Helping Women With Same-Sex Attraction

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I. The Fundamental Need for an SSA Woman: Attachment and Self

The quality of the attachment between a little girl and her mother (biological or step) will directly affect the girl's growth and development of her core self. *Solid, secure and ongoing attachment will typically yield a solid and secure self within a growing and developing girl.* Having a secure and ongoing attachment in her first and most primal relationship will also allow the girl to expect and experience secure and ongoing attachments in her future relationships.

In fact, for females, the self cannot come into existence except through its attachments with others,[1] primarily mother. Therefore, it is devastating and developmentally tragic for a little girl's initial and most foundational attachment with mom to be either nonexistent or fraught with insecurity or disruption, for whatever reason. *An unstable or insecure attachment with mom will usually create an unstable, undeveloped or insecure self within a developing girl*, leading to an overarching sense of not being safe in her skin or secure in the world of relationship.

Typical in the history of SSA women are interferences or failures of attachment with mother rooted in 1) a real maternal deficit or weakness arising out of mother's personal attachment history and developmental difficulties, 2) actual maternal abuse or trauma, 3) accidental separation or 4) a defensive detachment arising out of the daughter's perceptions, sensitivities and immature conclusions and/or beliefs with respect to mother.

This tentativeness in the pre-SSA girl's first experience of relationship may cloud her entire life with an underlying depression, doubt and insecurity.[2] It may also create obstacles not only to a girl's healthy development of a *basic* sense of self but her evolving concept as an unique self, a valuable self, relational self and female self.[3] Typically one, if not all of these internalized senses of self are missing or extremely fragile within SSA women. It is this lack of self and pervasive sense of insecurity that often creates a vulnerability within women to seek a *sense* of self and identity and a

[1] Female developmental theorists react against an objective definition of "a static and lone self" but suggest that the female "self" is inextricably linked to the social or relational interactions with others, primarily mother as her first caretaker. See Miller, 1991, p. 14.
[2] Clinicians specializing in attachment disorders in children note that the attachment between parent and child "profoundly influences every component of the human condition - mind, body, emotions, relationships, and values" (Levy & Orlans, 1998, p. 1).
[3] Siegel (1988) notes, "…because their mothers *appeared* not to love them and produced massive failures of empathy, my patients had no way to delineate a stable self" (italics mine) (p. 41).

sense of security and attachment through a same-sex emotionally dependent relationship.

The lack of a fully developed core self is one of the major distinguishing factors of SSA women. When asked who they are or what they feel, the SSA woman may emphatically exclaim, "I don't know." It is often difficult for the therapist to form a clear picture of the SSA woman's identity and consequently, develop effective treatment goals and plans. The SSA woman experiences a profound disconnection and inability to explore her inner spaces, let alone articulate or invite another into her inner spaces. Every SSA woman is, of course, unique in her own personal degree of growth and development. Some have established a greater sense of self and are able to connect with their inner emotions, desires and likes and dislikes. But even then, there may still be some aspect of either an underdeveloped, unknown or disconnected self.

Unfortunately, these women are therefore trapped within a dilemma:

> *Without a stable and defined self, a woman will not be able to healthily attach, connect or relate as we might expect an adult woman should.*
>
> *Without a secure attachment or consistent connection, a woman will not be able to establish a solid core or sense of self.*

Short of resolving this dilemma, the SSA woman will merely survive in an empty world and empty self or be driven into relationships that may, almost beyond her will or power, become dependent as she seeks to find her core self and home in another. Her most fundamental need therefore, is to simultaneously healthily attach and to discover, accept and solidify her *self* within this connection or relationship.

II. The Fundamental Therapeutic Task:

In order to resolve the above dilemma, we must:

- **Create a safe environment** in which a woman can be real and fully expose her relational difficulties, immaturities and defenses *and* her extremely vulnerable and fragile self,
- **Build trust**, and ultimately
- **Establish a secure attachment** so that *she* can solidify and develop a core sense of self and unique identity.

Additional therapeutic technique and content must be built upon this foundational work.

A. First Task: Creating Safety

A safe place provides emotional and physical protection.
A safe place has a sense of fullness, not emptiness.
A safe place offers care and containment.
A safe place is constant, without shocking surprises.

A safe place promotes respect.
A safe place is warm and relaxing.
A safe place is where you are known and accepted.
A safe place creates trust.
A safe place may become home to the homeless.
A safe place allows you to feel and talk.
A safe place allows you to be yourself.
A safe place is where you can grow and develop.

Due to the lack of a foundational secure attachment, SSA women often struggle with an overarching sense that life or others are not safe. So whether or not the SSA woman is in crisis at the initial stage of therapy,[4] the therapist will need to be deliberate in creating a safe place. The therapist must "prove" by their relational style, actions *and* words that they are a safe person for the SSA client.

The therapist will have a difficult time establishing safety with an SSA woman if they remain in a primary mode of analysis, interpretation or detached objectivity. The SSA woman does not feel safe with inauthentic or detached people. She needs someone real, authentic and caring with whom to connect. It will be within the therapist's connection with the SSA woman that her negative and self-defeating styles of relating, beliefs, patterns and attitudes can be confronted, addressed and experientially changed.

Following are therapeutic styles that can promote a sense of safety for the SSA woman:

- **Go Wherever the Patient Goes**
  Therapists must convey to the patient that their paramount task is to build a relationship together that will itself become the agent of change. It is extremely difficult to teach this skill in a crash course using a protocol. Above all, the therapist must be prepared to ***go wherever the patient goes****, do all that is necessary to continue building trust and safety in the relationship*.[5] (emphasis added)

Yalom's advice is no little thing when working with SSA women. "To go wherever the patient goes" requires a willingness to move, expend energy, make sacrifices and

[4] If a woman first comes to you in crisis due to the deterioration of a current relationship or excessive anxiety due to the unexpected beginning of a relationship, therapy must also be focused around stabilization and containment. If she is losing a relationship, she is experiencing a severe inner trauma that is excruciatingly painful. It can trigger PTSD-like symptoms and lead to suicide ideation. In the cases of possible self-injury or harm, you must intervene as you normally would by using Safety Contracts, psychotropic drugs, 24 hour on-call services, increased sessions and/or hospitalization as a last ditch effort to keep her safe. To maintain some equilibrium in her life, she will need all the resources she can get, including her not-so-healthy addictions, compulsions, and current community that may be primarily made up of lesbian women. Do not confront or require her to cut-off these important aspects of her life. They have been her means of survival. Now is not the time to address them. If you are able to successfully establish the foundation of trust and security as described above, you will have plenty of time in the future to address her survival modes.
[5] Yalom, I. (2002), p. 35.

perhaps even take risks on our parts as therapists. In other words, if the SSA woman with whom you work is not able to go to her abuse memories but wants to focus on her current relationship, you defer to her direction. After safety and trust have been established, she will be able to follow your lead.

- **Mirror and Remain Attuned**

Mirroring is a powerful technique that can communicate to an SSA woman that you are "with" her. This also creates a sense of safety. If my client has her chin lowered as she speaks, I lower my chin in a similar fashion. As she moves her body to the side and tilts her head, I mirror her shifting my body and tilting my head. As she glances out the window, I follow her glance, and then re-center my gaze on her face. When she smiles, I smile. When she is frowning, I frown with her. As she exudes a certain level of intensity in our conversation, I match her intensity as I speak and gesture. As she speaks metaphorically to describe, for instance, the condition of her heart, I respond using *her* metaphorical language. It should be our goal to stay attuned and engaged with each woman's inner experience and process as well as her unique temperament and stage of development.

- **Expect Defensiveness and Mistrust**

Unfortunately, many SSA women have unconsciously convinced themselves that "no one really cares" and "no one is truly safe." Trust has been betrayed in the past and relationships have been disappointing and painful. Therefore the SSA woman's survival has depended on the actual avoidance of trust and closeness. This is one reason why establishing safety and building trust must be deliberate and cannot be handled casually with the SSA woman. Do not expect your new SSA client to immediately appreciate or warmly respond to your efforts to offer safety and emotional connection.[6] She may:

- **Remain shut down and closed off.**
- **Question your sincerity and intentions, which may leave you questioning hers.**
- **Operate within her entrenched negative beliefs about others and the set roles and responses she has unknowingly established to protect herself.**

"A human being cannot suddenly give up all the images, roles and symbols of his existence, for he would have to face the unknown with extreme fear. He needs someone who can take him into and through his disorderedness to the reality of his impulses, thoughts, and expressions. He needs to make contact with another human being."[7] (emphasis added)

[6] Not *all* SSA women will present in such defended postures. Many, who have reached greater levels of maturity and healthy development, will be able to accept your involvement and care, although may still have vestiges of defensive detachment and other hidden defense mechanisms. But for those who have never fully entered into an experience of safety and trust, they will need to be convinced again and again of your safety and trustworthiness.

[7] Karle, W., Woldenberg, L. & Hart, J. (1976), p. 84-85.

As therapists, we must we able to weather an SSA woman's "disorderedness" if we are to establish safety and trust. This is similar to "going where she goes" or entering her existing world. Melanie, a 45-year-old woman who had embraced a lesbian identity for over 11 years, told me about her experience with a previous therapist. In their second or third session, Melanie felt such agitation that she got up out of her chair and began to pace as she and her therapist continued to talk.[8] Melanie's therapist eventually asked her to sit down because Melanie's walking distracted her. As you might guess, Melanie never returned.

What an opportunity this therapist missed. For whatever reason, she was unable to step into Melanie's "disorderedness." If she had merely asked Melanie what she was feeling as she paced, she would have made huge inroads with her client. *We must meet the SSA woman where she is* and not expect mature healthier relating until she has grown in her maturity and health. If we come with an expectation of how she should behave or operate within the therapeutic relationship, she will feel potentially dishonored, unknown, extremely insecure and ultimately unsafe.

- **Rely on defenses such as sarcasm, humor or intellectualizing to *gain* a sense of safety and distance.**

Safety for many SSA women is to *not* feel safe. Feeling safe means that her defenses may fall. She cannot allow this to happen, it is too risky. Feeling safe may also mean that she will feel other feelings that she has defended against perhaps her whole life. This prospect may also scare her. So as soon as a sense of safety or trust begins to develop, she may automatically react with an effort to defend against it. This requires the therapist to be patient and persevering with an SSA woman.

There have been many instances where I have relaxed into a comfortable sense of warmth and mutuality with a client, only to be abruptly awakened by a sarcastic or mocking response to my last heart-felt remark. It is crucial at these moments to remind myself that essentially, my client *was* feeling safe, but does not yet trust me to the point of allowing herself to rest in the *experience* of safety. She will need more time. I must respond with kindness and patience, not frustration and anger. When an SSA woman finally makes a choice to allow herself, perhaps for the first time in her life, to *feel* safe, you can be assured that the development of trust is well underway and you are on holy ground.

B. Second Task: Building Trust

Building trust with an SSA woman is *not* the same as building rapport with other clients.

[8] Often our body is used to relieve or process internal emotions and conflicts. This can be especially true of SSA women. Siegel notes "Often this use of bodily communication made for tense, restless sessions. The analysands could find no comfort, or even a comforting and comfortable position on the couch. At other times, I was implored to give answers immediately, to advise, and to guide" (Siegel, 1988, p. 40-41). I have had clients walk, sit on the floor, lay on the couch, ask to sit in my chair, cover themselves completely with pillows, throw pillows, abruptly stand to their feet, etc.

As you confront a woman's defensive maneuvers, you may be tempted to believe that she knows how to trust, but is simply refusing to trust. This is rarely the case. It is possible that the SSA woman with whom you work has *never* trusted anyone, and that includes God. Even though she may be very committed to God, at her core, she may believe God's promises are for everyone else but not for her. She may have had a glimpse of trust at the beginning of her spiritual journey or in the midst of one of her emotionally dependent relationships, but it was merely fleeting. She therefore may have no basic *sense of trust.* This also means that she has never had the opportunity to develop the full *capacity to trust.*

Fortunately, as *growing and developing* human beings (creatures who are in perpetual process of *becoming*), we can always be optimistic that what was seemingly lost or underdeveloped in our previous stages of development, can be addressed and appropriated in our future stages of development. In fact, attachment specialists note that as we continue to interact with our environment, we can indeed change our "emotional, behavioral and social traits and outcomes." Our inherent capacity to always grow and develop also "indicates that outside forces, such as effective parenting programs and *therapeutic interventions*, can go a long way towards attenuating early difficulties" (Levy & Orlans, 1998, p. 20).

Erik Erikson, in *Identity and the Life Cycle,* discusses the nature of effective therapeutic intervention with those struggling with deep mistrust in others and themselves. He suggests that, essentially, the therapist "must take over the task of a mother who introduces a baby to life's trustworthiness" (p.144). This means we must offer the same consistency, constancy, warmth, attentiveness, caring, gentleness, patience and unconditional love and regard that a good healthy mother would normally offer to her child.[9] If we regularly and consistently offer the traits of good mothering, combined with a long-term commitment to the SSA woman, trust will naturally develop, but only after she has thoroughly tested your consistency and commitment.

Establishing trust, in and of itself, *is* one of the most curative or healing aspects of the work you will do with an SSA woman. Never minimize the time that may be required to build trust. Of course, if you want a woman to trust you, then you must first establish yourself as trustworthy. The following is a practical list of behaviors and attitudes that, from an SSA woman's perspective, are generally considered traits of a trustworthy person:

- You are safe, as described in the discussion above
- You can give without expecting something in return
- You can handle her

[9] This does *not* mean that we can literally reparent her by directly meeting her primal need for such bonding experiences as nursing, cuddling or holding. But we can offer a nourishing and holding *environment* in which a woman's process of growth and development can be reinstated along the same trajectory or path that would have otherwise been taken had she had her attachment needs originally met. An adult woman can continue to *become* a unique self and grow and develop relational capacities.

- You view testing behaviors as a sign of fear and anxiety, not meanness and resistance
- You are patient
- You keep your promises
- You are consistently available for regularly scheduled appointments
- You show up on time for appointments
- You don't cancel unless there is an emergency
- You make sacrifices for her well-being
- You do *not* cross boundaries
- You will not take advantage of your power
- You will not use her
- You are genuine and real
- You allow her to see your humanity and "journey in life" when appropriate
- You care
- You show your emotions
- You apologize and own your failures
- You are honest and straightforward (no nonsense)
- You are not afraid, even if she says she is in love with you or says she hates you
- You genuinely enjoy her
- You never shame or humiliate
- You are willing to take all the time necessary to earn her trust

Unconditional Acceptance

Acceptance is not the same as condoning or affirming. I don't condone child abuse, but I accept that it is a reality within our confused and broken world. I don't affirm and encourage manipulation as a means to get your needs met, but I accept that I and most other people use manipulation, from time to time, for this very purpose. Unconditional acceptance of an individual is not condoning or denying aspects of their self or life, but is the willingness to know, love and journey with them, just as they are. In the initial stage of therapy with an SSA woman, you will need to be *accepting* of:

- The existence of her same-sex attractions and behaviors
- How she looks
- How she dresses
- How she acts
- The type of work she does
- The car (truck) she drives
- Her specific goals for therapy
- Her partner or spouse
- Her attitude towards men and towards women
- Her spiritual beliefs

It is not advisable to initiate a challenge, confrontation or even a conversation on any of

these aspects of her life until a firm foundation of trust as been established. These issues should not be dismissed as unimportant. They are, however, superficial to our primary goal of building trust and forming a solid attachment.

For trust to firmly develop, a woman will need to know that she is loved and accepted for who she is, right now. If she believes that she has to *change* before you can accept her, she may merely repeat her impulse to "please others" instead of completing the essential work of inner formation. As we unconditionally accept an SSA woman just the way she is, she is being given an opportunity to begin to accept her self, just the way she is.

It may also take time for your client to recognize that her trust in you can be trusted. It is one thing for an SSA to realize that you are trustworthy, but another for her to *trust her judgment* that you are trustworthy. It is a big step for her to admit to herself that she does indeed trust you. However, once she makes that one simple (yet huge) admission, she can begin to focus on other aspects of her life versus merely securing your own safety. Siegel (1988) notes that as clients first learn to trust in the therapeutic process and then trust the therapist, they "were able to confront their early deprivations and [perceived] lack of appropriate mothering" (p. 30).

C. Third Task: Establishing the Attachment

The final therapeutic task in the initial stage of work with an SSA woman is to establish the secure attachment that was "lost" or missing in the woman's childhood. She needs an *attachment* defined in the most classical sense: a warm and enduring bond between herself and a parent figure. In turn, as already mentioned, this secure attachment will allow her "to develop into an autonomous, distinct individual" (Levy & Orlans, 1998, p. 23), the overarching goal of this stage.

Levy and Orlans (1998, pp. 112-144), specialists in corrective attachment therapy with children note that the following ingredients are essential to the therapeutic process:

- structure
- attunement
- empathy
- positive affect
- support
- reciprocity
- love

These are the same ingredients necessary for establishing a secure attachment with an SSA woman; the most important of course, is love. The second most important is empathy. It is to this, and other relational processes that we now turn our attention.

III. The Primary Therapeutic Processes: Empathy and the "Here-and-Now"

A. Empathy

"*Therapy is enhanced if the therapist enters accurately into the patient's world. Patients profit enormously simply from the experience of being fully seen and fully understood."*[10]

Empathy is when one person steps into or momentarily comprehends and experientially shares the psychological and emotional state of another person. If you are the one receiving empathy, it is that moment when you experience the warm feeling of being completely heard, understood and known. It can feel like relief (I am finally understood) and oneness (I am joined with the one who understood) at the same time. *Empathy is the conduit through which care and compassion flow and on upon which secure attachment is based*. Empathy is the basis of a "holding environment." As illustrated in the following dialogue, creating an empathic environment involves:

- A primary focus on the person's inner needs and emotional experience (attunement),
- A release of focus on *content* of immediate situation,
- Accurate mirroring and validation,
- Genuine care and curiosity,
- Encouragement and support, and
- Possible identification with a person's feelings.

"Hi Stephanie, how are you doing today?" asks the therapist.

"Oh, I'm just fed up with everything," announced with an exacerbating tone. "I'm tired of processing, I'm tired of my depression, and I'm tired of counseling. Nothing is helping. It's no use. And *you* really made me mad last week."

"I can hear how tired and hopeless you are. You also sound angry with me (*accurate mirroring and validation*). All of these are important issues. Which one would you like to talk about first?"

"Oh I don't know and I don't care, you pick."

"Okay, let's go with the anger. You said you were mad at me last week. It must have been hard for you to come in today." (*Focus on her inner experience with care and compassion. I do not yet focus on the content of why she became angry*.)

"Yes," as she nods her head.

"Did you think about canceling?" (*Identification with her experience. If I had felt anger towards my therapist, I would have thought about canceling*.)

"Yes - but I decided, 'What the hell, if I can't tell *you* when I'm mad then what good is it for me to keep coming?'"

[10] Yalom, I. (2002), p. 18.

“Thank you Stephanie for trusting me enough to admit your true feelings (*encouragement and support*). I would have been disappointed if you had canceled (*genuine care*).

Pause, to see if she wants to say more about her process.

“It must have been very difficult to feel so angry during this past week (*genuine care*). Can you tell me more?” (*genuine curiosity*).

The therapist enters her world by exploring her feelings, their intensity and her process and experience of bearing up under the feelings. The therapist does not focus on the *content* of Stephanie’s anger, at least not at first. Nor does the therapist become defensive. For empathy to have its positive curative effect, the therapist must set aside their counter-transferences or reactions to the client’s attitudes, beliefs and accusations. After the client experiences empathy and compassion, then the cause of her anger can be explored.

“So, do you think you can tell me what specifically made you mad last week?” asks the therapist?

“I guess so. It was when we were talking about my relationship with Susan. At one point you emphasized how I knew, even before we got involved, that she probably wasn’t going to stick around. But when you said that, you pointed your finger at me. I felt like a child, like I was being scolded. I don’t deserve that from you.”

“You are right Stephanie, you don’t deserve that from me. I can see why you were upset with me.”

“You reminded me of my dad. He used to wave his finger at me all the time.”

“Oh I’m so sorry you thought I was scolding you. How difficult that must have been for you. I know that if I was in your shoes and felt scolded by my counselor, I would feel extremely hurt and angry. Thank for letting me know how I affected you.” *Pause for response and more interaction*.

“Stephanie, could you tell me more about a particular time your dad was waving his finger at you and scolding you. Does one stand out to you?” (Stephanie and her therapist can now safely move - together - into the historic material that may have been behind her strong reaction in the first place.)

If Stephanie had asked what her therapist was thinking when they waved their hand, the therapist should be completely honest about their feelings, thoughts, awareness or lack of awareness of their gesture. However, a therapist must be careful to not invalidate Stephanie’s feelings by offering this information out of hand. It is far more important to validate and empathize with Stephanie’s pain and anger than for the therapist to explain or defend herself. It is through this empathy that Stephanie will gain the sense that her therapist is *with* her, or in other words, attached, albeit as an imperfect person.

While admitting there are risks involved in empathy, Siegel (1988), after having worked with several SSA women, agrees with the observation that “freely hovering attention, trial identification, and *empathic immersal* are the only means that have been found to

grasp more fully the infantile needs of developmentally arrested patients" (emphasis added) (p. 43).

If we want to be able to get to the very core of an SSA woman's need, we will have to reassure her that we will go *with* her into the pain and emotions of her core needs through the avenue of empathy. She will not be able to *go* alone. Use empathy:

- **Before you address core negative beliefs or distorted views.**
- **When you've accidentally offended your client.**
- **To address defensive behaviors.**
- **To confront.**
- **When you don't know what to do.**
- **To contain and reassure her at the end of a session.**
- **To level the playing ground (friend vs. expert).**

Empathy can be strengthened by the ongoing use of:

- **Validation**
- **Mutuality**
- **Authenticity**
- **Reflective listening**
- **Encouragement**
- **Affirmation**
- **Light heartedness**

B. Here-and-Now versus Insight Oriented Therapy

The here-and-now process is another primary and effective therapeutic process with SSA women. "The here-and-now refers to the immediate events of the therapeutic hour," not the goals or outcomes of our agenda or treatment plan. It is what *happens* between the therapist and the SSA woman *is* most substantial and important. The here- and-now approach to therapy "de-emphasizes (but does not negate the importance of) the patient's historical past or events of his or her outside life," while emphasizing the curative power of a meaningful heart-felt connection with your client (Yalom, 2002, p. 174).

Yalom (2002) notes it is common for many therapists to "place a far higher value than patients on interpretation and insight. We therapists grossly overvalue the content of the intellectual treasure hunt; it has been this way from the very beginning" (p. 46). The SSA woman values and benefits from the process of the "hunt" much more than the insight gained. As therapists, we must enter into the process or adventure of building a real relationship with the SSA woman.[11] We must decide in any given moment whether

[11] In interpersonally focused attachment therapy, goals or change might be measured in terms of a woman using fewer pillows for protection, increasing eye contact, fleeting connection with an emotion and/or being open to receive a warm caring comment.

it is more important that the client understand (for example) why and how she developed her defensiveness *or* to experience, in the present moment, an open, intimate and unguarded relationship.

Until an SSA woman has a sense of safety, trust and a growing foundation of a core self, she will not be able to fully appreciate our "sagely wisdom," or insightful analysis or interpretation. She is ultimately looking for someone who cares, who can be *with* her in a heart-felt sense and will commit to her over the long haul. Analysis and interpretation are useless if she is going to be required to continue to walk through life alone. She intuitively knows that relationship is what she needs, more than information or even understanding.

When the time *is* appropriate for analysis and interpretation, it is always best to return to the here-and-now by asking a question such as "How are you feeling as we discuss your attraction to Annie?" Empathy can then be relied upon to help your client regain a sense of your care and compassion and reconfirm that she is indeed, still securely attached. Because our goal is to establish an *ongoing* secure attachment with the SSA woman, empathy and here-and-now processing should always be relied upon whether you are in the first, middle or final stages of therapy.

IV. Conclusion

The process of attaching may be traumatic for the SSA woman. It may disrupt every defense, fear, false belief and pattern of isolation and self-protection she has ultimately survived within her entire life. If this indeed is the first time your client has attached, the fear of being hurt or losing you will be immense. You must therefore be willing to make a long-term commitment even before you ever agree to see her for the first time.

As the SSA woman becomes convinced that we are willing to go wherever she goes - or wherever she *is*, she will begin to feel validated, accepted and ultimately safe and cared for. Built on the foundation of trust, a secure attachment and connection can be formed and *she* will be able to grow as the unique and special woman she was designed to become. She will fill out her inner spaces and eventually be able to enter another's world without dependency, fear or defensiveness. This is the basis of healthy adult intimacy. And it is this, the *real and true* gift of human connectedness that we are privileged to offer the women God directs into our presence.

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