homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities" (Conger, 1975, p. 633). This resolution followed a rigorous discussion of the 1973 decision by the American Psychiatric Association to remove homosexuality from its list of mental disorders (American Psychiatric Association, 1974). More than 25 years later, the implications of this resolution have yet to be fully implemented in practice (Dworkin, 1992; Firestein, 1996; Fox, 1996; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Greene, 1994b; Iasenza, 1989; Markowitz, 1991, 1995; Nystrom, 1997). Many of these authors have suggested that there is a need for better education and training of mental health practitioners in this area. This document is intended to assist psychologists in seeking and using appropriate education and training in their treatment of lesbian, gay, and bisexual clients.¹ 

The specific goals of these guidelines are to provide practitioners with (a) a frame of reference for the treatment of lesbian, gay, and bisexual clients and (b) basic information and further references in the areas of assessment, intervention, identity, relationships, and the education and training of psychologists. These guidelines build on APA's (1992) "Ethical Principles of Psychologists and Code of Conduct,"² two other APA policies, and policies of other mental health organizations. 

The term guidelines refers to pronouncements, statements, or declarations that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Thus, these guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help ensure a high level of professional practice by psychologists. These guidelines are not intended to be mandatory or exhaustive and may not be applicable to every clinical situation. They should not be construed as definitive and are not intended to take precedence over the judgment of psychologists.

These guidelines are organized into four sections: (a) attitudes toward homosexuality and bisexuality, (b) relationships and families, (c) issues of diversity, and (d) education.

Attitudes Toward Homosexuality and Bisexuality

Guideline 1. Psychologists understand that homosexuality and bisexuality are not indicative of mental illness.

For more than a century, homosexuality and bisexuality were assumed to be mental illnesses. Hooker's (1957) study was the first to question this assumption. She found no difference on projective test responses between non-clinical samples of heterosexual men and homosexual men. Subsequent studies have shown no differences between heterosexual groups and homosexual groups on measures of cognitive abilities (Tuttle & Pillard, 1991) and psychological well-being and self-esteem (Coyle, 1993; Herek, 1990; Savin-Williams, 1990). Fox (1996) found no evidence of psychopathology in nonclinical studies of bisexual men and bisexual women. Furthermore, an extensive body of literature has emerged that identifies few significant differences between heterosexual, homosexual, and bisexual people on a wide range of variables associated with overall psychological functioning (Gonsiorek, 1991; Pillard, 1988; Rothblum, 1994). When studies have noted differences between homosexual and heterosexual individuals with regard to psychological functioning (DiPlacido, 1998; Ross, 1990; Rotheram-Borus, Hunter, & Rosario, 1994; Savin-Williams, 1994), these differences have been attributed to the effects of stress related to stigmatization on the basis of sexual orientation. This stress may lead to increased risk for suicide attempts, substance abuse, and emotional distress.

The literature that classifies homosexuality and bisexuality as mental illnesses has been found to be methodologically unsound. Gonsiorek (1991) reviewed this literature and found serious methodological flaws, including unclear definitions of terms, inaccurate classification of participants, inappropriate comparisons of groups, discrepant sampling procedures, an ignorance of confounding social factors, and questionable outcome measures. The results from these flawed studies have been used to support theories of homosexuality as mental illness, arrested psychosexual development, or both. Although these studies concluded that homosexuality is a mental illness, they have no valid empirical support and serve as the foundation for beliefs that lead to inaccurate representations of lesbian, gay, and bisexual people.

All major American mental health associations have affirmed that homosexuality is not a mental illness. In 1975, APA urged all psychologists to "take the lead in removing the stigma long associated with homosexual orientations" (Conger, 1975, p. 633). APA and all other major mental health associations subsequently adopted a number of resolutions and policy statements founded on this basic principle, which has also been embodied in their ethical codes (cf. American Association for Marriage and Family Therapy, 1991; American Counseling Association, 1996; Canadian Psychological Association, 1995; National Association of Social Workers, 1996). In addition, this principle has informed a number of APA amicus curiae briefs (Bersoff & Ogden, 1991).

Thus, psychologists affirm that a homosexual or bisexual orientation is not a mental illness (APA, 1998). "In their work-related activities, psychologists do not engage in unfair discrimination based on ... sexual orientation" (APA, 1992, p. 1601). Furthermore, psychologists assist clients in overcoming the effects of stigmatization that may lead to emotional distress.

Guideline 2. Psychologists are encouraged to recognize how their attitudes and knowledge about lesbian, gay, and bisexual issues may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated.

The APA Ethics Code calls on psychologists to "strive to be aware of their own belief systems, values, needs, and limitations and the effect of these on their work" (APA, 1992, p. 1599). This principle is reflected in training programs and educational materials for psychologists. The APA Ethics Code further urges psychologists to evaluate their competencies and the limitations of their expertise—especially when treating groups of people who share distinctive characteristics. Without a high level of awareness about their own beliefs, values, needs, and limitations, psychologists may impede the progress of a client in psychotherapy (Corey, Schneider-Corey, & Callanan, 1993).

The assessment and treatment of lesbian, gay, and bisexual clients can be adversely affected by therapists' explicit or implicit negative attitudes. For example, when homosexuality and bisexuality are consciously regarded as evidence of mental illness, a client's homosexual or bisexual orientation is apt to be viewed as a major source of the client's psychological difficulties, even when sexual orientation has not been presented as a problem (Garnets et al., 1991; Liddle, 1996; Nystrom, 1997). When psychologists are unaware of their negative attitudes, the effectiveness of psychotherapy can be compromised by heterosexist bias. Herek (1995) defined heterosexism as "the ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community" (p. 321). Heterosexism pervades the language, theories, and psychotherapeutic interventions of psychology (S. Anderson, 1996; Brown, 1989; Morin, 1977). When heterosexual norms for identity, behavior, and relationships are applied to lesbian, gay, or bisexual clients, their thoughts, feelings, and behaviors may be misinterpreted as abnormal, deviant, and

undesirable. Psychologists strive to avoid making assumptions that a client is heterosexual, even in the presence of apparent markers of heterosexuality (e.g., marital status, because lesbian, gay, and bisexual people can be heterosexually married; Glenn & Russell, 1986; Greene, 1994a).

Another manifestation of heterosexism in psychotherapy is approaching treatment with a "sexual-orientation-blind" perspective. Like "color-blind" models, such a perspective denies the culturally unique experiences of a population—in this case, lesbian, gay, and bisexual populations—as a strategy for avoiding a pathologizing stance. However, when psychologists deny the culture-specific experiences in the lives of lesbian, gay, and bisexual people, heterosexist bias is also likely to pervade that work in a manner that is unhelpful to clients (Garnets et al., 1991; Winegarten, Cassie, Markowski, Kozlowski, & Yoder, 1994). When psychologists are uninformed about the unique issues of lesbian, gay, and bisexual people, they may not understand the effects of stigmatization on these individuals and their intimate relationships.

Because many psychologists have not received sufficient current information regarding lesbian, gay, and bisexual clients (Buhrke, 1989; Pilkington & Cantor, 1996), psychologists are strongly encouraged to seek training, experience, consultation, or supervision when necessary to ensure competent practice with these populations. Key issues for practice include an understanding of human sexuality; the "coming out" process and how variables such as age, gender, ethnicity, race, disability, and religion may influence this process; same-sex relationship dynamics; family-of-origin relationships; struggles with spirituality and religious group membership; career issues and workplace discrimination; and coping strategies for successful functioning.

According to the APA Ethics Code, psychologists "are aware of culture, individual, and role differences, including those due to ... sexual orientation ... and try to eliminate the effect on their work of biases based on [such] factors" (APA, 1992, pp. 1599-1600). Hence, psychologists are encouraged to use appropriate methods of self-exploration and self-education (e.g., consultation, study, and formal continuing education) to identify and ameliorate preconceived biases about homosexuality and bisexuality.

Guideline 3. Psychologists strive to understand the ways in which social stigmatization (i.e., prejudice, discrimination, and violence) poses risks to the mental health and well-being of lesbian, gay, and bisexual clients.

Many lesbian, gay, and bisexual people face social stigmatization, violence, and discrimination (Herek, 1991). Living in a heterosexist society may precipitate a significant degree of stress for lesbian, gay, and bisexual people, many of whom may be tolerated only when they are "closeted" (DiPlacido, 1998). Sexual minority status increases risk for stress related to "chronic daily hassles (e.g., hearing anti-gay jokes, always being on guard)" and to more serious "negative life events, especially gay-relevant events (e.g., loss of employment, home, custody of children, anti-gay violence and discrimination due to sexual orientation)" (DiPlacido, 1998, p. 140). Greene (1994a) noted that the cumulative effects of heterosexism, sexism, and racism might put lesbian, gay, and bisexual members of racial and ethnic minorities at special risk for social stressors.

Research has shown that gay men are at risk for mental health problems (Meyer, 1995) and emotional distress (Ross, 1990) as a direct result of discrimination and negative experiences in society. DiPlacido (1998) reported that research on psychosocial stress factors for lesbian and bisexual women is virtually nonexistent. She suggested that "some lesbians and bisexual women may be coping with stressors resulting from their multiple minority status in maladaptive and unhealthy ways" (DiPlacido, 1998, p. 141). Social stressors affecting lesbian, gay, and bisexual older adults, such as a lack of legal rights and protection in medical emergencies and a lack of acknowledgment of couples' relationships, particularly following the loss of a partner, have been associated with feelings of helplessness, depression, and disruption of normative grief processes (Berger & Kelly, 1996; Slater, 1995). Stress factors have been examined in lesbian, gay, and bisexual youth, for whom social vulnerability and isolation have been identified as prominent concerns. Social stressors affecting lesbian, gay, and bisexual youth, such as verbal and physical abuse, have been associated with academic problems, running away, prostitution, substance abuse, and suicide (Savin-Williams, 1994, 1998). Antigay verbal and physical harassment has been found to be significantly more common among gay and bisexual male adolescents who had attempted suicide compared with those who had not (Rotheram-Borus et al., 1994). These stressors have also been associated with high-risk sexual behavior (Rotheram-Borus, Rosario, Van-Rossem, Reid, & Gillis, 1995).

Lesbian, gay, and bisexual people who live in rural communities may experience stress related to the risk of disclosure because anonymity about their sexual orientation may be more difficult to maintain. Fears about loss of employment and housing may be more significant because of the limited opportunities within small communities. Less visibility and fewer lesbian, gay, and bisexual support organizations may intensify feelings of social isolation. Furthermore, lesbian, gay, and bisexual people may feel more vulnerable to acts of violence and harassment because rural communities may provide fewer legal protections (D'Augelli & Garnets, 1995).

Given the real and perceived social and physical dangers that many lesbian, gay, and bisexual clients face, developing a sense of safety is of primary importance. Societal stigmatization, prejudice, and discrimination (e.g., antigay ballot initiatives or the murders of lesbian, gay, and bisexual individuals) can be sources of stress and create concerns about workplace and personal security for these clients (Fassinger, 1995; Prince, 1995; Rothblum & Bond, 1996). Physical safety and social and emotional support have been identified as central to stress reduction (Hershberger & D'Augelli, 1995; Levy, 1992) among lesbian, gay, and bisexual people.

In addition to external stressors, Gonsiorek (1993) described the process by which many lesbian, gay, and bisexual people internalize negative societal attitudes. This internalization may result in self-image problems ranging from a lack of self-confidence to overt self-hatred (Gonsiorek, 1993), depression (Meyer, 1995; Shidlo, 1994), or alcoholism and other substance abuse (Glaus, 1988). Meyer and Dean (1998) showed that gay men scoring high on a measure of internalized homophobia were significantly more likely than less homophobic gay men to experience sexual dysfunction and relationship instability and to blame themselves for antigay victimization.

Psychologists working with lesbian, gay, and bisexual people are encouraged to assess the client's history of victimization as a result of harassment, discrimination, and violence. This assessment enables the psychologist to understand the extent to which the client's worldview has been affected by these abuses and whether any posttraumatic concerns need to be addressed. Furthermore, the psychological consequences of internalized negative attitudes toward homosexuality and bisexuality are not always obvious or conscious (Shidlo, 1994). Therefore, in planning and conducting treatment, psychologists are encouraged to consider more subtle manifestations of these consequences, such as shame, anxiety, and low self-esteem, and to consider the differential diagnostic implications of such stressors, both historically and in a client's ongoing psychosocial context.

Guideline 4. Psychologists strive to understand how inaccurate or prejudicial views of homosexuality or bisexuality may affect the client's presentation in treatment and the therapeutic process.

Bias and misinformation about homosexuality and bisexuality continue to be widespread in society (APA, 1998; Haldeman, 1994). Because of the stigmatization of homosexuality and bisexuality, it is to be expected that many lesbian, gay, and bisexual people will feel conflicted or have significant questions about aspects or consequences of their sexual orientation (see Guideline 3). Fear of multiple personal losses—including family, friend, career, and spiritual community losses—as well as vulnerability to harassment, discrimination, and violence may contribute to an individual's fear of self-identifying as lesbian, gay, or bisexual. These factors have been considered central in creating a lesbian, gay, or bisexual person's discomfort with his or her sexual orientation (Davison, 1991; Haldeman, 1994). Many clients who are conflicted about or are questioning the implications of their sexual orientation seek psychotherapy to resolve their concerns. A psychologist who harbors prejudice or is misinformed about sexual orientation may offer responses to the questioning or conflicted client that may exacerbate the client's distress (see Guideline 2). Such a stance would consist of a psychologist's agreement with the notion that the only effective strategy for coping with such conflict or discrimination is to seek to change the lesbian, gay, or bisexual person's sexual orientation.

APA's (1998) "Appropriate Therapeutic Responses to Sexual Orientation" policy offers a framework for psychologists working with clients who are concerned about the implications of their sexual orientation. The policy highlights those sections of the APA Ethics Code that apply to all psychologists working with lesbian, gay, and bisexual clients. These sections include prohibitions against discriminatory practices (e.g., basing treatment on pathology-based views of homosexuality or bisexuality), a prohibition against the misrepresentation of scientific or clinical data (e.g., the unsubstantiated claim that sexual orientation can be changed), and a requirement for informed consent (APA, 1992). Based on the APA Ethics Code, the "Appropriate Therapeutic Responses to Sexual Orientation" policy calls on psychologists to discuss the treatment, its theoretical basis, reasonable outcomes, and alternative treatment approaches. In providing clients with accurate information about the social stressors that may lead to discomfort with sexual orientation, psychologists may help neutralize the effects of prejudice and inoculate clients against further harm.

If psychologists are unable to provide this or other relevant information because of lack of knowledge or contravening personal beliefs, they should obtain the requisite information or make appropriate referrals (see Section 1.08 of the APA Ethics Code; APA, 1992). Furthermore, when clients present with discomfort about their sexual orientation, it is important for psychologists to assess the psychological and social context in which this discomfort occurs. Such an assessment might include an examination of internal and external pressures on clients to change their sexual orientation; the presence or absence of social support and models of positive lesbian, gay, or bisexual life; and the extent to which clients associate homosexuality or bisexuality with negative stereotypes and experiences. These and other dimensions of sexual orientation discomfort are important for psychologists to explore, because the meanings associated with them are

invariably complex. The role of psychologists, regardless of therapeutic orientation, is not to impose their beliefs on clients but to examine thoughtfully the clients' experiences and motives. Psychologists may also serve as a resource for accurate information about sexual orientation (e.g., by providing clients with access to empirical data on such questions as the development of sexual orientation or the relationship between mental health and sexual orientation).

Relationships and Families

Guideline 5. Psychologists strive to be knowledgeable about and respect the importance of lesbian, gay, and bisexual relationships.

Lesbian, gay, and bisexual couples are both similar to and different from heterosexual couples (Peplau, Veniegas, & Campbell, 1996). They form relationships for similar reasons (Klinger, 1996) and express similar satisfactions with their relationships (Kurdek, 1995). The differences are derived from several factors, including different patterns of sexual behavior, gender role socialization, and the stigmatization of their relationships (Garnets & Kimmel, 1993). Lesbian, gay, or bisexual people in relationships may seek therapy for reasons common to many couples or for reasons that are unique to those in same-sex relationships (Cabaj & Klinger, 1996; Matteson, 1996; Murphy, 1994).

Common relationship problems, such as communication difficulties, sexual problems, dual-career issues, and commitment decisions, can be affected by societal and internalized negative attitudes toward same-sex relationships. Problems that present in therapy specific to lesbian, gay, and bisexual couples include disclosure of sexual orientation as a couple to family, work colleagues, health professionals, and caregivers; differences between partners in the disclosure process; issues derived from the effects of gender socialization in same-sex couples; and HIV status (Cabaj & Klinger, 1996; Slater, 1995). External issues, such as pressure from families of origin or current or former heterosexual partners, may also arise.

Parenting may present unique issues for lesbian, gay, and bisexual people (possible risks to child custody from previous heterosexual partners or grandparents, lack of legal rights for one of the parents, etc.). Changes in physical health may present unique issues, especially to older lesbian, gay, and bisexual couples (e.g., possible separation and loss of contact for partners in nursing homes or other inpatient settings).

Psychologists are encouraged to consider the negative effects of societal prejudice and discrimination on lesbian, gay, and bisexual relationships. It is important for psychologists to understand that, in the absence of socially sanctioned forms and supports for their relationships, lesbian, gay, and bisexual people may create their own relationship models and support systems. Therefore, psychologists strive to be knowledgeable about the diverse nature of lesbian, gay, and bisexual relationships and value and respect the meaning of these relationships.

Guideline 6. Psychologists strive to understand the particular circumstances and challenges faced by lesbian, gay, and bisexual parents.

Research has indicated no significant differences in the capabilities of lesbian, gay, and bisexual parents when compared with heterosexual parents (Allen & Burrell, 1996; Bigner & Bozett, 1990; Bozett, 1989; Cramer, 1986; Falk, 1989; Gibbs, 1988; Kweskin & Cook, 1982; Patterson, 1996a). However, lesbian, gay, and bisexual parents face challenges not encountered by most heterosexual parents because of the stigmata associated with homosexuality and bisexuality. Prejudice has led to institutional discrimination by the legal, educational, and social welfare systems. In a number of instances, lesbian, gay, and bisexual parents have lost custody of their children, have been restricted in visiting their children, have been prohibited from living with their domestic partners, or have been prevented from adopting or being foster parents on the basis of their sexual orientation (Editors of the Harvard Law Review, 1990; Falk, 1989; Patterson, 1996b).

The primary difficulties that children of lesbian, gay, and bisexual parents face are associated with misconceptions about their parents that are held by society at large. Those in the legal and social welfare systems have raised three areas of concern about the impact that a parent's lesbian, gay, or bisexual orientation may have on children. These concerns include the influence of a lesbian, gay, or bisexual parent on a child's gender identity, gender role conformity, and sexual orientation. The body of research on lesbian mothers is currently considerably larger than that on gay fathers. In a comprehensive review of the literature, Patterson (1996b) concluded that there was no evidence of gender identity difficulties among children of lesbian mothers. She also reported studies indicating that gender role behavior among children of lesbian mothers was within normal ranges. Furthermore, children of lesbian, gay, and bisexual parents appear to be no different than peers raised by heterosexual parents in their emotional development and their likelihood of becoming homosexual (Bailey, Bobrow, Wolfe, & Mikach, 1995; Golombok & Tasker, 1994, 1996).

Psychologists rely on scientifically and professionally derived knowledge and avoid discriminatory practices when conducting assessments for suitability for child custody, adoption, or foster parenting. Psychologists provide accurate information, and they correct misinformation in their work with parents, children, community organizations, and institutions (e.g., educational, legal, and social welfare systems).

Guideline 7. Psychologists recognize that the families of lesbian, gay, and bisexual people may include people who are not legally or biologically related.

The recognition of diverse family forms, including extended and blended families, is central to effective psychotherapy with ethnically and culturally diverse clients (Ho, 1987; Thomas & Dansby, 1985). For many lesbian, gay, and bisexual people, the primary partner, a network of close friends, or both constitute an alternative family structure. In the absence of legal or institutional recognition, and in the face of societal, workplace, and familial discrimination, these alternative family structures may be more significant than the individual's family of origin (Kurdek, 1988; Weston, 1992). The importance of alternative family structures to lesbian, gay, and bisexual adults and youth is not always understood. Furthermore, these relationships have been devalued or denied by some psychologists (Garnets et al., 1991; Laird & Green, 1996).

Social support is an important resource in a heterosexual couple's capacity to handle relationship distress (Sarason, Pierce, & Sarason, 1990). People in same-sex relationships tend to derive less support in adulthood and old age from their families of origin than do their heterosexual counterparts (Kurdek, 1991; Laird & Green, 1996). Close relationships with a network of supportive friends also are considered by lesbian, gay, and bisexual youth to be extremely important. A strong friendship network has been viewed as pivotal in sexual identity exploration and development (D'Augelli, 1991).

Given the importance of social support in overall relationship satisfaction and longevity, psychologists are encouraged to consider the importance of lesbian, gay, or bisexual alternative family relationships. Psychologists are also aware of the stress that clients may experience when their families of origin, employers, or others do not recognize their family structure. Therefore, when conducting assessments, psychologists are encouraged to ask clients whom they consider to be part of their family.

Guideline 8. Psychologists strive to understand how a person's homosexual or bisexual orientation may have an impact on his or her family of origin and the relationship to that family of origin.

Families of origin may be unprepared to accept a lesbian, gay, or bisexual child or family member because of familial, ethnic, or cultural norms; religious beliefs; or negative stereotypes (Chan, 1995; Greene, 1994b; Matteson, 1996). The awareness of a family member's homosexuality or bisexuality may precipitate a family crisis that can result in the expulsion of the homosexual or bisexual member, rejection of the parents and siblings by the homosexual or bisexual member, parental guilt and self-incrimination, or conflicts within the parents' relationship (Griffin, Wirth, & Wirth, 1996; Savin-Williams & Dube, 1998; Strommen, 1993). Even when reactions are more positive, adjustments may be necessary to accommodate a new understanding of the lesbian, gay, or bisexual family member (Laird, 1996). Many families face their own coming-out process when a family member discloses his or her homosexuality or bisexuality (Bass & Kaufman, 1996; Savin-Williams & Dube, 1998).

Families may need to adjust to the loss of hopes, perceptions, or expectations associated with the presumption of heterosexuality (Savin-Williams, 1996). Families may also need assistance in developing new understandings of sexual orientation, in confronting the ways in which negative societal attitudes about homosexuality and bisexuality are manifested within the family, and in addressing difficulties related to societal stigmatization. Psychologists also are sensitive to the cultural variations in a family's reaction and ways of adapting to a lesbian, gay, or bisexual member. Local and national resources are available that can provide information, assistance, and support to family members (e.g., Parents, Family, and Friends of Lesbians and Gays; Children of Lesbians and Gays Everywhere).

Issues of Diversity

Guideline 9. Psychologists are encouraged to recognize the particular life issues or challenges that are related to multiple and often conflicting cultural norms, values, and beliefs that lesbian, gay, and bisexual members of racial and ethnic minorities face.

Racial-ethnic minority lesbian, gay, and bisexual people must negotiate the norms, values, and beliefs regarding homosexuality and bisexuality of both mainstream and minority cultures (Chan, 1992, 1995; Greene, 1994b; Manalansan,

1996; Rust, 1996). Cultural variation in these norms, values, and beliefs can be a major source of psychological stress. There may be no one group or community to which a racial–ethnic minority lesbian, gay, or bisexual person can anchor his or her identity and receive full acceptance. This problem may be an even greater challenge for racial–ethnic minority youth who are exploring their sexual identity and orientation.

In offering psychological services to racially and ethnically diverse lesbian, gay, and bisexual populations, it is not sufficient that psychologists simply recognize the racial and ethnic backgrounds of their clients. Multiple minority status may complicate and exacerbate the difficulties these clients experience. Clients may be affected by the ways in which their cultures view homosexuality and bisexuality (Gock, 1992; Greene, 1994c). The effects of racism within lesbian, gay, and bisexual communities are also critical factors to consider (Gock, 1992; Greene, 1994a; Morales, 1996; Rust, 1996). Sensitivity to the complex dynamics associated with factors such as cultural values about gender roles, religious and procreative beliefs, degree of individual and family acculturation, and the personal and cultural history of discrimination or oppression is also important. All of these factors may have a significant impact on identity integration and psychological and social functioning (Chan, 1995; Greene, 1994a; Rust, 1996).

Guideline 10. Psychologists are encouraged to recognize the particular challenges that bisexual individuals experience.

Bisexual adults and youth may experience a variety of stressors in addition to the societal prejudice resulting from same-sex attractions. One such stressor is that the polarization of sexual orientation into heterosexual and homosexual categories invalidates bisexuality (Eliason, 1997; Fox, 1996; Markowitz, 1995; Matteson, 1996; Ochs, 1996; Paul, 1996; Shuster, 1987). This view has influenced psychological theory and practice as well as societal attitudes and institutions. As a result, bisexuality may be inaccurately represented as a transitional state. Although no evidence of psychological maladjustment or psychopathology has been found, bisexual individuals who do not adopt an exclusively heterosexual or homosexual identity may nevertheless be viewed as developmentally arrested or in other ways psychologically impaired (Fox, 1996).

Negative individual and societal attitudes toward bisexuality in both the heterosexual and homosexual communities adversely affect bisexual individuals (Fox, 1996; Ochs, 1996). Such attitudes may be due to a lack of information about or access to a visible and supportive community of other bisexual individuals (Hutchins, 1996). According to Hutchins (1996) and Matteson (1996), information on community resources can facilitate the development and maintenance of positive bisexual identities.


Psychotherapy with bisexual clients involves respect for the diversity of their experiences and relationships (Fox, 1996; Klein, Sepekoff, & Wolf, 1985; Matteson, 1996). Psychologists are encouraged to adopt a more complex understanding of sexual orientation, rather than a dichotomous model, in their approach to treatment (Matteson, 1996).

Guideline 11. Psychologists strive to understand the special problems and risks that exist for lesbian, gay, and bisexual youth.

It is important for psychologists to understand the unique difficulties and risks that lesbian, gay, and bisexual adolescents face (D'Augelli, 1998). Lesbian, gay, and bisexual youth may experience estrangement from their parents when they reveal their sexual orientation (Cramer & Roach, 1988). When lesbian, gay, or bisexual youth have been rejected by their parents, they are at increased risk of becoming homeless (Kruks, 1991), may resort to prostitution (Coleman, 1989), and increase their risk for HIV infection (Gold & Skinner, 1992) and stress (Hershberger & D'Augelli, 1995; Savin-Williams, 1994). Youth who identify as lesbian, gay, or bisexual at an early age are also at increased risk of becoming victims of violence (Hunter, 1990), even within their families (Harry, 1989); of abusing substances (Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998); and of attempting suicide (Remafedi et al., 1998).

Such difficulties may also complicate the developmental tasks of adolescence (Gonsiorek, 1991). The social stigmata associated with lesbian, gay, and bisexual identity may also complicate career development and choice issues (Prince, 1995). Perceived parental and peer acceptance has an important impact on lesbian, gay, and bisexual youths' adjustment (Savin-Williams, 1989). Although peers and educators may be helpful in improving the psychosocial environment for these youth (J. Anderson, 1994; Caywood, 1993; Lipkin, 1992; Woog, 1995), they may not be useful if they lack the appropriate information and experience. When these potential sources of support are heterosexist, they may cause additional conflict and distress (Martin & Hetrick, 1988; Telljohann & Price, 1993).

Appropriate therapeutic strategies for work with lesbian, gay, and bisexual youth have been described in the professional literature (Browning, 1987; Coleman & Remafedi, 1989; Gonsiorek, 1988; Ryan & Futterman, 1998). Psychologists

strive to create a safe therapeutic context for youth to explore sexual orientation issues. Psychologists should be aware of the ways in which psychological, ethical, and legal issues involved in working with minors are made even more complex when working with lesbian, gay, and bisexual youth.³ 

Guideline 12. Psychologists consider generational differences within lesbian, gay, and bisexual populations and the particular challenges that lesbian, gay, and bisexual older adults may experience.

Psychologists are encouraged to recognize that (a) lesbian, gay, and bisexual people of different generations may have had significantly different developmental experiences and (b) older lesbian, gay, and bisexual people grew into adulthood with peers who shared characteristics that may make them distinct as a generation (Kimmel, 1995). Examples of factors influencing generational differences include changing societal attitudes toward homosexuality, the AIDS epidemic, and the women's and civil rights movements. These cohort effects may significantly influence gay identity development as well as psychological and social functioning (Fassinger, 1997; Frost, 1997; McDougal, 1993).

Psychologists are encouraged to be aware of the special transitions and life tasks that lesbian, gay, and bisexual older adults face, such as normative changes in health, retirement, finances, and social support (Berger, 1996; Slater, 1995). In many respects, these issues are the same as those of heterosexual older adults (Kimmel, 1995; Kirkpatrick, 1989; Reid, 1995; Slater, 1995). However, clients' multiple minority status may exacerbate problems, and gender may create different issues (see Guideline 9; Quam & Whitford, 1992; Turk-Charles, Rose, & Gatz, 1996). Moreover, end-of-life-span tasks for lesbian, gay, and bisexual older adults are often complex and can develop into crises because of psychosocial stressors and heterosexism (Adelman, 1990; Berger & Kelly, 1996). Older lesbian, gay, and bisexual couples present potential issues, particularly because they lack legal rights and protection that are afforded to older heterosexual couples (see Guideline 5). Psychologists are encouraged to (a) be aware that state laws and regulations may affect the rights of their clients and (b) support clients in seeking legal consultation related to medical crises, financial crises, and death.

Older adults are a diverse group, and normative changes in aging may be positive as well as negative and are not necessarily related to pathology or a client's sexual orientation. There are several descriptions of positive adaptation to aging among lesbian, gay, and bisexual older adults (Friend, 1990; Lee, 1987) that may be helpful to psychologists treating these clients. Having already addressed issues of being a stigmatized minority may help older gay men, lesbians, and bisexual people to address ageism and transitions in old age (Fassinger, 1997; Kimmel, 1995).

Guideline 13. Psychologists are encouraged to recognize the particular challenges that lesbian, gay, and bisexual individuals experience with physical, sensory, and cognitive-emotional disabilities.

Lesbian, gay, and bisexual individuals with physical or sensory disabilities may experience a wide range of challenges related to the social stigmata associated with both disability and sexual orientation (Saad, 1997). One concern is the extent to which the individual's self-concept is affected by social stigmata, which in turn may affect the individual's sense of autonomy and personal agency, sexuality, and self-confidence (Shapiro, 1993). For example, people with disabilities may be particularly vulnerable to the effects of "looksism" (i.e., basing social value on physical appearance and marginalizing those who do not conform, for reasons of age, ability, or appearance, to socially constructed standards). Another area of concern relates to how physical disability affects a person's relationships with partners, family, caregivers, and health care professionals. Within partner relationships, there may be issues related to life management, including mobility, sexuality, and medical and legal decision making. Family support may not be available because of negative reactions to the person's sexual orientation (McDaniel, 1995; Rolland, 1994). There may also be stress associated with a lesbian, gay, or bisexual person's need to come out to caregivers and health care professionals (O'Toole & Bregante, 1992).

Lesbian, gay, and bisexual people with disabilities may not have access to information, support, and services that are available to lesbian, gay, and bisexual people without disabilities (O'Toole & Bregante, 1992). Lack of societal recognition for lesbian, gay, and bisexual people in relationships affects those with ongoing medical concerns, such as medical insurance coverage for domestic partners, family medical leave policies, hospital visitation, medical decision making by partners, and survivorship issues (Laird, 1993).

Saad (1997) recommended that psychologists inquire about the person's sexual history and current sexual functioning, provide information, and facilitate problem solving in this area. Studies have reported that many lesbians and gay men with disabilities have experienced coercive sexual encounters (Swartz, 1995; Thompson, 1994). It may be important for psychologists to assess the extent to which the person may have experienced sexual or physical victimization. Finally, given the prejudice, discrimination, and lack of social support both within and beyond the lesbian, gay, and bisexual communities, it also may be important that psychologists recognize that when physical, sensory, or cognitive-emotional disabilities are present, social barriers and negative attitudes may limit life choices (Shapiro, 1993).

Education

Guideline 14. Psychologists support the provision of professional education and training on lesbian, gay, and bisexual issues.

A gap remains between policy and practice in the psychotherapeutic treatment of lesbian, gay, and bisexual clients (Dworkin, 1992; Fox, 1996; Garnets et al., 1991; Greene, 1994b; Iasenza, 1989; Markowitz, 1991, 1995; Nystrom, 1997). Despite the recent addition of diversity training during graduate education and internship, studies have shown that graduate students in psychology often report inadequate education and training in lesbian, gay, and bisexual issues (Buhrke, 1989; Glenn & Russell, 1986; Pilkington & Cantor, 1996) and that graduate students and novice therapists feel unprepared to work effectively with lesbian, gay, and bisexual clients (Allison, Crawford, Echemendia, Robinson, & Knepp, 1994; Buhrke, 1989; Graham, Rawlings, Halpern, & Hermes, 1984). The gap between policy and practice can be addressed by including information regarding these populations in all training programs.

Faculty, supervisors, and consultants are encouraged to integrate current information about lesbian, gay, and bisexual issues throughout training for professional practice. Resources are available to assist faculty in including lesbian, gay, and bisexual content in their curricula (e.g., APA, 1995; Buhrke & Douce, 1991; Cabaj & Stein, 1996; Croteau & Bieschke, 1996; Greene & Croom, 2000; Hancock, 1995; Pope, 1995; Savin-Williams & Cohen, 1996). Psychologists who have expertise in lesbian, gay, and bisexual psychology may be used on a full-time or part-time basis to provide training and consultation to faculty as well as course and clinical supervision to students. Faculty and supervisors may be encouraged to seek continuing education course work in lesbian, gay, and bisexual issues.

Guideline 15. Psychologists are encouraged to increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation.

The APA Ethics Code urges psychologists to "maintain a reasonable level of awareness of current scientific and professional information ... and undertake ongoing efforts to maintain competence in the skills they use" (APA, 1992, p. 1600). It is unfortunate that the education, training, practice experience, consultation, and supervision that psychologists receive regarding lesbian, gay, and bisexual issues have often been inadequate, outdated, or unavailable (Buhrke, 1989; Glenn & Russell, 1986; Graham et al., 1984; Pilkington & Cantor, 1996). Studies have revealed psychotherapists' prejudice and insensitivity in working with lesbian, gay, and bisexual people (Garnets et al., 1991; Liddle, 1996; Nystrom, 1997; Phillips & Fischer, 1998; Winegarten et al., 1994). Preparation for the provision of psychotherapy to lesbian, gay, and bisexual clients may include additional education, training, experience, consultation, or supervision in such areas as (a) human sexuality; (b) lesbian, gay, and bisexual identity development; (c) the effects of stigmatization on lesbian, gay, and bisexual individuals, couples, and families; (d) ethnic and cultural factors affecting identity; and (e) unique career development and workplace issues that lesbian, gay, and bisexual individuals experience.

Guideline 16. Psychologists make reasonable efforts to familiarize themselves with relevant mental health, educational, and community resources for lesbian, gay, and bisexual people.

Knowledge of community resources has been found to be a factor that lesbian, gay, and bisexual clients consider in their selection of psychotherapists (Liddle, 1997; Matteson, 1996). The availability of lesbian, gay, and bisexual community resources varies dramatically according to location; thus, it is helpful for psychologists to know that sources of information and support can be found at the local, regional, and national levels. Several authors have provided discussion and overviews of lesbian, gay, and bisexual communities (D'Augelli & Garnets, 1995; Esterberg, 1996; Hutchins, 1996).

It is useful for psychologists to be aware of the nature and availability of lesbian, gay, and bisexual community resources for clients and their families. Of particular use are organizations that provide support to the parents, young and adult children, and friends of lesbian, gay, and bisexual clients (e.g., Parents, Family, and Friends of Lesbians and Gays; Children of Lesbians and Gays Everywhere); programs that provide special attention to the victims of hate crimes; programs for lesbian, gay, and bisexual youth; and groups that focus on parenting issues, relationships, or coming out. There are also professional organizations and groups for lesbian, gay, and bisexual people of color; groups for people with HIV issues; groups for socializing and networking in business; and groups that can provide spiritual assistance. Electronic resources such as Internet news groups, mailing lists, and web pages can be used by clients and psychologists as valuable sources of information and support. In addition, there are businesses that cater to lesbian, gay, and bisexual clientele. Psychologists who are unfamiliar with local lesbian, gay, or bisexual resources may obtain consultations or referrals from local agencies, state psychological associations, or APA.

AUTHOR'S NOTE

The Division 44/ Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients (JTF) cochairs were Kristin A. Hancock, PhD (John F. Kennedy University, Orinda, CA), and Armand R. Cerbone, PhD (independent practice, Chicago, IL). The JTF members included Douglas C. Haldeman, PhD (independent practice, Seattle, WA); Christine M. Browning, PhD (University of California, Irvine); Ronald C. Fox, PhD (independent practice, San Francisco, CA); Terry S. Gock, PhD (Asian Pacific Family Center, Rosemead, CA); Steven E. James, PhD (Goddard College, Plainfield, VT); Scott D. Pytluk, PhD (independent practice, Chicago, IL); and Arid Shidlo, PhD (Columbia University).

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ENDNOTES

¹Throughout this document, the term clients refers to individuals across the life span, including youth, adult, and older adult lesbian, gay, and bisexual clients. There may be issues that are specific to a given age range, and when appropriate, the document identifies those groups.

²Hereinafter, this document is referred to as the APA Ethics Code.

³Psychologists should be aware of relevant federal and state laws, regulations, and professional standards that address these treatment issues, such as confidentiality and informed consent.

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