Introduction

Although this chapter can be helpful for any therapist, it is most helpful for newer therapists who have not had much experience working with lesbian clients. Sometime soon in your career as a therapist you will likely have a lesbian client. This chapter highlights some issues that lesbians may bring to therapy and suggests ways to effectively engage the client in a therapeutic alliance.

I am a licensed professional clinical counselor in Ohio, working as a therapist for adults, children, and families. Although I have earned my doctorate in counselor education and supervision, most of my learning as a mental health professional has come from working for over 20 years with clients in various settings, most recently as a therapist in a community mental health center. I have enjoyed working with lesbians and other sexual minority clients. My gestalt therapy training has been most helpful in shaping my understanding of relationships, teaching me that my best connection occurs when I am being fully present with my clients. My hope is that as you read this chapter you increase your desire to learn more about working with lesbian clients. No single chapter, however, can prepare you for all that lesbians may bring to counseling.

Self-Identification and Labels

“Don’t label me!” These words rang in my ears as my client, a college student, answered my question, “Do you consider yourself a lesbian?” She had just told me about various sexual encounters with women. I felt guilt and quickly apologized. I then explored with her what her statement meant. She told me that she did not believe in labeling. She did not want to self-identify as lesbian, bisexual, or heterosexual, or even as having “friends with benefits.” She was free to be and to act as she wanted in the moment. I learned so much in this session. I had narrowed my mind and made assumptions. This client did not want to be “outside the box”; she didn’t believe a box should exist. When she did not return for a third session, my supervisor and I explored what I might have done differently. I spoke too soon about a label.

As a therapist with many choice points during a session, what aspects of the client’s story do you explore, respond to, challenge, or support? Before you speak, ask yourself, “Is the question I am about to ask going to help the therapy relationship, or am I seeking client data to help me interpret, analyze, conceptualize the case, or feel more confident?” One unnecessary or ill-timed question can make it so difficult to connect and build trust with your client. Consider how you can respond and be with
your client in the most affirming way possible for her (regardless of your theoretical orientation). Ask yourself what is helping connect you with the client and what, if anything, is interfering with the connection. The goal is to be more present with your clients and not concern yourself with defining her sexual orientation. Just because you might self-identify as a gay man or lesbian, heterosexual male or female, bisexual, transgender, queer, pansexual, or asexual person, does not mean the client must self-identify as one of these.

Some lesbians are uncomfortable saying the word lesbian. They may refer to themselves as gay, referring to both gay men and women. Respect the client’s word choices and voice. Some, like my college student client, do not like to be labeled. Others want to shout out that they are lesbian. Lesbian pride is seen in many communities, expressed by pride parades, bumper stickers, rainbow decorations, lesbian music festivals, and other examples of lesbian or LGBT (lesbian gay bisexual transgender) pride. Your affirmation of the client’s self-identifying process is critical to building trust and connection. Your client’s pride expressed with other lesbian women in community may be as much of a resource for her as the therapy experience. We all long to belong. Where a client belongs may be difficult to identify. She may be feeling alone, isolated, rejected, or at the edge of her family system or friendship circle. Lesbian clients who struggle with belonging may display depression and suicidal thoughts or actions. You need to be direct in your discussions about the pain of her loneliness, fears of being different, and sense of being lost. Do not fear this because carefully assessing for self-harm risks provides powerful emotional support.

Some lesbians have slept with men or were married to a man before they came out to themselves. Those women may consider themselves bisexual and still always choose a female partner in the future. It is not a therapist’s place to label a client. Clients who self-identify are empowered to do so themselves. Those who are unsure of their orientation may seek to explore this with a therapist. This may be part of their coming out process. Allow for this exploration and at the client’s pace.

Self-identification may not be a concern to clients. They may never say they are lesbian. They may only say their partner’s name and you notice it is typically a female’s name. They use female pronouns. You conclude they have partner who is likely a female or whose gender expression is one of being female. That is it. As time goes on, more may be shared. If you are feeling you need to know for sure and ask her, you may miss a clear picture of why she has sought therapy. More important, you may have missed an opportunity to connect with her. Being present with your client means listening not only to the words of your client but also to the flow of her story, non-verbal expressions, areas of emphasis, and areas where the energy is strongest. Watch that your agenda does not get in the way of you being fully present and building trust with her.

The Therapeutic Relationship With Your Lesbian Client

Building Trust: Know Your Biases and Assumptions

Mental health professionals learn in their education and training programs to be culturally competent. Biases are exposed and challenged about different cultural areas such as race, ethnicity, gender, sexual orientation, finances, geographical location, differing abilities, and religion. During this time, biases can be examined and changed, or they can be solidified. When lesbian clients are face-to-face with a mental health professional whose heterosexist bias is unchanged, they know right away. They feel the disconnection.

Clients may have different ways of approaching this disconnection. They may be compelled to try to help you be comfortable, taking care not to bring up topics that would elicit a blank look of “Oh, I have no idea what to say, so I will listen to you and try not to let my bias show.” Some clients may simply walk out and never come back. Others may try to defend themselves against perceived anti-gay heterosexism. Clients might even get angry and confront the therapist. All of these responses
indicate the client is not fully benefiting from therapy. Lesbians want their therapist to be open and comfortable addressing these issues. Galgut (2005) conducted a qualitative study of 24 lesbian women. She found that clients wanted their therapists to be explicit about lesbianism and able to own and voice what they don’t know. The clients also wanted heterosexual therapists to affirm them as lesbians, talk more about sexuality issues, and be less cautious. Ultimately, over 90% of the sample preferred a lesbian therapist. However, they wanted one who was not concerned about political correctness and who didn’t make assumptions about the client based on her own cultural beliefs. Therapists who own their own bias, ignorance, and assumptions and use immediacy skills can work through the therapist–client disconnection. This is when trust grows.

Immediacy skills refer to the capacities of therapists to openly reveal their feelings and observations about the client and their relationship in the immediacy of the session. Immediacy skills can be used to explore differences between client and counselor. A therapist may also ask a client to describe what she feels is going on between them in the here and now of the session. This focus on the experience of one another in therapy may enable the client to recognize and describe her pattern of relating during the session. This often is an important first step to helping the client to gain clarity about her relationship patterns outside of therapy.

Connecting with your client with immediacy and empathy skills can support intense connections and deep therapy work. Setting and keeping boundaries with your client helps them to not become your “friend” or “lover.” Be ethical. Avoid dual relationships, and certainly seek supervision and consultation from colleagues if you have any feelings of attraction for your client. You risk losing your license with any dual relationship ethical violation.

Self-Disclosure

Self-disclosure by a mental health professional is helpful only if intended to benefit the client and the therapeutic relationship. Lesbian clients may want to know their therapists’ sexual orientation. How much to disclose is guided by many personal considerations. Your work environment may be considered. How confident you are in your own sexual orientation may play a role in what you share. Sharing can build trust, but it can also have some negative outcomes. If a lesbian is working with a heterosexual male therapist, she may feel he does not “get her” completely since he does not live in the same culture as she does. The therapist may state that he or she is uncertain about revealing private personal matters to the client in general and politely ask whether the client is willing to share the concerns behind the question. The client’s response helps the therapist to decide whether disclosure would benefit the client. For example, a teen client of mine when I was still a new therapist asked me whether I was a lesbian. I disclosed to her, and she would not say what thoughts were behind the question. I discovered later that my client was attempting to set me up to date her mother, who was a lesbian. Her mother was fearful of coming into the office from the parking lot because of what her daughter said. I had no idea the client was planning all this until she shared her plan and assumptions. I clarified with her mother what had happened. After this experience, I have been cautious about what I disclose to my child clients and more determined to explore what lies behind questions about me.

Clinical Issues for Lesbians

Coming Out to Self

Coming out to oneself is often the first step in the coming out process and is a key clinical issue for some women. This process may start as a child, recognizing an attraction to an admired woman such as a teacher or a softball coach. A first crush might be a close friend. It may be a classmate whose presence causes her stomach to flutter with excitement. Some lesbians can tell the moment when
this occurred. They knew then that their attraction was to the same gender, even when they did not have a name for it. Throughout life, the self-acceptance as a lesbian grows, and coming out to self continues with hills and valleys, joys and pains. Self-acceptance is not a linear process; it does not have clearly defined stages.

A 23-year-old woman comes to therapy wondering if she is “gay.” She feels scared and at times hates the idea that she has feelings toward other women. She talks about dressing a little more masculinely and liking it. Guilt feelings consume her. She states, “I was not raised this way.” Fear sometimes overtakes her. She fears what others would think, is afraid of being treated badly if others knew, of letting down her family and friends. She sometimes wants to hurt herself. Her close friend, a lesbian, talks her out of harming herself. The friend is happy and okay with herself. The client has frequent anxiety and does not know what to do.

There are different ways to treat a woman who struggles with coming out to herself. How you choose to work with her may depend on your theoretical orientation, your experience, and other factors. Research supports various ways to approach a lesbian client. Gay affirmative therapy has been the primary approach (Kort, 2008). The name was later changed to sexual and gender minority therapy to be inclusive of lesbians, bisexuals, and transgender clients, among others. Therapies like this are intended to provide the client with support and empowerment.

**Coming Out to Others**

After coming out to oneself, a frequent next step is coming out to others. Sometimes, this means taking risks with family, friends, co-workers, or strangers. It always means having courage. The coming out process is multifaceted and is defined in degrees. One is out to some and not others. Many may come out to friends first and pretend to be straight with family and co-workers until the time is right to share. For some, that time may never come. If a lesbian is out to friends and family, but not co-workers or neighbors, then anxiety arises when in a position of having to lie or fearing they will find out. Lesbians must ask themselves, “Am I safe?” For example, days after a fun time at a lesbian festival, fear floods your client’s body as she opens her mailbox to find LGBT event advertising. She forgot she signed up for a social group and didn’t read the fine print. The mail carrier knows everyone in her small rural town. She calls them up to cancel her membership. It is too late. A neighbor acts a little different around her, and she hides even more. It is not safe to be out in this town. Lesbians may get hurt.

There are many community supports for the coming out process, whatever degree of “out” the client is or wishes to be. Supports can come from friends, family, and support groups in the community. Loss is an issue that many coming out lesbians want to address in therapy. Some are disowned by their family of origin. If married to a man, the woman may have to cope with divorce and loss of a spouse who was their best friend. Family may not allow the lesbian to see children or grandchildren. Sometimes a friend or a circle of friends will reject her. This might appear as a bold angry rejection or a quiet “unfriending” through social media. When seeing a client with these issues, pay attention to the most important person who has been lost. The loss of a friend may be more upsetting than that of a parent. Pay close attention and allow therapy to proceed at the pace set by the client. The process of coming out to others is often lifelong, and there are many different ways to do it. Whatever way the client wants is the right way. It will be different from client to client.

As clients come out to others, often emotions are strong and can range from pride and joy to terror and sadness. Depression and anxiety may be prevalent at this time. Be sure to attend to any signs of suicide risk. Even with the support of others, the fears of being rejected by specific people, or being shamed or made fun of by strangers, can impact in powerful ways. You may be the one support
the client can depend on during this difficult time. The client has a place to go, to share anger and sadness and have her feelings validated. You may be the first person the client comes out to. No matter what your sexual orientation or gender, your response can help support and heal, or oppress and shame. You can empathize by remembering that you, too, have felt fear, loss, shame, sadness, anger, and hurt. As you listen to your coming out client, her sharing may include intense feelings. Don’t start guessing or pushing for details to help her get through it. What she shares will be enough for her at that time. Support her process and pace.

**Relationships**

Lesbian relationship therapy issues involve sex, marriage, families (whether creating or blending them), couples conflicts, affairs, and violence. There is a common saying of lesbians, “Take the U-Haul on the second date.” This reflects the sense that lesbians move in together quickly. Of course, this is not always true. Some date for years without wanting to move in together. Couples sometimes break up when one wants to move in together and the other does not. The therapy issues in these situations may be conflicts about increasing commitment and decreasing autonomy, or about maintaining a sense of personal control.

**Sexual Intimacy**

Lesbian couples struggle with similar issues as other couples, such as money, sex, and parenting. Therapists working with these couples may try to approach them in the same way as heterosexual couples. A therapist may focus on gender roles, such as attempting to identify one as more masculine than the other. Which is butch? Which is femme? Both homosexual and heterosexual therapists fall into the trap of assuming specific gender roles for their clients. Pay attention to the self-identification of each individual. Couples do not have to follow a gender role stereotype. Assumptions can be hurtful. As each individual identifies her sexual orientation, she also may identify her gender roles. Have a curious attitude. Explore each one’s gender role and expression within the dyad, and then support how their roles can complement each other. Address each conflict with ways in which they can compromise or learn to accept the other.

Sex is sometimes a very sensitive topic. Humor shared with a group of lesbians will often include sex or sexual overtones. This can often cover up many issues going on that couples don’t share. A therapist may be the safest place to share the details of sexual struggles. Are you comfortable hearing the details of a lesbian couple’s intimacy struggles? The more comfortable you are, the more open your clients will be. If you don’t know something, ask or educate yourself by contacting your local LGBTQ (lesbian gay bisexual transgender queer) organization, reading, or attending lesbian-friendly events.

A lesbian couple comes to you with the complaint that they no longer engage in sex. They have been together for 7 years. They used to have frequent sex in the beginning of their relationship. As time passed, they didn’t have time or energy anymore. One partner complains of low libido. The other wonders whether her partner is having an affair, and she is tired of hearing “no.”

As therapist, what are you curious about? Where do you explore first? You might start by making a connection with both partners. Listen to each and affirm each one’s perspective. It might be that there are numerous stressors going on that are unrelated to a lack of sexual intimacy. Exploring personal and relationship stressors is important because they may be creating the distance between them. What supports do each one have from outside and inside the partnership? Then, explore the feelings of each partner. After years of intimacy, sexual energy may be experienced differently. Bodies
Unique Clinical Issues Among Lesbians

change shape. The focus may be more on children, family, or work. Identify new ways the partners can attend to each other, see and hear each other, and be fully present. Imagery of their first year together might be a helpful reminder for renewal and reconnection.

Commitment/Marriage

There is an increase in lesbians living together as married or committed partners. In today’s world of financial, political, global, and family stress, individuals are seeking security, support, and community. Lesbians are seeking each other to build permanent partnerships to meet some of the day-to-day demands for human connection. Marriage is one way to find some security. Over half of the states in the United States supported marriage equality prior to the 2015 Supreme Court decision legalizing marriage equality in all states (National LGBTQ Task Force, 2014). Lesbians come to counseling to get clarity about what it means to be married or committed to each other. Sometimes, this is in preparation for having a family. At other times, one partner may have fears of making a commitment for life. Therapists may be asked to provide pre-marital therapy, attending to issues like finances, children, parenting styles, and beliefs.

Pregnancy

Lesbian couples may have a desire to have children. They might find a male friend or choose a sperm bank to try to conceive. Not all lesbians want to be moms, however, so couples have to discuss this and come to agreement. Who becomes pregnant? If a second child is planned, will the partner become pregnant? Many possibilities exist. At any time, either partner could have a change in the desire to become pregnant or to parent children. Although parents teach children, children also teach their parents. If the relationship between the partners is not solid, then bringing a child into the family can negatively impact the relationship, especially if the child has special needs or comes from a complicated adoption process. The therapist helps the couple to be a united front with their children, to provide structure and love.

Affairs

Affairs occur among lesbians. Sometimes it results in a breakup. At times, therapy can help the couple continue and improve their lives. Lesbian couples may come to therapy wanting forgiveness and reconciliation. It is important for the therapist to address the trust issues between them. When the affair was with a male, the reestablishment of trust is even more difficult because it also identifies a possible shift in sexual partner gender interest. The current partner may feel helpless to maintain the partnership. Affairs among lesbians often happen when needs are not being met in the relationship. Therapy is a place to explore this with questions such as:

1. Is the give and take balanced in the relationship? If no, where is the imbalance?
2. Did a crisis occur before the affair? If yes, how did each one handle it?
3. Had communication and time spent together decreased over time? If yes, in what ways?
4. Did sexual intimacy change or disappear before the affair? If yes, what happened?
5. Is the affair over? If no, what are the parameters of the partnership? Of the affair?
6. What does each of you think is missing in your relationship?

Safe Sex

What is safe sex? Among heterosexual couples, the answer is obvious—using a barrier to protect against the exchange of fluids so sexually transmitted diseases (STDs) are not shared. Lesbians are no
different. During sexual activity, fluids are exchanged. The risks may not be as high as with heterosexuals, yet the risk is present. Only one sexual encounter is needed to acquire an STD. Lesbians may ignore this risk. Therapists can be educated and informed, exploring with clients what taking a risk means. Getting tested for STDs, including HIV, is part of lesbian health and self-care. Ask yourself whether you could knowledgeably talk about these risks, if these issues arise.

**Chemical Dependency**

The prevalence of dependency on alcohol and other substances of abuse is higher among sexual minority youth and within minority communities. Clinicians should not be hesitant to ask about the use of alcohol and drugs. While the therapists’ aspirations might be to help women to deal more effectively with their personal and interpersonal conflicts, this goal is often undermined by unaddressed continuing dependence on alcohol, cocaine, heroin, and so on.

**Violence**

Lesbian couples might engage in domestic violence. There are organizations in communities that help women who have been assaulted by their partner. Support groups are available. Find these resources in your community to pass information on to your clients. Violence without consent is not acceptable. Such violence needs to be distinguished from consensual violence that is an agreed-upon part of a chosen lifestyle. This usually involves sexual behaviors, but it can also involve non-sexual interactions. When shocked by these behaviors, therapists have to guard against the perception that the client is a victim of unwanted violence. This is an opportunity to learn by exploring how the client thinks about the practices. Educate yourself about BDSM practices (bondage, domination, sadism, and masochism). Inquire about contracts and established safety measures. When you encounter a woman who does not want to remove herself from a violent relationship, respectfully ask her to help you to understand why. BDSM sexual encounters, as well as non-sexual dominance/submission lifestyles, are often criticized by therapists and others. Don’t be one of them.

**Growing Old**

**Health/Illness**

The population of older lesbians is growing. Consequently, health issues are common among this group. They may include all the maladies that affect people and in particular women—arthritis, cardiac issues, dementia, gastroenterology problems, cancer, and so on. When struggling with health and healthcare services, older lesbians often experience bias or ignorance from their healthcare provider. They fear going to physicians because of possible discrimination. A number of studies have revealed that physicians are not trained in areas of LGBT health issues (Obedin-Maliver et al., 2011). Older lesbian clients’ fear may also extend to mental health professionals. The older woman is yet another reason to carefully attend to non-verbal as well as verbal signs that your client may be anxious and fearful from the start of therapy. The extra time spent building rapport will serve you and the client well over time as you assist with her health concerns.

**Death of a Long-Term Partner**

Lesbian couples are staying together longer. Many report staying together for a decade or several decades. They are growing old together. When one person in the partnership becomes ill and dies, the other faces numerous legal issues, family issues, and grief. The loss is less painful if there are supportive
family members of both partners who respect the relationship of the couple, married or not. Your lesbian clients who become widowed need your support. A therapist’s office may be the only place a bereft person can talk about her loss freely. Rituals around burials, funerals, or life celebrations are important cultural elements of this grief process.

**Conclusion**

Perhaps the most important idea I can leave you with is to remind you that what you know about human psychology, psychopathology, and therapeutic processes applies to women who are attracted to other women, desiring sex and/or intimacy. The pain lesbians experience in the process of fully accepting themselves, sharing who they are with others, and living in a society that will not always welcome them generates unique social and psychological considerations that affect their inner lives, family relationships, and belonging in a community. This is often particularly stressful for young women. Those who reach out for support within the lesbian community seem to have a much easier time dealing with these conflicts than do those who remain isolated. To be helpful to the help seekers we must be skillful in establishing and maintaining a trusted therapeutic alliance. I hope that this chapter will prove useful in devoting yourself to applying your knowledge and support for your lesbian clients.

**References**


**Recommended Readings**


