ISSUES IN THERAPY WITH LESBIAN, GAY, BISEXUAL AND TRANSGENDER CLIENTS

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OPEN UNIVERSITY PRESS
Buckingham · Philadelphia

Open University Press
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world wide web: www.openup.co.uk

and
325 Chestnut Street
Philadelphia, PA 19106, USA

First Published 2000

A catalogue record of this book is available from the British Library

ISBN 0 335 20331 0 (pb) 0 335 20332 9 (hb)

Library of Congress Cataloging-in-Publication Data
Issues in therapy with lesbian, gay, bisexual and transgender clients / edited by Charles Neal and Dominic Davies.
p. cm.
Includes bibliographical references and index.
ISBN 0–335–20332–9 (hb) — ISBN 0–335–20331–0 (pbk.)
1. Gays—Mental health. 2. Bisexuals—Mental health. 3. Gays—Counseling of. 4. Bisexuals—Counseling of. I. Neal, Charles, 1948– II. Davies, Dominic, 1959–
RC451.4.G39 I87 2000
616.89′0086′64—dc21 99–056819

Typeset by Graphicraft Limited, Hong Kong
Printed in Great Britain by Biddles Limited, Guildford and Kings Lynn

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Denis Bridoux is a counsellor, a wellness coach and a licensed NLP trainer based in Yorkshire. He is a member of *Kink Aware Professionals*, an international body supporting the needs of the SM and sexual edge communities. Secretary of Halifax Area Gay Group from 1982 to 1992, he was involved with the establishment and running of HIV voluntary organisations in Yorkshire in both voluntary and management capacities from the mid-1980s and AIDS/HIV coordinator for South Humberside Health Authorities from 1991 to 1995. Denis runs licensed NLP courses for health-related professions with *Post-Graduate Professional Education*, for gay men as

Outcome, and business coaching on the telephone as *EnVision*. He was recently made Honorary Fellow of the international *Institute for Neuro-Semantics*® for his contributions to the expansion of the field.

Dominic Davies is a BAC accredited and UKRC registered independent counsellor and therapist who has been practising in the person-centred approach for 20 years. He was co-chair of the Association for Lesbian, Gay and Bisexual Psychologies UK, and co-editor with Charles Neal of *Pink Therapy* and *Therapeutic Perspectives on Working with Lesbian, Gay and Bisexual Clients* (Open University Press 1996 and 2000 respectively). Dominic runs an international consultancy developing sexuality training for therapists and other helping professionals in Europe and Australasia. He is a Visiting Fellow of Nottingham Trent University.

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Claire A. Lucius has worked as a counsellor in both university and health settings since 1991. She currently works in London and Brighton as a counsellor and supervisor in primary care and in private practice. She is a UKRC registered independent counsellor and a BAC accredited counsellor.

Timothy McMichael is a therapist, supervisor and trainer from the person-centred tradition. Using expressive therapy in differing forms for nine years, he passionately believes it helps in unlocking repressed gay identity. Away from counselling he's a family mediator and sometimes works in finance. Home is West London where he's 'married' to Glen who, along with his dearest friend and colleague Amanda Davidson, provides so much inspiration and encouragement to work and play expressively.

Ian McNally works as a clinical psychologist at the Royal London Hospital in Whitechapel and in private practice. He specialises in sexual health and HIV-related problems and is conducting research into transcultural aspects of male sexual problems. He is currently completing training as a cognitive analytic therapy (CAT) practitioner.

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Elizabeth Oxley qualified as a clinical psychologist 20 years ago. She has worked in a number of specialisms including adult mental health, substance misuse and sexual health. She established and managed a successful drugs team and has conducted research into service delivery and quality in drugs and HIV services. More recently she has worked extensively with people who have experienced serious sexual abuse or trauma. She favours an integrative, questioning approach.

Fiona Purdie is a BAC accredited counsellor who has been trained in both the person-centred approach and as a Gestalt psychotherapist (Metanoia). She has worked with survivors of childhood sexual abuse for over two decades, first as a social worker and founder member of ChildLine and latterly as a therapist and supervisor in private practice. She has extensive experience of training counsellors and therapists and taught at Metanoia in London for five years before moving to the East Midlands. Fiona currently works as Senior Lecturer in Counselling and Psychotherapy at Nottingham Trent University and also trains counsellors at Temenos in Sheffield.

Ian Rivers is currently Senior Lecturer in social psychology at the University College of Ripon and York St John. He is an active researcher in the field of human development and his previous work has included a study of the nature and long-term implications of bullying at school for lesbians, gay men and bisexual men and women, partly funded by the Froebel Educational Institute and the University of Luton. His current research interests surround the social implications and development of sexual orientation, and in particular bisexuality.

Jan Schippers studied clinical psychology at the Vrije Universiteit in Amsterdam. For 14 years he worked at the SAD-Schorerfoundation, the Dutch national agency for homosexuality, specialising in psychotherapy and psychosocial care for gay men. During this period he wrote several books and many articles on these issues. In 1996 he published his doctoral thesis, *Gay Identities* at the medical faculty of the University of Amsterdam. Since 1996 Jan has worked as a psychologist-sexologist at the Leijenburg Hospital in The Hague.

Tony Zandvliet studied social sciences at the University of Amsterdam, majoring in psychology, sociology and political science and training in

psychotherapy. Since 1987 she has specialised in gender identity development and has an independent practice as a gender therapist in Amsterdam and London. Tony also lectures and is a consultant for individuals and groups concerned with the social and political implications of transgender and sexuality, including relatives, partners and children of trans people.

MOIRA WALKER

Foreword

I am delighted to write this brief introduction to what promises to be a further valuable addition to the literature on gay affirmative therapy, following the first two volumes in this trilogy. This has been an area previously consistently neglected in the therapeutic literature and often sidelined, misunderstood, or avoided in both therapeutic practice and training. As a result, counsellors and therapists have been misinformed or uninformed: inevitably this has resulted in clients not always receiving a sufficiently sensitive, knowledgeable and respectful response. Prejudices, stereotypes and oppression have been rife both in a wider society and within some 'therapeutic' circles.

This book marks a significant step forward in informing and challenging. It puts firmly on the therapeutic map an area that should have been there long ago. The rapid success of the first volume has demonstrated that the demand for good literature, in what has previously been marginalised and invalidated as supposedly an area of minority interest only, is very considerable. This success reflects the growing awareness among counsellors and therapists, both those who would identify themselves as members of sexual minorities and those who do not, of the need for a greater knowledge base, a greater skill base, and far more awareness of the complexity of issues that can be presented. This volume and the others in this trilogy also succeed in making this complexity of ideas, subjects and material accessible to a wide range of readers working across a variety of helping contexts. It brings together an impressive array of authors representing a range of theoretical approaches and key areas.

The subjects covered in this volume are crucial to effective practice. It offers therapists, counsellors and others insights and information into aspects

of their work with lesbian, gay, bisexual and transgender people that they will not find elsewhere. Some of the material will be challenging to some readers in terms of their existing knowledge and pre-conceptions. Stereotypes are recognised and described, questioned and challenged; myths and prejudices are explored; and areas of particular concern and relevance are highlighted and analysed in terms of their origins and their ongoing impact. Such challenges and questions are essential if counsellors and therapists are to offer a service to clients that is relevant to their experiences of themselves and their world, and that recognises the impact of a wider culture.

The book is particularly valuable in that the authors and editors have a wealth of practical experience that is effectively communicated to the reader. Practitioners will benefit greatly from the suggestions for good practice that are a theme running throughout these chapters. Clinical practice and clinical issues are emphasised and explored sensitively and creatively. Through this book, readers will find access to both an increased theoretical awareness and an important contribution to the range of their therapeutic skills.

Finally, as a trainer and a practitioner myself, I would like to thank the editors and all the authors for the contributions they make in this volume. It poses both a crucial challenge to many existing ideas and, perhaps most importantly, thereby contributes to improving the therapeutic responses to our clients.

Moira Walker
Leicester

Acknowledgements

Dominic wishes to thank all his close friends and colleagues for their support and encouragement to undertake and pursue this project. He is also grateful for the expert consultation of Mani Bruce Mitchell on aspects of the book.

Charles offers loving thanks to Rex Bradley, Terry Cooper and Jenner Roth, for so many years as wonderful teachers, and Dominic Davies, for doing more than his fair share of this work, when life was difficult for me, with such good grace. Without the love of my sons, my sister, my mother and my dear friends, I would not be able to sustain my work.

The editors would like to thank Michael Jacobs for his valuable feedback and editorial support and all our contributors for their patience and commitment over a long period. We also thank Natalie Rogers and Science and Behavior Books for permission to use her illustration in Chapter 5.

CHARLES NEAL AND
DOMINIC DAVIES

Introduction

Welcome to the last in our trilogy of independent, closely related texts on what is currently known as 'gay affirmative therapy'. It has been vital to address issues for clients and practitioners about counselling and therapy with people from sexual minorities: there had been a dearth of constructive European material for clinicians, trainers, researchers and supervisors in this expanding field. In this volume we seek to further challenge prejudices and misconceptions about various aspects of living as lesbian, bisexual, transgender or gay people.

How healthy is gay affirmative therapy for the new millennium? We have now demonstrated that gay affirmative therapy is basically *person* affirmative and that therapists do not use a separate body of techniques and skills, but instead need a level of self-awareness and comfort with sexuality *per se*, and homosexuality in particular. Most practitioners like to claim an ease with sexuality and many claim expertise in working with clients from sexual minorities. Few UK therapy and supervision training programmes, however, include much in the way of personal development on human sexuality: even more rarely do their curricula include working with clients from sexual minorities. We know of no courses teaching 'gay positive' theories of child development or human relationships. Many therapists seem to feel that a common sexual orientation is by itself a qualification for working with clients from these minorities. We do not agree!

We are saddened by dwindling support for the Association for Lesbian, Gay and Bisexual Psychologies UK which one of us founded, both have chaired, and of which most of our contributors have been members, and the corresponding decline in the European network. Our training conferences and seminars were precious opportunities for practitioners to

share queer issues safely. Judging by advertisements in the gay press, plenty of therapists want to work with homosexual and bisexual clients. What a pity so few treat their responsibilities seriously enough to contribute to a healthy national professional association! There remains so much to do.

It is also lamentable that the British Association for Counselling and the United Kingdom Council for Psychotherapy have yet to develop lesbian or gay sections equivalent to those long established in the USA. Such a section was finally established at the end of 1999, after a lengthy struggle by the British Psychological Society to resist: congratulations! As we write the Labour government, upon which many pinned high hopes of legislative change against homophobic discrimination and injustice, has failed to deliver substantive change.

Some chapters here reveal the grim consequences for young people. For example, Ian Rivers, an academic psychologist, discusses the lifelong effects of a widespread form of abuse: bullying. His groundbreaking research at the University of Luton horrifyingly reveals children's daily experiences of homophobia in action and the long-term consequences for self-esteem, intimacy, trust and depression in adulthood. His work is invaluable to clinicians and educators and demands addressing in our schools and wider communities. How can we protect our children and young people when educators remain afraid to be seen as 'promoting' homosexuality?

Abuse continues in other forms. Fiona Purdie writes from extensive clinical experience with 'survivors' of sexual abuse. Many practice issues are shared with other survivors, yet inadequate attention has been paid to the specific contexts, power dynamics and issues for children from sexual minorities who are abused, in spite of their over-representation in both sexually abused, and client, populations. Purdie examines some underlying myths and suggests ways of working ethically.

The need to heal the wounds of homophobic oppression also continues. Pavlo Kanellakis explores the impact of HIV not only for those who are infected, but also for others who are affected – partners, friends, families, practitioners and gay, lesbian and bisexual communities as a whole. He explores the traumatic effects of adjusting to multiple cumulative losses and the relevance of psychosocial factors, particularly social support, in maintaining wellness. Kanellakis importantly highlights the effects of working with these client groups on the therapist's own well-being.

Timothy McMichael shows how creative techniques help clients rediscover their creativity and self-awareness when so many queer people have learned to repress these parts of themselves, and this has stunted their fuller growth. He offers numerous practical methods for working creatively at the client's pace towards self-actualisation. Some practitioners will find these techniques especially challenging and others will be inspired.

Charles Neal shares his experience, methodology and influences in working with gay men in groups through explorations of being male, gay and in groups. He discusses what seems important about these identities, and how vital the healing of group work can be. He describes the styles, exercises and foci which have proved valuable and what emerges from group members' own feedback.

European Association for Lesbian, Gay and Bisexual Psychologists' founder, Jan Schippers, has considerable experience demystifying issues of gay male sex and sexuality. Here he explores the awkward relationship between intimacy and sex in male subcultures and advances a theory about 'sexual lovestyles'. Other issues illustrated through his case examples include body image, identity development and aversion to anal sex.

Exclusion continues and the ostracism of minorities is not just by majority cultural groups. In this volume we learn about the particular issues faced by people frequently excluded by homosexual and bisexual communities and practitioners. Rita Brauner, for instance, stresses the importance of practitioners processing their own history around culture, race and ethnicity and of clearly addressing differences between client and therapist, not ignoring these. She explores racism and heterosexism in therapy and the dangers of holding a solely 'White' perspective.

Elizabeth Oxley and Claire A. Lucius believe distinctly bisexual experience remains underrepresented in traditional or 'gay affirmative' psychology. They look at definitions of bisexuality and some consequences of embracing such an identity and outline issues clients may bring and what therapists need to address themselves, as well as giving examples of helpful and unhelpful practice.

Tony Zandvliet challenges us to reconsider gender and sexuality through some experiences and issues for transgender people. In her critique of clinical assumptions she argues that, while changing gender has implications for sexual orientation, the concepts of gay, lesbian, straight and bisexual imply dichotomies that are undermined by transgender. Her case studies, discussion and practical guidelines increase our awareness and the sensitivity of our responses to clients.

And there are still taboo subjects. Denis Bridoux addresses working with clients interested in SM sexual practices and 'kink' lifestyles. Despite a rapidly expanding 'kink' community in the UK, clients are wary of discussing their issues because of ignorance and prejudice on the practitioner's part. Bridoux discusses common myths about SM and gives guidelines for working respectfully.

Further taboos are challenged when ethical dilemmas arise from dual relationships between practitioners and clients living in the same or overlapping communities. These are explored by Lynne Gabriel and Dominic Davies. Theoretical and ethical perspectives are related to the management of such dilemmas, including boundary maintenance, and Gabriel's problem-solving models are applied to practical examples.

Ian McNally and Naomi Adams, psychologists in sexual health clinics, challenge heterosexist paradigms of treatment for sexual problems. They root their theoretical and practical experience in a clinical context via case studies which illustrate affirmative, culturally sensitive ways of working with specific issues of sexual functioning which clients from sexual minorities bring.

These texts go some way to providing information about how to work ethically with lesbian, gay, bisexual and transgender clients: they are not a substitute for the deep personal development and training needed to provide a high-quality service. It is not sufficient to read texts. It takes extraordinary hard work in personal therapy and supervision with therapists and supervisors with whom one feels safe enough not to self-censor, or hide one's shame, grief and discomfort with oneself. Too often therapists (queer ones perhaps more than most) are unable to admit failings and lack of knowledge, paying lip-service to political sensibilities instead. We have been trained all our lives to 'pass' and curry favour, to make ourselves acceptable to powerful majority communities. Supervisors and trainers are too frequently identified with those communities.

As editors, practitioners and trainers, we are increasingly developing our own work on gay affirmative issues in Europe and elsewhere.[1] We hear of lesbian and gay therapists who do not 'agree' with bisexuality or transgender and refuse to work with clients who identify thus. We hear of therapists 'disapproving' of SM sex, believing all casual sex is unhealthy, seeking to help clients cure their 'sexual addiction', or believing only long-term single partner relationships are desirable. Such examples of unprofessionalism display a want of experience and training in matters of sexual diversity. Sexual minorities experience the world differently: therapists working with us need training in understanding the resulting differences in psychology.

Irrespective of sexual orientation, therefore, we believe that therapists need to be prepared to work at depth on their attitudes, prejudices, feelings and behaviours about lesbian, gay, transgender and bisexual issues *before* working with people from these communities. We need to find ourselves before we are able to find our clients. We need specific training to do so.

It is our wish that in this trilogy as a whole, those interested in updating their thinking and practice and challenging their own assumptions and prejudices about sex and sexuality, in order to make themselves open to experiences of others, are gifted with a great deal to think and talk about. More than 40 practitioners have shared a mass of positive information and experience with us all in these books: many of them had never written about their work before. We have reason to be grateful and motivated as a result. Good practitioners continually refine their own frames of reference in order to see the world as clients might.

We desperately need more open-minded, open-hearted and culturally sensitive therapists, researchers and trainers so that sexism and homophobia

do not continually contaminate our lives and cultures, to say nothing of our psyches. We profoundly hope that this work encourages others to take these issues forward in research and debate, clinical practice and training, in all the many places that need to let in fresh air and daylight to clear away archaic ways of oppressing one another.

Notes on case examples and terminology

'Case examples' are used in most chapters. In order to protect confidentiality they are composites which do not refer to specific clients or their work. Exceptions are clearly identified and always have informed permission given.

'Gay affirmative' has come to us to mean truly *person affirmative*. Authors in all three volumes argue persuasively that treating *all* people with respect, compassion, equity and as having equal value is fundamental to the work of therapists, counsellors and related occupations, not an additional, special way of being with people from particular groups (See Davies and Neal 1996, 2000).

Defining sexualities: we use terms such as 'gay', 'lesbian', 'queer', 'bisexual', 'transvestite', 'transgender', 'transsexual' and 'straight' to refer to people who describe themselves this way. While the development of distinct identities is important, we increasingly recognise that all categorising of the range of human experience is inadequate and over-defining. Each of us must be allowed to define ourself. People of different sexualities can support each other in fighting oppression, without forcing themselves or others into falsely homogeneous groups.

'Therapy' and 'the therapeutic relationship' are used to include the whole range of counselling and psychotherapy approaches as well as closely related encounters. We hope that no terms used have inadvertently excluded or offended readers.

Contributors to this volume do not necessarily share the views expressed by fellow contributors. We are all, however, committed to respecting diversity of opinion.

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Note

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1

RITA BRAUNER

Embracing difference: addressing race, culture and sexuality

Introduction

I am writing this chapter from my personal perspective as a lesbian psychotherapist committed to anti-oppressive clinical practice and as a white bicultural practitioner who has made the decision to acknowledge and work with issues related to race, culture and racism. By sharing my cultural background and the influence that shaped me I want to highlight the multitude and complexity of issues related to sexuality, race and culture.

I grew up in Germany in a small, working-class mining town where the dominant society was defined mainly through white, male, middle class and heterosexual values. Like many other lesbian women worldwide, I had no positive role modelling when I was trying to come to terms with my sexuality. As a lesbian I continue to experience discrimination and, despite my British passport, continue to be at the receiving end of xenophobia because of my German background. As a German I have to come to terms with the painful history of my birth country in killing six million Jews and other 'unwanted' persons, some of whom were black or gay. As a British person I have to accept the role Britain had in the history of imperialism, colonialism and slavery. As a white person I learnt to accept that I am privileged in comparison to members of the black communities and that I am, by definition, part of the racist system that operates in Britain. This meant that I had to take responsibility for the painful truth of being potentially racist myself.

For the last 15 years I have worked through many aspects of my conscious personal racism and my internalised homophobia. For me it was a long way from knowing what the issues were to integrating them into my belief system and professional practice. I believe this is an ongoing lifelong task.

My training background includes humanistic and cognitive as well as psychodynamic approaches and I define myself as an integrative psychotherapist. I work in private practice and in a number of HIV related settings. In my anti-oppressive approach to therapy I am guided first by the concept of gay affirmative therapy, which Maylon (1982: 69) defines as: 'Not an independent system of psychotherapy. Rather it represents a special range of psychological knowledge which challenges the traditional view that homosexual desire and fixed homosexual orientations are pathological'.

Clients who are gay, lesbian or bisexual have different life experiences from those of their heterosexual counterparts. This difference needs to be taken into account rather than pathologised in therapeutic work, just as much as the experience of black clients who live in a white dominant, racist society. As a therapist, guided by gay affirmative principles, I therefore see homosexuality, bisexuality and transgender as 'valid and rich orientations in their own right' (Davies 1996: 40).

Second, as a therapist trained in intercultural therapy, I believe that white therapists can help black clients appropriately if they understand the basic concepts of intercultural therapy, are willing to address their own racism, have understanding of cultural issues relevant to their black clients and have the insight to decide when to refer on to a black therapist if that becomes necessary.

The main concept of intercultural therapy, as I practise it, is based on being comfortable with difference. In the broadest sense this can address all differences between therapist and client (e.g. gender, religion, age, class, disability and sexual orientation). In a more focused sense it means working with difference in the context of race and culture and thereby addressing the issues of racism. The late J. Kareem, co-founder of intercultural therapy as practised by NAFSIYAT, the London-based intercultural therapy centre, describes it as:

> A form of dynamic psychotherapy that takes into account the whole being of the patient – not only the individual concepts and constructs as presented to the therapist, but also the patient's communal life experience in the world – both present and past. The very fact of being from another culture involves conscious and unconscious assumptions, in the patient and in the therapist. I believe that for the successful outcome of therapy, it is essential to address these conscious and unconscious assumptions from the beginning. So this means that when we are treating patients from black and ethnic minority groups we have to take up the issues of their real life experience of racism.
>
> (Kareem 1988: 63).

I am also guided by another important concept of intercultural therapy which assumes that the relationship between a white therapist and a black client started long before the two first met and that this historical relationship

has often been based on distorted beliefs and attitudes about each person's race or cultural group. In order to get to a therapeutic relationship and for clients to be able to develop real transference, these issues have to be addressed. Curry (1964) describes this as the concept of 'pre-transference'.

As a white lesbian integrative psychotherapist, committed to the principles of gay affirmative and intercultural therapy, I feel well equipped to work with the multifaceted issues that can arise with black clients who are also gay, lesbian or bisexual. I will use a number of examples and illustrations to demonstrate aspects of my clinical work: these are all fictional in order to prevent identification of my clients.

A word about definitions

The terminology used in the areas of race, culture and sexuality is plentiful and there are many concepts and theories explaining racism, race, culture and blackness. Therefore it is necessary to define my use of the term 'black'. The definition I have found most useful is that of the London Black Lesbian and Gay Centre, quoted in Mason-John and Khambatta (1993: 9): 'Descended (through one or both parents) from Africa, Asia (i.e. the Middle East and China, including the Pacific nations) and Latin America, and lesbians and gay men descended from the original inhabitants of Australasia, North America and the islands of the Atlantic and Indian Ocean'.

Although bisexuality and transgenderation are not stated in this definition I extend it to include black bisexual and transgender people. Mason-John and Khambatta (1993) point out that all these groups have suffered racial discrimination or cultural subjugation in the colonial past and have experienced racism in Britain on a personal or institutional level. I support this point of view because it emphasises the commonality of black people's experience in relation to the European former colonial and imperialistic powers rather than the diversity of their cultural heritages.

Being black

Before I focus on the issues that black clients from sexual minorities have to deal with on a daily basis, it is essential to first draw attention to the impact of what it means to be black in Britain. It is crucial for me to hold an overview of black history and stay informed about current issues affecting the black communities in order to work in a client-centred, intercultural way with these client groups. From my perspective it is vital to integrate discussions about race, gender, sexuality, age and other relevant differences that exist between myself and my black clients into the therapeutic work.

Lago and Thompson (1996) remind us that black clients do not exist in a vacuum but within social systems. Therefore, I need to view my black clients, in the context of these systems and be aware of the influence that environment has on their development, history and identity as well as their thoughts, emotions and actions. This means that I keep in mind that the external and internal worlds of my clients are interrelated. One way of demonstrating my awareness is through the use of empathy in order to attempt to see 'through my client's eyes'. I encourage my black clients to discuss their experience of racism, heterosexism and discrimination during the assessment and in ongoing work. I will acknowledge their experience and help them explore the impact this has on them. For many it is important and healing in itself that I, as a white person, will listen and accept their experience of racism without denial or justification.

Case example 1

Arni is a 29-year-old working-class black British gay man with Caribbean roots. He presented to therapy because he was not succeeding with his career and felt like a failure. He had looked for a gay therapist and been given my number by a former client. That meant he knew I was a lesbian practitioner. He had chosen to contact me as I was close to where he worked. After taking a detailed history and exploration of his presenting concerns and his current situation the conversation continued as follows:

R: Arni, you have now been here for a while. I am wondering how you are getting on with me?
A: Fine.
R: Can you tell me what this means?
A: I guess you are OK.
R: Um, you seemed a little hesitant as you said this? Perhaps part of you feels that I could be OK and another part of you is not so sure if you can trust me?
A: Yeah, well, I think that this is true. You see, I saw a therapist before but I didn't go back after the first meeting. I did not feel she understood me because she kept on telling me that she had no prejudices against black gay people and she treated all people the same anyway when I asked her if she worked with black people before.
R: It sounds like you did not feel seen and acknowledged as the black gay man that you are?
A: Yes that's it.
R: But I guess that this was probably not the first time that you had such an experience?
A: Well, no, no.

R: Yes, I can see that you might be in two minds about me. Will I just be another white person who is racist, even though we are both gay?
A: Yes that's been on my mind. It's very important to me.
R: Of course it is. Are you willing to talk about this further?

Arni agreed. He recalled, over a substantial number of sessions, the impact discrimination, racism and homophobia had on his past and current life. We then went on to issues related to his conflict as a black gay man and his low self-esteem. In therapy Arni was able to link his sense of 'feeling like a failure' to his experiences of being bullied at school for being gay (see also Chapter 10), to issues related to internalised racism and internalised homophobia which were constantly enforced through his father telling him he was stupid, and to racist and homophobic attitudes that he experienced, often on a daily basis, in his interaction with other people. Arni learned to appreciate his coping strategies as strengths that he had developed in dealing with societal racism and homophobia.

In my view, when addressing racism and heterosexism in psychotherapy, practitioners need to re-evaluate the models, concepts and value systems that we use, and understand the potential effects on black clients from sexual minorities. We need to acknowledge that psychotherapists and counsellors in Britain are mostly from the white racial majority, middle class and heterosexual. Furthermore, we white therapists have to remind ourselves that the social, historical, economic and political contexts in which most black clients live are radically different. However, we also have to remember that black people are not a homogeneous group; they arrived in Britain from diverse places, for different reasons and at different points in history. A substantial number of black people are British born and define themselves as black-British or black Asian-British despite the enormous level of racism they have to deal with.

The majority of black people in the UK arrived after World War II but they were not the first. Fryer (1984) reminds us that in the 1770s about 10,000 slaves arrived in Britain. Slavery is a major landmark in black history. Colonialism took over where slavery left off. Some of my black clients have initially been very cautious about my German background as they associate this with Fascism and Nazism. With my encouragement they eventually freely speak of their assumptions in relation to me as a powerful destructive white person. This often uncovers their fears, held consciously as well as unconsciously, of being 'wiped out' and 'killed off': a reality for many of their ancestors. With a few clients this has also led to an understanding of their internalised oppression.

Fatinilehin (1989) draws attention to the effect of having a different culture from the experiences of white Jewish immigrants to Britain who escaped Nazi Germany. He points out that, in the process of acculturation, a white person may lose aspects of their original culture and be given the

same treatment as the host population due to lack of observable differences. This does not happen with members of black communities. No matter how much acculturation in terms of accent, language, education and values, black people still form a visible racial minority in British society. White clients can opt in or out of coming out with regard to sexuality in order to protect themselves from discrimination. Although this is also true for our black peers, because of their visual difference they do not have the option of preventing racial discrimination.

It is important not to stereotype black people from the same ethnic group. Although there are similarities there will also be differences due to religion, gender, sexual orientation, social class before and after migration, the length of time in Britain and the degree of acculturation. However, a substantial number of black people are British-born and have grown up living in two cultures. Some of my clients recall that part of their distress is due to being black in Britain rather than being a migrant with a different culture.

Rack (1982) noted cross-cultural differences in manifestations of distress and in the interpretations of these. A good example is the manifestation and diagnosis of depression. Many British-born white clients describe their mood first and corresponding somatic symptoms afterwards. Some of my clients from an Indian or Pakistani background describe their somatic symptoms first. McGovern and Cope (1987) discuss how this can lead to misdiagnosis of depression and underdiagnosis of affective disorders in black clients.

Another factor that, in my experience, can lead to depression and low self-esteem in black clients is the negative images that pervade the media and all aspects of our society. Even everyday language portrays 'white' as good and desirable, and 'black' as bad and undesirable. This is one example of racist language we have learnt to use without reflecting what impact it might have. I remember exploring this with one of my working-class clients. She had internalised that she was worthless as a black person. Her 'sense of worthlessness' was further reinforced through negative messages as a result of homophobic, sexist and classist language. This meant that we had to address all the different layers of her 'worthlessness' in therapy before she was able to resolve this issue for herself.

These are some aspects of the historical, social, political and economic contexts in which many black clients from sexual minorities live in Britain and which have an impact on their mental health. Interactions between white and black people have been shaped by these influences since the days of slavery 400 years ago. They are part of British history which, whether we want it or not, is brought into the therapy room when white therapists and black clients, despite sharing the same sexuality, work together. They have potential impact on the therapeutic relationship.

Lago and Thompson (1996) describe different philosophical assumptions underlying world views. They refer to three sets of hypotheses which I have found helpful in my clinical work. These describe the differences between

European, Asian and African conceptual systems. Below are brief descriptions of these concepts as I understand and use them.

European cultures place high values on the owning of objects. External knowledge is assumed to be the basis of all knowledge. The outcome of this cultural assumption is a view of the world based on science, technology and dualism – the split between mind and body. The consequence of this belief system is an identity based on body image, wealth, prestige and status symbols.

Asian cultures promote the concept of cosmic unity with the highest value placed on cohesiveness of the community. Internal and external knowledge is assumed to be the basis of all knowledge. This focuses on an integration of mind, body and spirit. The logic of the cultural assumption is defined as unity of thought and mind which ultimately leads to the concept of universal harmony.

African cultures promote both spiritual and material value systems with the highest value placed on interpersonal relationships between the sexes. Self-knowledge is seen to be the basis of all knowledge that one is assumed to access through symbolic imagery. This cultural assumption emphasises co-unity between and through humans and spiritual networks. The consequence of this belief system is an identity and sense of self-worth that are intrinsic.

Lago and Thompson (1996) suggest that these cultural assumptions inform different concepts of healing and influence black people's perceptions and expectations of therapy and, indeed, access to therapy. This is also my experience. A number of my black lesbian, gay and bisexual clients describe initial reluctance to seek outside help with mental and emotional problems. This is because mental distress or illness is associated with shame and stigma and there is an expectation that these problems should only be solved within the family system.

Case example 2

Bena is a 29-year-old who defines herself as working class and from mixed racial heritage (Asian-Malaysian). She heard from a friend about my intercultural background. She did not know about my sexuality. She had been in heterosexual relationships all her adult life and had recently felt more and more in doubt about her sexual identity, especially since the break up with her last boyfriend. She came to therapy feeling very confused. She felt there was something wrong with her as she was sexually attracted to women. She felt she needed to find a clearer way of expressing her feelings in general, not just in relation to her sexuality. Bena also felt very confused as to whether she was black or white as she had light skin, had lived in England for most of her life and saw this as home in contrast to her parents, who planned to return to Malaysia when they reached retirement.

Bena was initially hesitant to engage in therapy. The Asian part of her felt that therapy was not an acceptable way to solve personal conflicts and the western part believed that she would be able to find a solution. She also felt that, by entering therapy, she was betraying the value system of her family, which was to sort out problems among themselves. It took about four months before she felt comfortable with coming to therapy and taking space for herself. During that time we explored the different cultural aspect of herself, her identity confusion and her attachment to her family and culture. After that we worked on her racial, cultural and sexual identity. Had I stayed within a Eurocentric framework I would probably have misinterpreted her reluctance to engage with therapy and pathologised her ambivalence rather than respected and explored it.

Being black and gay, lesbian, bisexual or transgender

In Britain there has recently been an increased publication of psychological literature that explores gay and lesbian issues and, to a lesser extent, bisexual issues, from an affirmative perspective. Similarly there has been a significant growth in researching the roles of culture, race and ethnicity in psychological development and therapeutic work. I refer to some of these writings and research findings in this chapter. However, very little attention has been paid to gay men, lesbians and bisexuals who are also members of black communities. Research into gay and lesbian issues mostly involves white middle-class people and such research rarely addresses differences in sexual orientation among members of black communities. Greene (1997: 217) concludes that: 'There has been little exploration of the complex interaction between sexual orientation and ethnic identity development, nor have the realistic social tasks and stressors that are a component of gay and lesbian identity formation in conjunction with ethnic identity formation been taken into account'.

Black gay men, lesbian women, bisexual or transgender people, men who have sex with men and women who have sex with women are minority groups within their communities. As black people they already face multiple levels of discrimination and have to come to terms with the additional task of integrating two major aspects of their identity which are generally devalued by society: race and sexuality. For a significant number of clients with whom I have worked, their families and friends also devalued their sexual orientation as a 'white disease'.

Many black people grow up with strong ties to their birth and extended families, and are socialised into their communities and their racial and cultural identities long before they become aware that they have a different sexual orientation. Many black lesbian, gay, bisexual and transgender people identify very strongly with their communities. This helps to deal with the

racism of the dominant culture they confront, often on a daily basis. Like their white counterparts, black people are exposed to, and subsequently internalise, a range of negative stereotypes about minority sexualities. Hence they must not only manage the heterosexism and racism of the dominant society but also the heterosexism and internalised racism of their own communities.

There are several problems that face the majority of my black clients:

- Concerns about 'coming out' to their families. Several fear bringing shame and dishonour to their families and being ostracised if they disclose their sexual orientation.
- Difficulties in identifying as black as well as gay, lesbian, bisexual or transgender. Many feel a sense of selfhatred because they have internalised negative stereotypes related to homophobia, biphobia and racism. I have worked with several black lesbians who felt torn between challenging racism, issues of sexuality and women's oppression.
- Difficulties in finding places as black people in the gay, lesbian, bisexual or transgender communities due to the discrimination and racism of their white peers. Some of my male clients especially have spoken of being seen as 'exotic' or 'a nice piece of black meat' by white gay men.

Additional problems arise for black gay and bisexual men living with HIV or AIDS because of the stigma still associated with these illnesses. I have worked with a number of black HIV positive, gay and bisexual male clients who presented with the issues described above. The stress of having to constantly keep aspects of themselves hidden or separate, depending on who they are with, is enormous and poses a great risk to their health (see also Chapter 4). This needs to be taken seriously by therapists. For quite a few of my clients I was the first person who acknowledged the enormity of the multifaceted issues they have to deal with. Our therapy time became a safe space where they could work towards a more integrated self, without being pathologised, and eventually also address issues of internalised oppression.

Case example 3

Ciso is a 28-year-old middle-class gay man of mixed race. His mother is white and English and his father is African American with roots from Haiti. He also has an AIDS diagnosis. One year ago he nearly died and was put on combination drug therapy. Then his health rapidly improved, which was perceived by everyone around him as a miracle. Ciso himself did not share this point of view. He presented with depression: he felt lost and confused and struggled to find his place in the world. He was unemployed and received benefits. We slowly discovered that his 'sense of being worthless' had many layers. We worked on the multifaceted issues that HIV and

AIDS brought up for Ciso: living with uncertainty and fear of his future, of a further illness and the enormous task of coming to terms with living on a daily basis in the face of death. Ciso disclosed that he felt ambivalent about his mixed-race heritage and his sexual orientation. After detailed exploration he realised that he actually felt confused about his racial identity and was acting out his social marginalisation further through his sexual ambivalence. This facilitated work around his internalised oppressions. Ciso associated white and heterosexual as good and black and gay as bad. These aspects had been in constant struggle with each other: he was eventually able to integrate them. At the end of therapy Ciso felt more comfortable with being a mixed-race gay man living with AIDS.

Being black, gay, lesbian or bisexual and coming out

'Coming out' and 'being out' are seen in the white gay, lesbian and bisexual communities as an acknowledgement of one's sexual identity to oneself and others. They are usually related to positive self-acceptance and self-esteem and are often seen to be an important political statement in the context of living in a heterosexist society. Not 'coming or being out', is described by Smith (1997: 279) 'as presumed to be negative and less healthy psychologically and is characterised by negative terms such as being *in the closet*' (original emphasis). This is often associated with shame and denial about one's sexual identity.

From an intercultural perspective the above values and assumptions are Eurocentric. Chan (1997: 240) points out that 'non-Western cultures, such as East Asian cultures, may not have concepts of sexual identity, comparable to the concept found in Western cultures'. Hence there might be several reasons why clients from different cultural and racial communities may not relate to these matters in the same way as their white peers. Concepts such as lesbian, gay and bisexual are predominantly based on the philosophy of the 'individual' in western societies. In many eastern cultures the focus is on the family and community. For example: one of my black Asian clients describes herself as defined by her role and responsibilities in her family as oldest daughter and sister. I've noticed also that some black Asian male clients who were having sex with men defined themselves as married rather than gay or bisexual, their focus being on their role in the family and community. All of these clients reported that the concept of 'coming out' as an individual does not necessarily fit into the value systems of themselves, their families and communities.

Furthermore, in many black communities, expectations of gender roles are strongly embedded and have implications for coming out. Conformity to traditional gender and role expectations, and especially reproductive sexuality, is viewed by many as a means of continuing the community's

presence in a racist society. Greene (1997: 218) suggests that the following factors need to be considered:

> The importance of procreation and the continuation of the family line; the nature, degree and intensity of religious values; the importance of ties to the ethnic community; the degree of acculturation or assimilation of the individual or family into the dominant culture; and the history of discrimination or oppression the particular group has experienced from members of the dominant culture.

Coming out may result for a black client in an additional burden to the level of discrimination already dealt with. The social gains and costs are, for example, very different for a white, middle class, affluent man than they are for a black working-class woman. Coming out to their family was, for a number of my white male clients, crucial to their psychological health and, for a number of my black clients it was equally crucial to psychological health *not* to come out to their families. For the latter it was more important to maintain their closeness to their community and racial identity and to continue to fight racism, rather than address homophobia within the community and the wider society. This choice was sometimes linked to negative experiences that some had in trying to find niches in the sexual minority communities. It is important not to pathologise such choices. Our job as therapists is to help support what is important and appropriate for clients even though it may differ from our point of view.

Smith (1997: 295) points out that an Afrocentric way of coming out 'may be better understood in this context as "taking in" a significant other as if they were a member of the biological family' and refers to the fact that 'African American families may display appreciation for the importance of an individual member's partner even in the absence of overt acknowledgement of the label lesbian or gay'. This has been my experience with some clients.

Case example 4

Donny (42 years) and Emir (37 years) are an interracial gay male couple. Donny is a white Scottish man and Emir is black British with Ugandan roots. They have been together for one year. Donny's parents have always been supportive of his gay identity and his family has welcomed Emir as their son's partner. Emir feels that Donny's family treat him like a son. Emir is 'out' to his friends but has never 'come out' to his family. However, over the years his family has stopped commenting on the fact that he mostly has male friends and is not married. Donny was introduced to Emir's family as his friend. Their sexuality was never discussed in Emir's family: discussions about sexuality in general were not encouraged. Yet Emir's family

accepted their couplehood in the same way as all the other family member's marriages. Donny appreciated this, yet he was becoming more and more resentful about the fact that he was not able to be 'openly gay'. On the other hand, Emir felt fine about his family's approach and found it hard to understand why Donny was angry. This had recently become the reason for several arguments between the couple. When they came to me for couple's therapy, they had reached an impasse in communication. Detailed exploration of the problem revealed that they had never been able to discuss their racial and cultural differences and the different value systems and approaches to being gay men. This became the focus of the therapeutic work. At the end of the therapy they were able to understand, accept and acknowledge their differences.

Implications for clinical practice

So far I have considered several issues that are relevant for black clients from sexual minorities in relation to sexual, racial or cultural identity and the multidimensional aspects of coming out. I will now focus on some implications that I consider relevant for clinical practice when working with these client groups.

Berman (1979) stressed the importance of the personal influence of the therapist in psychotherapy. He indicates that the therapist's ability to communicate to the client that they are understood and can be helped is crucial to the development of the therapeutic relationship. To Carl Rogers (1962) the relationship which the therapist forms with clients is the most significant aspect of the therapy process. In my experience there are several factors that may influence the development of the therapeutic relationship negatively when the therapist is white and the client is black, despite sharing sexual orientation. The client will have had previous experience with white people who were racist, homophobic or biphobic. This will undoubtedly influence their attitudes towards the therapist.

Barbarin (1984) points out that the therapist can be experienced by clients as holding power compounded by whiteness. This may lead to an attitude of caution or suspicion in the client that can initially hinder the establishment of the therapeutic bond between them. The views that some white gay, lesbian and bisexual therapists may hold in terms of racial or sexual stereotypes can also have an effect on the therapeutic relationship.

A mistake, which I made in the early days of my clinical work, was overidentification with black lesbian, gay, bisexual and transgender clients. This hindered the development of our therapeutic relationship as I oversimplified client problems by accounting for everything through race or sexuality issues. I had, in good faith, focused too much on the external process of oppression at the expense of attention to intra-psychic processes.

In order for white therapists to deal effectively with the issues of racism and heterosexism in black clients' lives they have to be aware of their own attitudes, assumptions and behaviours. Green (1987) suggested that white therapists and white people in general could be helped to deal with their feelings of and about racism by investigating their own experiences of oppression. I think this is equally true in relation to heterosexism. This has helped me very much in understanding some aspects of my racism and internalised homophobia, and especially how much oppression hurts.

It is necessary for white therapists to explore and work through their guilt and defensiveness with regard to racism and internalised homophobia or biphobia. Turner and Armstrong (1981) found that white therapists who reported distress around race issues were less able to confront and work through client's negative attitudes about therapy. I was only able to address issues of racism and heterosexism with black clients from sexual minorities once I had acknowledged and worked with these issues myself.

Challenging racist and heterosexist assumptions in our theoretical orientations is another important issue. Rack (1982) maintains that therapists encountering a different and unfamiliar culture will encounter difficulties in distinguishing what is 'normal' and what is 'pathological' behaviour. He argues that cultural differences in behaviour are those determined by beliefs and values of an individual culture – any dysfunction, therefore, needs to be seen in relation to that culture. We have to remember that white therapists are also influenced by biased attitudes from their own cultures towards members of black communities. These biases can become the basis of prejudice when working with black clients. It is the task of every therapist to take responsibility for cultural, racial and sexual biases, which may have impact on their therapeutic work.

The perception of black people merely as subjects of racism or heterosexism has resulted in their being seen as victims, who are disadvantaged, underprivileged and oppressed. It is essential to acknowledge the reality of racism and heterosexism and insufficient to do so in isolation from the systems and structures which surround black clients, including an acknowledgement of the strength of their families and communities. Failure to take account of this can result in an approach which operates within a framework of cultural deficit, excluding the possibility of empowerment, community resources, self-help strategies and self-determination. It is important to assist clients to develop positive self-concepts, followed by strategies to safeguard self-esteem. This involves facilitating client's work around internalised oppression. I recall a woman client who was in a positive transference with me. When I carefully named and explored this with her she was eventually able to talk about her negative self-image as a black lesbian woman.

Finally I want to focus on the issue of self-disclosure. Depending on the different settings I am working in, my clients may or may not be aware of

my sexual orientation. I do not routinely disclose my sexual orientation but believe that appropriate self-disclosure is important after an exploration of my client's fantasies and assumptions about me. I have found that appropriate self-disclosure has been of therapeutic value for most of my gay and lesbian clients and helped to alleviate concerns and fears of being pathologised. My experience with bisexual clients has been that it was more therapeutic to explore our sexual differences, and for me to openly share my non-discriminatory value system in terms of a bisexual lifestyle. Where clients present with sexuality conflicts, early self-disclosure is not helpful as it can be experienced as threatening or an expectation to conform to the therapist's sexuality.

Conclusion

To conclude this chapter I suggest that white gay affirmative therapists, besides having a clear and explicit knowledge and understanding of the generic characteristics of therapy, need to have additional skills in order to operate from an intercultural, anti-racist and therapeutic frame of reference. These skills are:

- to be aware of their own cultural and racial heritage in order to be able to value and respect differences within the areas of race, culture and sexuality;
- to be aware of their own racial, cultural and sexual values and biases and how these may affect black clients;
- to have a good understanding of the social-political systems operating with respect to the treatment of black people, who are also members of sexual minorities;
- to take responsibility for having access to relevant knowledge about the particular group worked with in terms of race, culture and sexuality;
- to be aware of institutional barriers which prevent black clients from sexual minorities from using mental health and therapy services.

Acknowledgements

I would like to thank my friends Mita Hiremath and Linda Brown for their support and contributions to this chapter.

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