

A systematic review of research on
counselling and psychotherapy for lesbian,
gay, bisexual & transgender people

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Counselling & Psychotherapy

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A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people is published by the British Association for Counselling and Psychotherapy, BACP House, 15 St John's Business Park, Lutterworth, Leicestershire, LE17 4HB.

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BACP is the largest professional organisation for counselling and psychotherapy in the UK, is a company limited by guarantee 2175320 in England and Wales, and a registered charity, 298361.

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First published April 2007.

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ISBN: 1-905114-23-0

ISBN: 13: 978-1-905114-21-4

Price: £8.00 for BACP members, £10.00 for non-members, p&p free. Copies may be obtained from the Book Orders Department at BACP in Rugby at the address given above. Cheques should be made payable to BACP. The text is also downloadable from the BACP website, www.bacp.co.uk

Acknowledgements

We thank Rosalind Lai for her guidance and advice in developing the search strategy for this review, and Nika Fuchkan for assisting as a co-rater.

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Executive summary

Background

Counselling and psychotherapy services for lesbian, gay and bisexual (LGB) people have developed against a historical background of medical and psychological pathologisation of homosexuality over the past 130 years. Prejudice against homosexuality amongst therapists and the rest of society is similar to prejudice against transgenderism, as, in contrast to discrimination against characteristics such as race or sex, both have been regarded as unnatural and morally perverse. Although a lesbian-, gay-, bisexual- and transgender(LGBT)-affirmative strand of mental health services provision has developed over the last 20–30 years, particular areas of need for knowledge and understanding remain to be addressed. These are: homosexuality as one of a range of acceptable sexual identities; LGBT people's lifestyle, social networks and support systems; how sexuality and gender are understood and responded to within families and cultures; the difficulties of growing up LGBT, and how information and disclosure about LGBT identity is managed; the coming-out process; the expertise and sensitivity of therapists to these issues; therapist sexual orientation and its relevance to the process and outcome of therapy; and the particular mental health vulnerabilities and needs of LGBT people. Although there is evidence for effectiveness of psychotherapy, we know little about how talking therapies are provided for LGBT people, or the effectiveness of such therapies within this group.

Research questions

- 1) What is the research evidence on the type and provision of counselling and psychotherapy for LGBT people?
- 2) What research measures have been applied to assess participation in, satisfaction with, and effectiveness of these interventions?
- 3) Is there evidence on the effectiveness of counselling and psychotherapy that is specifically affirmative of LGBT people?
- 4) Can this evidence (a) identify implications for policy and practice in this field, and (b) inform future priorities for research?

Objectives

To undertake a systematic review of quantitative research and a thematic review of the qualitative literature in order to:

- a) Review existing research on counselling and psychotherapy for LGBT people.
- b) Describe and evaluate the contribution of different research measures, techniques and designs used in this area.
- c) Identify future priorities for policy, practice and research.

Method

We undertook a systematic search for:

- a) Quantitative studies of counselling or psychotherapy for LGBT people focusing on:
 - The specific nature of therapies used in this group
 - Research instruments used to assess effectiveness and client-centred satisfaction

- Effectiveness within experimental or quasi-experimental designs

- b) Qualitative studies of psychotherapy and counselling for LGBT people.

We searched the following medical databases: Medline, Embase, PsycInfo, Cinahl, Cochrane Library Database, and the Web of Knowledge; and the following social science databases: ASSIA (Applied Social Sciences Index and Abstracts), IBBS (International Bibliography of the Social Sciences), Sociological Abstracts, and The Campbell Collaboration. We restricted our search to 1966 onwards, as we considered it very unlikely that LGBT-affirmative psychotherapy was prevalent to any significant extent before that year. We decided, at the tendering stage for this review, not to include papers on psychotherapy or counselling that formed part of, or were aimed at, successful gender reassignment. We considered that this lay outside our main remit of psychotherapy and counselling services for LGBT people and that it had already been the subject of specific publications. We were also concerned that to include such studies would mean a loss of focus on the lack of services for other issues in transgender people.

We searched the following grey literature: Aslib Index to Theses; Dissertation Abstracts; and the ESRC website. We also reviewed the reference lists of each study and review paper found, to ensure that no publications were missed. We also carried out a search on the Internet using the 'Google' search engine. For the purposes of the literature search, we included papers where sexual orientation or transgender was examined as a variable. This included papers that: (1) considered self-identification as gay, lesbian, bisexual or transgender; (2) used the terms 'homosexual' or 'bisexual' and/or (3) made an assessment of same-sex attraction, fantasy, or behaviour; and/or (4) used the terms 'gender identity', 'transsexualism' or 'transgender'. In the remainder of this report, we use the term LGBT to cover this range of definition. We screened the titles and abstracts of each citation and identified for full review any where there was a possibility that the study met eligibility criteria A and B described above. Citations that lacked sufficient information or did not have an abstract were retrieved in full text for further consideration. To determine eligibility for inclusion of each study/paper in the review, JS and colleagues, working in pairs, independently evaluated the articles retrieved. Disagreements were resolved by consensus at steering-group meetings.

Results

From 7,775 citations identified in the electronic search, 92 papers were obtained as potentially appropriate for the review. A further 18 potential papers were obtained for the review, identified from the grey literature, from hand searching of journals and reference lists, and from searching the Internet using the Google search engine. Thus, 110 papers in all were read and considered for inclusion, of which 22 papers were eventually retained in the review. Fourteen provided quantitative data and 10 qualitative data; two papers contained both quantitative and qualitative data. There were no trials evaluating the effectiveness of psychological interventions in LGBT people, nor were there any longitudinal follow-up studies of people who had received a specific service or therapy. Two papers provided quantitative data on transgender participants, but none provided qualitative data for this group. For simplicity, however, we use the abbreviation LGBT and clarify when findings are specific to particular sub-groups.

Quantitative review

We identified no randomised trials of effectiveness of general or specialised mental health treatments for LGBT people. Nor did we identify any 'before and after' or cohort studies assessing outcomes of therapy and counselling for LGBT people. There was no consistency in the instruments used to assess past or current therapy, satisfaction with care or other outcomes. None of the studies reviewed measured mental health outcomes using validated psychometric measures. Early studies showed that stress around being LGBT often precipitated first contact with a therapist. This finding was absent from most of the later studies, and this change is likely to reflect a 'period effect' over these decades as homosexuality has become more socially acceptable. The outcomes measured mainly concerned the client's satisfaction with the therapy and therapist, and the helpfulness of therapy. The majority were rated positively. Positive therapist attitude was associated with positive experiences of therapy, and greatest perceived benefits were reported by clients when there was matching in sexual orientation between client and therapist. Recency of the therapy and a greater investment of time in therapy were also associated with more positive reports of outcome. Any attempt to change sexual orientation was judged very negatively and generally led to poor perceptions of therapy.

Qualitative review

Our principal findings were that therapists' attitude, knowledge and practice are more important than their sexual orientation; that LGBT clients need to understand (and examine) in the therapy their desire to seek or avoid an LGBT therapist; and that therapists need to be aware of the reality and stereotypes of the LGBT world.

The studies revealed that therapists cannot, and should not, rely on being educated about LGBT cultures by their clients. Firstly, they may simply fit in with whichever dominant discourse their clients subscribe to; secondly, it simply wastes the client's time; and thirdly, it may make clients feel odd and misunderstood. Both therapist and client need to be aware of the dominant discourses and stereotypes in the LGBT world, because, if they fail to do so, the possibility of collusion and shared assumptions may limit the depth and utility of the therapy. Adequate knowledge usually led to fewer biased attitudes and fewer heteronormative assumptions on the part of (LGBT or non-LGBT) therapists. Therapists need to be free of anti-homosexual bias, and that requires careful attention to their own psychological function, training, knowledge and experience, and therapeutic relationship with each patient. There appears to be no simple rule for therapists about whether to disclose their own LGBT or heterosexual identification. Findings on whether or not LGBT clients prefer an LGBT therapist were very mixed, and there is probably no overall conclusion to make. If anything, it would appear that this was of greatest importance to lesbians.

Conclusions

Despite an extensive search, we identified relatively few papers for inclusion in the review. Therefore, although the findings are somewhat limited, they are based on the best available evidence. These studies reveal that affirmative talking therapies appear to help LGBT people to normalise their day-to-day experiences, face and counteract the homophobic nature of their early development and receive therapy that is appropriately focused on issues brought to therapy, rather than on their sexual identity. We would recommend that:

- 1) All psychotherapy training institutes regard knowledge of LGBT development and lifestyles as part of core training.
 - a. Heteronormative bias must be recognised and avoided.
 - b. Therapists should increase their knowledge of LGBT issues and keep up to date.
 - c. Psychotherapeutic practice that pathologises homosexuality, bisexuality and transgenderism should be replaced by more modern understandings of sexual identity.
 - d. Therapists should become aware of internalised bias in the LGBT clients themselves.
 - e. Therapists should receive training on the impact of self-disclosure for all clients, including the sensitive issue of their own sexual orientation and gender identity.
- 2) All psychotherapy training institutes encourage greater numbers of LGBT people to train as therapists in order to improve knowledge in the professional therapeutic community and enable choice of therapists for clients where possible.
- 3) Psychotherapists consider very carefully the advantages and disadvantages of self-disclosure of their sexual identity, gender identity or lifestyle for each particular client and not expect to follow any general rules.
- 4) Psychotherapists take care to inform themselves about LGBT cultures and lifestyles through their personal or professional lives, rather than expecting their LGBT clients to educate them.
- 5) More services are provided for transgender people that focus on general psychotherapeutic issues rather than exclusively on the pathway to or from gender change.
- 6) Affirmative psychotherapy for LGBT people is operationalised in order for it to be evaluated.
- 7) Funding is made available for the evaluation of the effectiveness of LGBT-affirmative therapy in cohort studies and randomised controlled trials.
- 8) Prospective research should evaluate the degree to which our training recommendations are implemented and determine predictors of their implementation.
- 9) Mental health and psychotherapy services should routinely audit outcomes for LGBT people, including satisfaction, access, engagement, perceived homophobia, and mental health outcomes, including psychological and emotional wellbeing and functioning.

1.0 Background

The emotional wellbeing of lesbian, gay and bisexual (LGB) people and their approach to help seeking can only be understood in the context of homosexuality's peculiar history. Religious and moral objections to same-sex sexual attraction have existed since at least the Middle Ages¹. Official sanction of homosexuality as illness hindered the development of a gay and lesbian identity and led to oppression, shame, guilt and fear for many men and women and their families. Between the 1950s and the early 1980s in Britain, the United States and Australasia, unknown numbers of LGB people (particularly men) underwent psychoanalytical and psychiatric 'treatments' to become heterosexual – treatments that had a negative impact on their sense of identity, self-esteem and mental health^{2,3,4}. At the same time, LGB professionals were excluded from entry to the main psychoanalytical training institutes⁵. In a recent survey, only one out of 218 psychoanalysts surveyed in the UK reported that he or she was homosexual⁵. Changing social and professional attitudes eventually led the American Psychiatric Association to remove homosexuality as a mental disorder from the Diagnostic and Statistical Manual of Mental Disorders in 1973 (APA 1973)⁶. However, it took until the early 1990s before it was removed from the International Classification of Diseases (ICD) (WHO 1992)⁷. Although transgenderism is still considered a psychiatric condition (Gender Identity Disorder/Gender Dysmorphia), the aim of therapy (and surgical reassignment, where sought) is usually to assist or enable people to live in the way that best suits their preferred gender rather than seek to 'cure' the transsexualism itself. Sexual orientation in transgender people may be complex. Most regard themselves as heterosexual if given the chance to function as the opposite sex. However, some transitioned individuals who were heterosexual before will, without change in their sexual feelings, become identified as homosexual in their new role^{8,9}. Alternatively, sexual orientation may change following transition, either with or without surgical reassignment¹⁰.

Prejudice against homosexuality amongst therapists and in society is similar to prejudice against transgenderism, as, in contrast to discrimination against characteristics such as race or sex, both have been regarded as unnatural and morally perverse. Despite the gloomy history of lesbian, gay, bisexual and transgender¹ (LGBT) people's experiences of the psychological therapies, it appears that they seek help for emotional difficulties more often than do heterosexuals¹¹. However, they may receive a mixed reception. The London-based Project for Advice, Counselling and Education (PACE) and the UK charity MIND have both published evidence on the difficulties gay men, lesbians and bisexual people experience in mental health care^{11,12,13}. These include depreciation of their domestic circumstances, refusal to accept partners as next of kin, professionals' excessive curiosity about LGB lives, concern about confidentiality, and fear that their sexuality will be regarded as the 'pathology' requiring attention.

Counselling and psychotherapy services for LGBT people have developed against this historical background, and an LGBT-affirmative strand of mental health services provision is slowly developing¹⁴. Particular areas of need for knowledge and understanding remain to be addressed. The most important of these are: homosexuality and bisexuality as part of a range of acceptable sexual identities; LGBT people's cultures with respect to their lifestyle, social networks and support systems; how sexuality and gender are understood and responded to within families and cultures; the difficulties growing up LGBT and how information and disclosure about sexuality and transgender is managed; the coming-out

process; the expertise and sensitivity of therapists to these issues; therapist sexual orientation and its relevance to the process and outcome of therapy; and the particular mental health vulnerabilities and needs of LGBT people.

Although there is a considerable body of evidence underpinning the effectiveness of psychotherapy in general¹⁵, and some evidence for effectiveness of counselling in particular^{16,17}, we know little about how such services are provided for LGBT people or their effectiveness in this group of people.

2.0 Research questions

- 1) What is the research evidence on the type and provision of counselling and psychotherapy for LGBT people?
- 2) What research measures have been applied to assess participation in, satisfaction with, and effectiveness of these interventions?
- 3) Is there evidence on the effectiveness of counselling and psychotherapy that is affirmative of homosexual, bisexual and transgender people?
- 4) Can this evidence (a) identify implications for policy and practice in this field, and (b) inform future priorities for research?

3.0 Objectives

To undertake a systematic review of quantitative research and a thematic review of the qualitative literature in order to:

- a) Review existing research on counselling and psychotherapy for LGBT people.
- b) Describe and evaluate the contribution of different research measures, techniques and designs used in this area.
- c) Identify future priorities for policy, practice and research

4.0 Method

4.1 Eligibility

Definitions

There are concepts in this review that require careful definition. First are 'psychotherapy' and 'counselling'. Psychotherapy is the psychological treatment of a mental disorder or emotional distress. It consists of specialised talking therapies that have arisen from psychological, philosophical and sociological theories. These are principally psychoanalysis and cognitive and behaviour therapies. 'Counselling' is a word that is understood differently in different cultures and has frequently been applied in settings that have little in common with psychological treatments. It may refer to advice giving rather than treatment. When referring to a talking treatment, it has been defined in a variety of ways and each definition contains within it features specific to the discipline in which it is practised. For example, counselling in generic settings has often taken the form of a non-directive, client-centred intervention, based on the theories of the American psychotherapist Carl Rogers. However, in making these simplistic distinctions, we did not intend to reduce the complexity and sophistication available across the range of psychotherapies; rather, we required a pragmatic classification for the purposes of a complex review. Defining sexuality may also be problematic. Firstly, sexual responsiveness to others of the same sex, like most

human traits, is believed to be continuously distributed in the population. Secondly, it may be incorrect to presume that such traits are stable within each person over time. Thirdly, conflating any same-sex experiences with a categorisation of the person as homosexual is a limited definition of sexuality. Lastly, defining sexuality solely on the basis of sexual experience may exclude people who fantasise about sex with others of the same sex but never have sexual contact. Modern conceptions of sexual orientation consider personal identification, sexual behaviour and sexual fantasy¹⁸. Few studies, however, utilise all three of these definitions in arriving at a composite categorisation of sexuality. One widely established definition is: a person 'with an orientation towards people of the same gender in sexual behaviour, affection or attraction, and/or self-identity as gay/lesbian or bisexual'¹⁹. For the purposes of the literature search, we included papers where sexual orientation or transgender was examined as a variable. This included papers that: (1) considered self-identification as gay, lesbian, bisexual or transgender; (2) used the terms 'homosexual' or 'bisexual'; and/or (3) made an assessment of same-sex attraction, fantasy, or behaviour; and/or (4) used the terms 'gender identity', 'transsexualism' or 'transgender'. In the remainder of this report we use the term LGBT to cover this range of definition.

Search

We undertook a systematic search for:

- a) Quantitative studies of counselling or psychotherapy for LGBT people, focusing on:
 - The specific nature of therapies used in this group
 - Research instruments used to assess effectiveness and client-centred satisfaction
 - Effectiveness within experimental or quasi-experimental designs
- b) Qualitative studies of psychotherapy and counselling for LGBT people. We defined qualitative research as a method that uses narrative, observation or examination of texts to address a specific question or questions; that selects participants or sources in order to include the widest possible range of views, behaviour or sources of information; and that examines the data mainly in non-quantitative ways using thematic, grounded theory and other approaches. While quantitative researchers strive to be objective in the sense of reducing the impact of the observer on the findings, qualitative researchers may use their subjectivity to enhance the value of the analysis. They are not unaware of their subjectivity; rather, they see it as integral to the research itself. Qualitative research may be regarded as descriptive, analytic or hypothesis generating, and the approaches used are normally based on a clear social, cultural or political theory.

4.2 Search strategy

For the purposes of the search strategy, the review question was reduced to two concepts: (1) Psychotherapy and counselling; (2) LGBT groups, as defined above, as the population of interest. For each concept, a list of synonyms was created, and these were searched both as thesaurus and free-text terms. This strategy retrieved studies conducted in LGBT groups that focused on the nature and provision of counselling and psychotherapy, outcome measures and effectiveness. A wide range of psychological, social science and biomedical databases and websites were searched to identify published literature, grey literature and ongoing research (see below). In order to capture both quantitative and qualitative studies, methodology filters were not used.

The search strategy we used was ((explode "Transsexualism-" / all SUBHEADINGS in MIME,MJME) or (gender adj identi*) or ((sexual adj orientation) or (sexual adj preference*) or (sexual adj minorit*)) or ((lesbian*) or (gay*) or (homophobi*)) or ((transsexual*) or (bisexual*) or (homosexual*)) or (explode "Homosexuality-" / all SUBHEADINGS in MIME,MJME) or (explode "Bisexuality-" / all SUBHEADINGS in MIME,MJME) or (explode "Gender-Identity" / WITHOUT SUBHEADINGS in MIME,MJME) and (((psychotherap*) or (talking adj therap*) or (complex adj intervention*)) or (explode "Counseling-" / all SUBHEADINGS in MIME,MJME) or (explode "Psychotherapy-" / all SUBHEADINGS in MIME,MJME) or ((psychological adj therap*) or (counsel*))) and (LA:MEDS = ENGLISH)

4.3 Data sources

We searched Medline, Embase, PsycInfo, Cinahl, the Cochrane Library Database, the Web of Knowledge, the Applied Social Sciences Index and Abstracts, the International Bibliography of the Social Sciences, Sociological Abstracts, and the Campbell Collaboration. Grey literature resources consulted were Aslib Index to Theses, Dissertation Abstracts and the ESRC website. An Internet search was also carried out using Google and Google Scholar using the above search terms. Furthermore, authors were contacted where necessary. We also searched the reference lists of relevant papers to ensure that no publications were missed.

4.4 Restrictions to scope

Time span

We restricted our search to 1966 onwards, as it is very unlikely (apart from a small number of papers that took a stand against the view that LGBT people were psychologically disordered) that LGBT-affirmative psychotherapy was prevalent to any significant extent before that year.

Transgender people

We did not include papers on psychotherapy or counselling aimed at successful gender reassignment. Although it is an important question in its own right, psychotherapy in the setting of gender identity clinics has a specific aim which is not closely related to that for LGB people, where there is no issue of gender identity problems. We were also concerned not to lose our focus on services for transgender people that do not deal exclusively with gender reassignment. Thus, we decided, at the tendering stage for this review, not to include papers on psychotherapy or counselling that formed part of, or were aimed at, successful gender reassignment.

Language

Papers were limited to those written in English.

4.5 Screening process

JS, and a second rater, NF, screened the titles and abstracts of each citation and identified for full review any where there was a possibility that the study met eligibility criteria A and B described above. Citations that lacked sufficient information or did not have an abstract were also retrieved in full text for further consideration.

4.6 Assessment of study eligibility

To determine eligibility for inclusion of the study/paper in the review, the research fellow and each applicant, working in pairs, independently evaluated the articles retrieved and agreed on inclusion. When disagreements occurred, the

reviewers discussed the reasoning for their decisions at a steering-group meeting in order to reach a final consensus.

4.7 Data quality

Quantitative review

We did not use a formal scoring system. Although there are several systems for appraising the quality of observational studies such as sampling, representativeness, definition of LGBT²⁰, they are most applicable to treatment outcome, rather than epidemiological studies. Moreover, empirical research has shown that summary scores (numeric scores based on weights given to each item in a scale) are arbitrary, unreliable and difficult to interpret²¹.

Qualitative review

We followed published guidelines to assess quality of studies as follows: description of sampling strategy; character of field work; independent inspection of data; clear description and justification of procedures for data analysis; repeatability of analysis; and use of supportive quantitative methods²².

4.8 Data extraction

We categorised the studies into: (1) quantitative, descriptive studies of counselling and psychotherapy services for LGBT people; (2) prospective studies that aimed to assess outcome; (3) experimental studies of effectiveness; and (4) qualitative studies. We planned to extract detail on the type of therapy and the research instruments used from studies in 1–3, if any were found.

For all papers/reports we extracted data on: details of the authors, geographic location, study setting, sampling details, sexuality/gender identity of the groups involved (eg studies may focus only on transgender or gay men), types of counselling or psychotherapy, profile of clients, and outcome measures. For case-control studies and cohort studies, we planned to extract (or calculate, where necessary) odds ratios and relative risks as appropriate. For intervention studies, we planned to extract (or calculate) data that enabled estimates of effect sizes. For qualitative studies we extracted the key themes identified by the authors for each study.

4.9 Data synthesis

■ Quantitative analysis

In our main quantitative analysis we (1) categorised the type of talking therapy delivered; (2) described ingredients of the therapy that were linked by clients to outcomes; (3) described how sexuality/gender was defined; and (4) compared outcomes where possible between LGBT and heterosexual people.

Type of talking therapy

This part of the review was descriptive. Where possible, we categorised the therapy given, together with any modifications for LGBT people, the nature of the clients, the health care or social setting in which it was delivered, and the training of the counsellors/therapists.

Meta-analytic assessment of the effectiveness of interventions

There were no published evaluations of the effectiveness of psychotherapy and counselling for LGBT people. It was, therefore, not possible to undertake a meta-analysis.

■ Qualitative analysis

We reviewed and collated the main themes in each qualitative

study from the authors' reports and synthesised these in an overall view.

5.0 Results

From 7,775 citations identified in the electronic search, 92 papers were obtained as potentially appropriate for the review. Twenty-two of these had no abstracts and were obtained solely on the basis of their titles; none were eventually included in the review. A further 18 potential papers were obtained for the review identified from the grey literature, from hand searching of journals and reference lists, and from searching the Internet using the Google search engine. Of these, 10 went on to be included in the review^{4,12,24–26,28,31,35,36,40}. Thus, 110 papers in all were read and considered for inclusion; 61 of these did not contain any quantitative or qualitative data^{43–103}. Many of these contained general discussion about the types of therapies that might be appropriate for LGBT people and how these might be delivered, but had no direct evidence underpinning them.

Excluded studies

Twenty-seven papers that contained data were excluded^{11,104–129}. Four of these were excluded because they did not include any form of standardised mental health outcome measure^{104–107}; eight studies were excluded because they did not provide any data about counselling or psychotherapy^{108–115,129}; three studies were not related to interventions for mental health^{117–119}; one paper was about treatment of homosexuality¹²⁰; six papers provided no data from LGBT clients^{121–126} and one paper was not about psychotherapy/counselling for LGBT clients¹¹⁶. One paper that would have been suitable for inclusion contained duplicate data¹¹ provided for in King, McKeown, Warner et al²³, and two papers provided only case histories^{127,128}.

Included studies

Thus, 22 papers were eventually retained in the review, of which 14 provided quantitative data^{4,23–25,27,29,30,33–37,40,42} and 10 qualitative data^{12,24,26–28,31,32,38,39,41}. Two papers contained both quantitative and qualitative data^{24,27} (Figure 1).

5.1 Papers concerning quantitative studies

Table 1 summarises the 14 papers containing quantitative data that met criteria for inclusion in the final review. Two studies were presented in more than one paper^{29,30,33–35}, leaving 12 quantitative studies in total. These studies varied widely in their aims, methods, setting, interventions and outcomes measured. There were no trials evaluating the effectiveness of psychological interventions in LGBT people, nor were there any longitudinal follow-up studies of people who had received a mental health service or therapy. All the studies were cross-sectional in nature and reported responses to questions regarding previous or current experience of psychological treatments. There was one quasi-controlled study that used an undefined heterosexual group for comparison³⁴. There was little detail regarding the type of intervention participants had received. Recall bias, and problems of representativeness, and generalisability of the findings were limitations recognised by some of the authors. The limited numbers of studies with similar aims, heterogeneous methods employed and varying outcomes precluded a meta-analysis of the effectiveness of psychotherapy and counselling for LGBT people. The main themes are described in the following sections.

5.1.1 Participants in the research

Eight studies^{25,27,29,33,36,37,40,42} only included respondents who were defined as LGBT, while five studies, in six papers^{4,23,24,34,35,36} compared the experiences of LGBT and non-LGBT groups. One study, presented in two papers, looked at whether the participants were conflicted about their sexuality at the beginning and then at the end of therapy^{29,30}. The numbers involved in studies, the methods used to define sexual orientation and the main outcomes studied are included in Table 1. A variety of sampling methods were used to recruit participants, reflecting the difficulties of achieving a representative sample of LGBT people. The majority of authors recruited convenience samples of LGBT people, using fliers or adverts in the LGBT press, at LGBT events and social or political meeting places. Several studies used more than one type of recruitment, in an attempt to minimise selection bias. In particular, some studies recruited from a wider variety of community resources and informal personal contacts to reach a greater proportion of LGBT people^{4,24,25,27,29,30}. Two studies^{4,27} employed 'snowballing techniques' whereby interviewees suggested other LGBT people who could be invited to participate. Only one study focused on transgender people⁴⁰, recruiting participants who had undergone psychotherapy; advertisements were placed at a transgender conference, through personal contacts and via the Internet. Due to the sampling strategies, response rates were impossible to determine accurately in most studies. Only one study gave a clear response rate of 24 per cent to their multi-modal recruitment methods, while a second gave an approximate estimate of 26 per cent²⁹.

5.1.2 Types of intervention studied and level of service use

Most studies conducted a retrospective examination of utilisation of a variety of psychotherapies in LGBT people. Gambrill et al compared the experience of mainstream versus specialist services for LGBT people²⁷. King et al examined proportions of LGBT and non-LGBT people who had consulted a mental health professional or approached their GP for an emotional difficulty⁴. LGB men and women were more likely to report both forms of service use. Two North American comparative studies also found that LGB people were more likely to report having used psychotherapy services than their non-LGB counterparts^{24,34}. The earlier study found no differences in the number of therapists ever seen, nor in the duration of each period of psychotherapy²⁴. The later investigation, a matched study of 81 LG and non-LG men and women³⁴, found that LG people had seen more therapists and for longer durations of treatment. Bell and Weinberg concluded that LGB people consult psychotherapists at slightly younger ages than non-LGB people²⁴.

5.1.3 Reasons for seeking help

Three studies^{24,40-42} examined reasons for embarking upon psychotherapy. The reasons LGBT people gave for consulting psychotherapists were diverse. Bell and Weinberg's study of LGB people in the 1970s reported that first contact with psychotherapists was most likely to be related to problems associated with their sexual orientation in some way²⁴. Moreover, LGB people were more likely to have been required to attend psychotherapy (for instance by a relative), compared to their heterosexual counterparts. However, less than 20 per cent of LGB people in their study aimed to 'give up' or alter their sexual orientation. But these results need to be considered within their historic context. A later study of 1,633 lesbians revealed that issues other than sexual orientation formed the majority of reasons for consultation, such as financial problems, relationship and family issues,

and depression⁴². Similarly, 150 transgender participants in a separate study cited wide-ranging reasons for undertaking psychotherapy, including personal growth, work conflicts and improving relationships⁴⁰. The same study found that for participants who had been treated by more than one therapist in their lifetime, the latest episode was less likely to have been related to seeking help for specific gender identity issues than the first episode of treatment.

5.1.4 Outcomes of the interventions

The studies' main focus in the description of therapy outcomes was on client satisfaction, perceived helpfulness of the therapy and predictors of these outcomes, particularly the sexual orientation of the therapist (see below). One study focused on satisfaction in people who used general psychiatric services (rather than counselling or psychotherapy) for those with severe mental illnesses²³. No study measured mental health, social functioning or mental ill-health outcomes, using validated psychometric instruments. However, several studies used scales for the assessment of respondents' satisfaction and perceptions of the helpfulness of the therapy. The measures included a dichotomous outcome comparing the responses 'gains' or 'no gains' from psychotherapy³⁶; three unstandardised four-point helpfulness scales in four papers^{24,25,33,35}; and a 10-point helpfulness scale in one study^{29,30}. Only three papers (from two studies) compared LGB and non-LGB outcomes^{24,34,35}. Bell and Weinberg²⁴ concluded that LGB people were as likely as heterosexuals to report positive outcomes from their first experience of psychotherapy. Similarly, LGB clients were as likely as non-LGB clients to rate their therapist as 'very helpful' (75 per cent versus 62 per cent). In their study, lesbians and gay men reported finding specialist LG services more helpful in comparison to mainstream services²⁷. Similarly, 516/600 (86 per cent) of LGB people felt that psychotherapy had had a 'positive influence', with 200/600 (33 per cent) stating it had 'saved their lives'³⁵. In a study restricted to gay men, 11/19 (58 per cent) were satisfied with their counselling/psychotherapy³⁷. Conversely, a study involving 67 LGBT people with chronic mental illness using New York inpatient or outpatient psychiatric services showed greater dissatisfaction in the LGBT group [12/67 (18 per cent) versus 9/301 (3 per cent)]²³. Mapou et al found that 81/93 (87 per cent) of the gay men in their study reported that a positive change occurred³⁷.

5.1.5 Sexual orientation, gender and attitude of professional

In several studies, helpfulness of psychotherapy was associated with the client's perception of their therapist's attitude to homosexuality. Negative attitudes predicted lower satisfaction²⁴. A number of studies found that LGB people would prefer to be seen by LGB therapists. In one study²⁹, 156/600 LGB people believed that only LGB therapists would be competent to provide 'gay/lesbian-affirmative therapy'. Greater numbers felt that LGB therapists ought to reveal their sexual orientation to their client²⁹. In another study, 261/329 LGB clients reported difficulties with counsellors who were not LGB, such as lack of mutual understanding, pathologising homosexuality or prejudice²⁷. More women in this survey reported difficulties working with non-LGB counsellors than did men (see Table 1). Liddle³⁴ explored preferences for therapist gender and sexual orientation among LG clients. Lesbians ranked their therapist preference as lesbian, then heterosexual female, then gay male, with heterosexual male therapists being least popular. Gay men ranked gay male therapists most strongly while a lesbian therapist was least preferred and heterosexual male and female therapists were ranked equally. An LGB therapist was also rated most highly in terms of helpfulness in two surveys involving 1,633

lesbians⁴² and 257 lesbians²⁵. Similarly, in a small study (15 LGB and 9 non-LGB) comparing adults who had received psychotherapy, greater benefits were reported when the client and therapist shared the same sexual orientation³⁶.

5.1.6 General predictors of satisfaction with psychotherapy or counselling

Recency of the therapy and greater numbers of psychotherapy sessions during the treatment episode predicted better self-reported outcomes in one multivariate analysis of wide-ranging factors in 600 LGB psychotherapy clients³⁰, confirming a previous finding³⁴. Therapists who were trained as social workers or psychologists rather than analysts also predicted better outcomes reported by LGB respondents in one study³⁰. Attempts to change sexual orientation during therapy were associated with worse outcomes in the same study. LGB people who did not identify as LGB when commencing therapy, or who had more conflict regarding their orientation also experienced worse outcomes. Similarly, clients who were clear about their sexual orientation at the outset of therapy did better.

5.1.7 Experience of therapy

Jones and Gabriel²⁹ presented positive findings in 1999 from their survey of 600 LG men's and women's experiences of psychotherapy. Their results suggested that most clients felt respected, understood, accepted and liked by their therapist. They also scored their therapists highly for honesty, integrity, warmth, sensitivity, skill and intelligence. Using forced-choice responses, the majority (69 per cent) indicated that they believed their therapist viewed homosexuality as 'perfectly normal and acceptable', with a minority believing their therapist viewed homosexuality as a disease to be overcome (three per cent) or a sin (one per cent).

5.1.8 Summary

A major gap revealed by this quantitative review is the lack of randomised trials of effectiveness of general or specialised mental health treatments for LGBT people. We also did not identify any 'before and after' or cohort studies assessing outcomes of therapy and counselling for LGBT people. All the studies included were cross-sectional surveys of past or current therapy, and all findings were limited by the methods in which participants were recruited and studied. The potential for selection bias inherent in recruiting LGBT people through LGBT organisations and/or advertising must be acknowledged. This is especially important if the psychotherapeutic nature of the study was indicated in the recruitment adverts. The representativeness and generalisability of the quantitative results must therefore be treated with caution. There was no consistency in the instruments used to assess past or current therapy, satisfaction with care or other outcomes. None of the studies described in this review measured mental health outcomes using validated psychometric measures. Apart from receiving therapy from a LGBT therapist and/or therapy that was described as gay affirmative, there was little description of therapy specifically tailored for LGBT people. By 'gay-affirmative therapy', authors appeared to mean that therapists regarded LGBT lifestyles positively, were knowledgeable and non-prejudiced about LGBT issues and provided therapy that did not pathologise minority sexual identities. We are aware that there is an extensive literature in which LGBT-affirmative therapy is described and discussed, and our search identified much of this literature. However, our remit was restricted to the study of therapy outcomes and therefore we did not review this extensive theoretical literature. Early studies, such as that by Bell and Weinberg²⁴, showed that stress around being LGB often precipitated first contact with

a therapist. This finding was absent from most of the later studies, and this change is likely to reflect a 'period effect' over these decades as homosexuality has become more socially acceptable. The outcomes measured in these studies mainly concerned the client's satisfaction with the therapy and therapist and the helpfulness of the therapy; the majority were rated positively. The latter is surprising, given the somewhat coercive nature of referral to therapy described in the early studies²⁴ and some of the therapists' attitudes arising in the qualitative review (below). Positive therapist attitude was associated with positive experiences of therapy and there was some evidence that clients reported greater benefits from therapy when there was matching in sexual orientation between client and therapist. Recency of the therapy and a greater investment of time in therapy were also associated with more positive reports of outcome. Any attempt to change sexual orientation was judged very negatively and generally led to poor perceptions of therapy.

5.2 Papers reporting qualitative studies

Ten qualitative papers met our inclusion criteria, the details of which are shown in Table 2. The principal issues identified and discussed in the studies were that of knowledge about, and attitudes to, gay or lesbian sexuality. None of the qualitative papers included the experiences of transgender people. All clients have concerns about how their therapist regards them and their problems. However, for LGB clients there was an extra and profound level of uncertainty and one that was often difficult to articulate for both client and therapist. A number of themes (often overlapping) emerged, many of which had changed or evolved for the better over the years of the studies. For example, in the study by Bell and Weinberg²⁴, most gay men who had sought therapy had experienced 'difficulties' with regard to their sexuality, although this did not mean they necessarily wanted to change it. Many gay men had undertaken therapy after an arrest by police for homosexual behaviour, or discovery of their sexuality when they were in the armed forces. There was a clear evolution from McFarlane's study³⁴ to that of King and McKeown³¹, in that attitudes of mental health professionals towards LGB clients seemed to have improved over a relatively brief period.

5.2.1 Heterosexual (heteronormative) assumptions

Many of the qualitative studies revealed the heteronormative assumptions of mental health professionals, who were insensitive to, or unaware of, the issues facing LGB clients. In a large community survey of gay men and lesbians that contained qualitative data, Gambrell et al²⁷ reported that many respondents feared that therapists would make heterosexual assumptions and/or regard their sexuality as part of their problem. More common than actual rejection was subtle discrimination in the guise of heterosexuality as the assumed norm³¹. This heterosexism had the effect of preventing clients bringing up important issues about their sexuality or relationships. Heterosexism assumes the supremacy of social practice, cultural structures and norms, and idioms of heterosexuality. In McFarlane's study of mental health service users, many spoke of the difficulties of getting staff to recognise that their same-sex partners were next of kin and to treat them accordingly by sharing information and taking them into their confidence¹². In his interviews with 14 gay men about their experiences of therapy or counselling, Mair reported that heterosexual therapists might lack knowledge about gay and lesbian lifestyles and make assumptions about heterosexual lifestyles being the norm³⁸. He emphasised the need for therapists to gain knowledge through reading, discussion with friends and colleagues and

contact with LGB organisations. In a study of nine gay men who had experienced gay-affirmative psychotherapy, the role of the therapist in 'equalising' gay experiences with that of mainstream heterosexual experience was important³².

5.2.2 Safety

In her study of 35 mental health service users and 35 mental health professionals, McFarlane reported that lesbians frequently feared or experienced intimidation, sexual harassment or sexual assault from other male service users (and, much less commonly, staff) when in mental health care settings¹². However, she acknowledged that some of these experiences arose from being female, rather than specifically lesbian, and might well have been experienced by all women. Whereas lesbians in her study usually preferred single-sex settings (particularly as inpatients), gay and bisexual men commented on feeling safer when women were present, and preferred mixed-sex wards. McFarlane recommended clear statements in services to the effect that both homophobia and heterosexism were unacceptable behaviours and a disciplinary matter, and that an accessible complaints facility be available for LGB service users¹². Clearly, issues of safety of this kind are less pertinent in outpatient settings. However, the sexual orientation of the mental health professional or therapist may also promote a feeling of safety. Golding also found considerable fears among LGB mental health service users that they would face prejudice and discrimination should they come out to staff – 73 per cent reporting actual experiences of prejudice, even violence²⁸. As will be discussed again below, many LGB people prefer to consult an LGB therapist/professional, as it increases feelings of comfort and safety^{12,24,27}. However, for a minority, it can lead to fears of seduction^{38,40}. Therapy that affirms and normalises a client's homosexual or bisexual orientation and/or their transgendered identity, regardless of the therapist's sexual orientation, appears to be particularly helpful in making clients feel safe and secure in therapy³².

5.2.3 Knowledge of lesbian, gay and bisexual culture

Gambrill et al's mixed quantitative and qualitative community survey of lesbian and gay people's need for social services in San Francisco asked for respondents' views on potential difficulties in consulting a heterosexual therapist or counsellor²⁷. These included the therapist having inadequate knowledge of the dynamics of gay and lesbian lifestyles and resources, and concern that the therapist would expect the client to educate them about gay and lesbian cultures. Gay men who do not seek out gay or lesbian therapists nevertheless often feel the need to censor the information (particularly about sexual issues) which they give to their presumed heterosexual therapist, as they take for granted that their experiences will not be fully understood³⁸. There may also be frustration that a heterosexual therapist cannot help them fully explore what it is to be lesbian, gay or bisexual³⁸. Golding cautioned that knowledge of so-called LGB communities is complex²⁸; communities are not homogenous, and mental health professionals must take account of differences within gay culture, such as ethnic minorities and the disabled. King and McKeown³¹ and Mair³⁸ reported that respondents in their studies had either felt that they should, or had been directly asked to, educate their therapists about gay and lesbian lifestyle and culture. Similar experiences were reported by Ryden and Loewenthal in their qualitative study of lesbians' experience of therapy, where clients attempted to broaden their therapists' knowledge of homosexuality and reduce the impact of stereotypes⁴¹. However, educating the therapist could also make them feel like a 'freak' on display. Ryden and Loewenthal regarded their participants' attempts

to break the (particularly butch) stereotypes into which they felt they were placed as a 'resistance to the dominant discourses regarding lesbian identity', but they were less clear what a therapist might do about it⁴¹. Pixton's³⁹ and Lebolt's³² studies of recipients of gay- and lesbian-affirmative therapy found that the therapist's understanding of gay and lesbian culture allowed the client to relax and open up more easily as they did not feel any sense of judgment or misunderstanding about their lifestyle. Therapists who worked in lesbian or gay communities were particularly valued for their knowledge and understanding of LG issues³².

5.2.4 Misattribution of the problem

Misattribution of the LGB client's distress to their sexuality has historically been an issue that has influenced therapy with LGB people^{12,28}. As recently as the 1970s, referral for therapy simply for being LGB remained common²⁴. In the San Francisco survey by Gambrill et al²⁷, between five and 10 per cent of people who had undergone therapy reported that their therapists had suggested that LGB people were sick. Many more respondents in that study feared that therapists would assume their problems were due to their sexual orientation, regardless of the issue for which they had sought help. Fifty-one per cent of mental health users in Golding's study reported that their sexual orientation had been inappropriately used by mental health workers in order to explain the causes of their mental distress²⁸. Although in recent decades this behaviour appears to have declined, even in King and McKeown's study³¹ a number of respondents reported that their mental health professional misattributed their mental health problems to their sexual identity. Pixton found that one of the most important aspects of gay-affirmative therapy was the therapists' 'having a holistic view of sexuality' and the mental health issues affecting gay, lesbian and bisexual clients for which help was being sought, without the therapist making the assumption that the client's sexual orientation was the core problem³⁹.

5.2.5 Internalised anti-homosexual attitudes

Regardless of how open and at ease many LGB people in these studies may have claimed to be, the authors of at least some of them had an impression that therapy was complicated by internalised negative feelings about homosexuality or bisexuality that prevented their clients from being able to use the therapy fully⁴¹. Mair commented that gay men in his sample might have avoided dealing with painful personal issues by projecting negative and judgmental attributes onto the therapist³⁸. There was also a paradox seen in the men's claim that their sexual orientation was irrelevant to their current problems, while at the same time expressing frustration that the therapist's background prevented them from engaging fully as gay men. Sometimes the language used by participants in the qualitative studies revealed that they had been socialised to be defensive and to expect negative reactions when disclosing to therapists or doctors. Their surprise when the response they received was positive revealed their expectation of rejection or disapproval³¹.

5.2.6 Sexuality of therapist

There were mixed views on the pros and cons of seeing an LGB therapist. Fifty-two per cent of participants in one study said they would prefer an LGB therapist and that this would increase feelings of comfort and safety and provide a role model²⁷. Eighty-three per cent of the lesbian women in Galgut's study wanted their therapist to be explicit about his/her own sexual orientation, and 92 per cent preferred to talk to a lesbian therapist²⁶. The women felt that knowing their therapist's sexual orientation helped them to 'bond' and reduced the power of the therapist. They also presumed that lesbian therapists would better

understand the dynamics of a lesbian relationship than would a heterosexual therapist. However, for others, having an LGB therapist may provoke fears of seduction or a type of political correctness, in that they felt hesitant to express negative attitudes to aspects of LGB lifestyles, or to reveal their distress and own homophobic attitudes³⁸. In this study of 14 gay men, four respondents had wanted to work with a gay therapist but only two had been able to find one, and for one of these the therapist was unsuitable. Gay men in their study who were more comfortable with their sexual orientation (in particular, those who were out of the closet) were less likely to express a preference for a gay therapist. In fact, six of the nine respondents who did not believe it was important to have a gay therapist were even opposed to it. For some this appeared to be due to their own internalised homophobic views but for others, it was based on fear of collusion and possible seduction. One respondent felt that political correctness would prevent him from exploring feelings about his attraction to women if he were to see a gay therapist. Ryden and Loewenthal also reported that the lesbians in their study had concerns about seduction by lesbian therapists⁴¹. In addition, they reported that clients might be unable to explore painful homophobic material with a lesbian therapist because of a perceived need to portray a confident and proud lesbian persona. In their studies of clients who had experienced what they regarded as gay-affirmative counseling or psychotherapy, Pixton³⁹ and Lebolt³² found that far more important than the therapist's sexuality was his or her understanding of the stresses associated with being homosexual and their contribution to the mental health problems presenting. Although only five of the 17 therapists described by participants in this gay-affirmative therapy study were known to be gay or lesbian, participants sometimes found their therapists easier to talk to than their LGB friends who tended to cover up their negative experiences of being lesbian or gay³⁹. LGB people's assumption that an LGB therapist is likely to be empathetic and safe can be questioned, since the therapist may nevertheless hold homophobic attitudes and beliefs^{38,41}. How assumptions are made may also reveal much about what is going on in therapy and in clients' minds. Ryden and Loewenthal reported that lesbian clients sometimes appraised a female therapist in terms of their own stigmatised assumptions. For example, they would assume a therapist of masculine appearance was lesbian or that a married therapist was heterosexual⁴¹. Lesbians in this study also used popular terminology for dealing with the 'enemy', eg using 'radar' to detect lesbian therapists and terms such as 'the other side' to indicate heterosexuality⁴¹. These findings echoed Mair's view that clients' attitudes to the sexual orientation of their therapists often reflected their own stereotypes of homosexuality³⁸. Golding concluded that gender was a key choice which LGB mental health users should have when working with their key staff, whereas staff in general should be trained in LGB issues²⁸.

5.2.7 Disclosure by therapists of their sexual orientation

It was difficult to establish clear findings for or against therapists disclosing their sexual orientation. Disclosure by LGB therapists may give rise to strong feelings in clients, who may continue to project their fears and negative feelings onto the therapist³⁸. Disclosure that the therapist is heterosexual also needs careful reflection on why it might be necessary, what is to be gained and what may occur in the way of unforeseen circumstances. Certainly it seems that, in at least some cases, LGB clients welcome open discussion of the therapist's own sexual orientation, be that LGB or heterosexual²⁴. However, a number of clients in other studies

were relieved when therapists did not disclose their sexual orientation³².

5.2.8 Facilitative factors

Respondents in Pixton's³⁹ and Ryden and Loewenthal's⁴¹ studies reported that the safety of the counselling 'space' was an important contribution to the helpfulness of the therapy. General therapy skills of being encouraging, reassuring and validating were crucial to communicating a non-pathological view of homosexuality³⁹. Ryden and Loewenthal found, despite caveats about its meaning and the transference, that this sense of safety was helped by the client's knowledge of the therapist's sexual identity⁴¹. Lebolt, Pixton, and King and McKeown also reported that the quality of the relationship – in terms of the amount of empathy, support and equality felt by the client – was a key factor in maximising the helpfulness experienced^{31,32,39}. In addition, the sense that the therapist was seeing the client with a holistic perspective, where their sexual orientation was only one part of their identity, was also reported as highly important^{31,39}. In Bell and Weinberg's study, most complaints by men and women who had sought therapy were related to the professional's manner²⁴. These included coldness or lack of understanding, or in one case making a pass at a patient to make sure she was really homosexual. Sometimes, too, it seems that professionals do not allow much discussion following a client's disclosure about their sexuality, and seem reluctant to talk clients through it. This can be very discouraging, especially if the disclosure is among the first ever attempted by an LGB person³¹. LGB people particularly appreciated it when mental health professionals recognised and accepted positively their sexual orientation, when their relationships were respected and when they were respected for having 'come out'¹². Therapists who were explicit about sexual matters and readily addressed their client's sexuality often helped their clients to relax and speak about things they might otherwise have avoided²⁶. Being relaxed and confident about discussing sexual orientation 'embodied' positive attitudes in those therapists.

5.2.9 Training of therapists

King and McKeown³¹ and Mair³⁸ both noted the importance of therapists' training to improve their cultural competence with non-heterosexual clients. They highlighted that therapists have a responsibility to understand the implications of growing up having a non-heterosexual sexual orientation and how LGB people's psychological development may differ from mainstream heterosexual development³⁸. Mair³⁸ felt that therapists may lack a repertoire of questions on the social and sexual history of their non-heterosexual clients or are unaware why such questions might be necessary. He commented that, in particular, therapists need to understand that a client who appears to have completely accepted his or her sexual orientation may not have dealt completely with internalised anti-homosexual feelings. Unconscious internal 'homophobia' (in homosexuals or bisexuals) in both therapist and client would appear to be a recipe for stalemate. He concluded that therapists need to be aware of the potential significance to a client when he says (often early in therapy) that he is gay, and therapists need to be thoughtful about how to respond to and explore this disclosure where appropriate³⁸. It seems that when therapists pick up and use the words their clients employ to describe their sexuality – rather than assuming one set of language is appropriate for all occasions – this leads to a better therapeutic relationship and greater mutual understanding.

5.2.10 Evaluation of the therapy

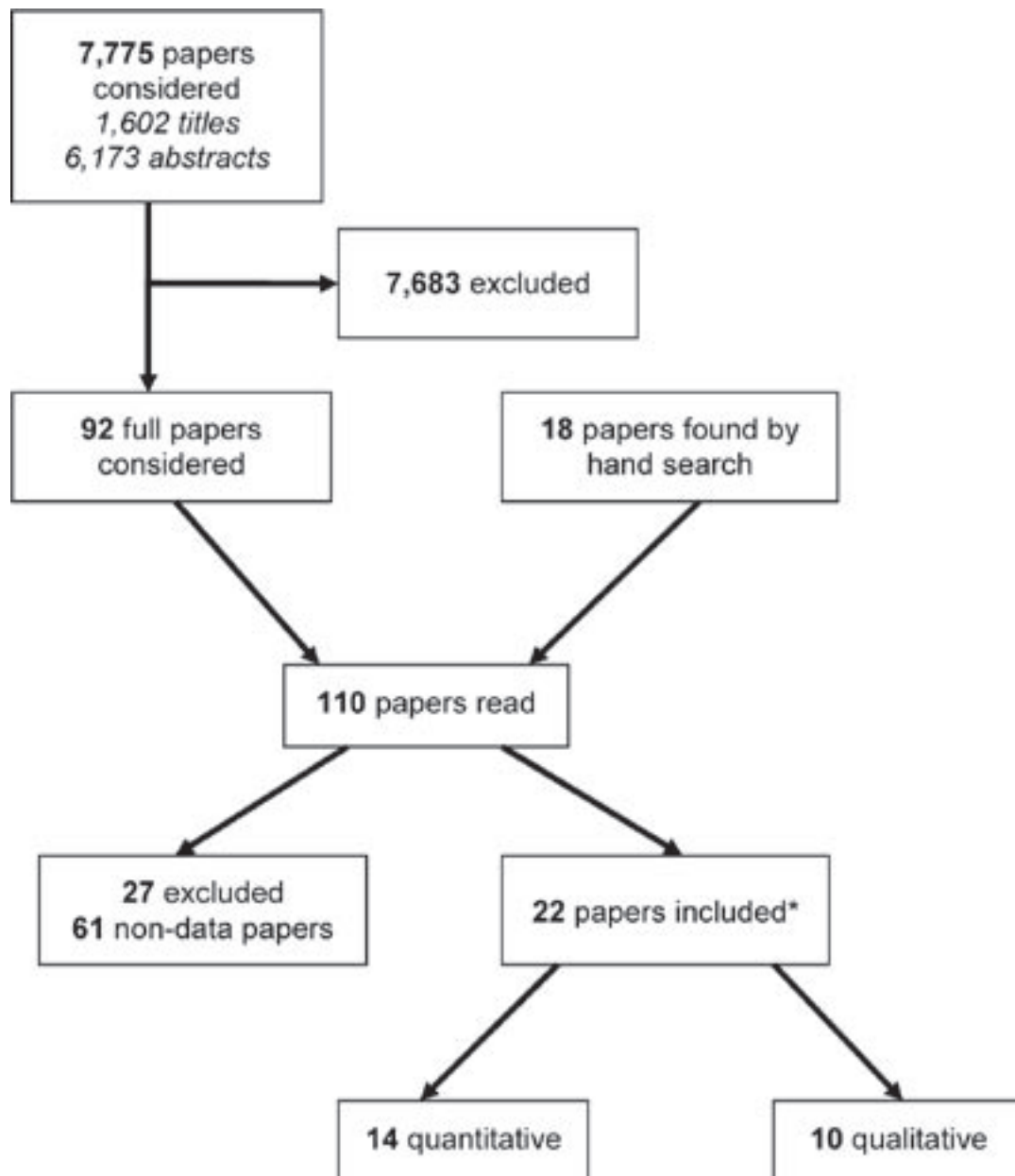
Despite many of the above issues and reservations, LGB people were usually appreciative of the quality and usefulness of the therapists, regardless of that therapist's background^{31,38,39}. Even in earlier studies, where contact with mental health professionals was not always completely voluntary, many clients found some benefit by way of increased self-understanding and a greater sense of wellbeing²⁴. Negative experiences often reflected internalised feelings of guilt or shame about the client's sexual identity and must be seen within the context of the time²⁴. In later studies, negative attributions by clients usually related to feeling stereotyped or misunderstood, or when their sexual orientation was regarded as part of the problem. In two UK surveys of LGB people who had had contact with mental health services^{28,34}, there were reports of considerable insensitivity to LGB issues by professionals, and many instances of frank discrimination and poor practice. Ten years later, the situation seemed to have improved; King and McKeown³¹ carried out in-depth interviews with 23 people in the UK who had participated in a large community survey of lesbian, gay and bisexual people's mental health and wellbeing and who had used statutory or non-statutory services for their mental health problems. They reported that, despite occasional accounts of overtly homophobic comments or behaviours from professionals, participants had encountered broadly positive and accepting attitudes from staff about their sexual orientation.

5.2.11 Summary

The principal findings of these studies are that therapist attitude, knowledge and practice are more important than their sexual orientation; that LGB clients need to understand (and examine)

in the therapy their desire to seek or avoid an LGB therapist, and that therapists need to be aware of the reality and stereotypes of the non-heterosexual world. Our perspective as authors of this report is that this is a tall order for both parties. Therapists cannot and should not rely on being educated about LGB culture by their clients, because, firstly, they may simply fit in with whichever dominant discourse their clients subscribe to; secondly, it simply wastes the client's time; and thirdly, it may make clients feel odd and misunderstood. Both therapist and client need to be aware of the dominant discourses and stereotypes in the LGB world, because if they fail to do so, the possibility of collusion and shared assumptions may limit the depth and utility of the therapy. Adequate knowledge may lead to fewer biased attitudes and fewer heterosexual assumptions on the part of (LGB or non-LGB) therapists. However, therapists need to be free of heteronormative bias, and that requires careful attention to their own psychological function, training, knowledge and experience, and therapeutic relationship with each patient. There is no simple rule for therapists about whether to disclose their own LGBT identity, as this process depends critically on the ability of the patient to deal with the information and the relevance of any personal disclosure in therapy. When a client self-discloses, it may be necessary for both therapist and client to pause for a moment and think through its meaning and implications, rather than the therapist simply to accept it with little comment, in an attempt to be accepting and non-judgmental, or focus on it in a way that implies it holds the key to the client's pathology or recovery. Findings on whether or not LGB clients prefer an LGB therapist were very mixed, and there is probably no overall conclusion to make. If anything, it would appear that this was of greater importance to lesbians than gay men.

Figure 1: Flowchart



**Two papers contained both qualitative and quantitative data^{24,27}*

Table 1: Description of the 14 studies with quantitative data

Study description Author/Year/ Country	Nature of population	Sampling/ recruitment technique and response rate	Numbers of participants (LGB/Non-LGB)	Definition of sexual orientation/ gender identity <i>Type of counselling/ therapy</i>	Study outcomes of interest	Prevalence (%)/ Mean (SD)
Avery, Hellman, and Sudderth (2001) ²³ USA	Adult inpatient and outpatients with chronic mental illness; age unspecified		23 LGBT females 44 LGBT males 160 Non- LGBT ² females 141 Non- LGBT males	Self ID <i>Inpatient/outpatient psychiatry</i>	Prevalence of dissatisfaction with mental health services	LGBT 12/67 (18) Non-LGBT 9/301 (3)
Bell and Weinberg (1978) ²⁴ USA	Community sample aged under 25–46+	Non-probability sample recruited from advertisements, LGB bars, organisations and personal contacts. Probability sampling of matched non-LGB participants.	686 Gay men 293 Lesbians 337 Non-LGB males 140 Non-LGB females	Kinsey Scale ³ <i>Consulted with a professional about emotional problems</i>	Helpfulness of therapist (4-point scale ⁴) Reasons why counselling/therapy helpful	0. Not at all: Gay male 133/391 (34) Non-LGB male 29/93 (31) Gay female 61/194 (31) Non-LGB female 12/60 (20) 1. Very little: Gay male 59/391 (15) Non-LGB male 20/93 (22) Gay female 37/194 (19) Non-LGB female 6/60 (10) 2. Somewhat: Gay male 93/391 (24) Non-LGB male 25/93 (38) Gay female 49/194 (25) Non-LGB female 20/60 (33) 3. A great deal: Gay male 104/391 (27) Non-LGB male 19/93 (20) Gay female 51/194 (26) Non-LGB female 22/60 (37) Gained <i>insight into self</i> : Gay male 126/382 (33) Non-LGB male 37/91 (41) Gay female 86/191 (45) Non-LGB female 29/58 (50)

^b Assumed to be heterosexual but not stated

^c Kinsey AC, Pomeroy WB, Martin CE. Sexual behaviour in the human male. Philadelphia, PA: Saunders; 1948.

^d 0 not at all helpful, 1 very little, 2 somewhat, 3 a great deal

<p><i>Felt better generally:</i> Gay male 62/382 (16) Non-LGB male 22/91 (24) Gay female 30/191 (16) Non-LGB female 11/58 (19)</p> <p><i>More self-accepting:</i> Gay male 61/382 (16) Non-LGB male 4/91 (4) Gay female 37/191 (19) Non-LGB female 8/58 (14)</p> <p><i>Nice to communicate feelings:</i> Gay male 50/382 (13) Non-LGB male 11/91 (12) Gay female 32/191 (17) Non-LGB female 5/58 (8)</p> <p><i>Accepted homosexuality more:</i> Gay male 45/382 (12) Non-LGB male 0/91 (0) Gay female 26/191 (14) Non-LGB female 0/58 (0)</p> <p><i>Other benefits:</i> Gay male 80/382 (21) Non-LGB male 13/91 (14) Gay female 20/191 (10) Non-LGB female 5/58 (8)</p> <p><i>Not helpful at all:</i> Gay male 97/382 (25) Non-LGB male 25/91 (27) Gay female 29/191 (15) Non-LGB female 11/58 (19)</p>		<p>Reasons why counselling/therapy disappointing</p>						
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* Also gave data on 'learned nothing about self', 'reason why it's a cure all', and 'other disappointments'

					<p>Reason for undertaking counselling/therapy</p>	<p>Problems connected to homosexuality: Gay male 176/390 (45) Non-LGB male 4/93 (4) Gay female 81/192 (42) Non-LGB female 0/58 (0) Ordered/forced to go: Gay male 87/390 (22) Non-LGB male 10/93 (11) Gay female 27/192 (14) Non-LGB female 4/58 (8) Feelings of distress not connected with homosexuality Gay male 42/390 (11) Non-LGB male 29/93 (31) Gay female 28/192 (14) Non-LGB female 14/58 (24) Other (situational/adjustment) Gay male 84/390 (22) Non-LGB male 50/93 (54) Gay female 56/192 (29) Non-LGB female 40/58 (69)</p> <p>18 or younger: Gay male 112/392 (29) Non-LGB male 27/93 (29) Gay female 42/193 (22) Non-LGB female 9/58 (16)</p> <p>Never: Gay male 296/680 (44) Non-LGB male 243/335 (73) Gay female 100/292 (34) Non-LGB female 80/138 (58)</p> <p>Less than 16 times: Gay male 269/390 (69) Non-LGB male 68/92 (74) Gay female 107/190 (956) Non-LGB female 41/58 (71)</p> <p>More than 16 times: Gay male 121/390 (31) Non-LGB male 24/92 (26) Gay female 83/190 (44) Non-LGB female 17/58 (29)</p>
					<p>Service use: Age at first consultation</p>	
					<p>Number of times consulted a therapist</p>	
					<p>Number of sessions with first therapist</p>	

Study description Author/Year /Country	Nature of population	Sampling/recruitment technique and response rate	Numbers of participants (LGB/Non-LGB)	Definition of sexual orientation/ gender identity <i>Type of counselling/ therapy</i>	Study outcomes of interest	Prevalence (%)/ Mean (SD)
King, McKeown, Warner et al (2003a) [†] UK	Community sample of men and women aged 16+ years.	Six snowball waves of lesbian, gay and heterosexuals recruited through advertising in national press, in venues and through LGB organisations. Response rate N/A	656 Gay men 430 Lesbians	Self ID Kinsey Scale <i>Mental health professional or GP seen for emotional difficulties</i>	Service use related to client characteristics ■ Sexuality ■ Gender	MHP seen for emotional difficulties Non-LGB Men 162/499 (32) Gay men 363/627 (58) Non-LGB women 253/586 (43) Lesbians 287/424 (68) GP seen for emotional difficulties Non-LGB Men 185/499 (37) Gay men 334/627 (53) Non-LGB women 281/586 (48) Lesbians 243/425 (57)
Liddle (1996) ^{§§} USA/Canada	Community sample aged 22-71	National sample recruited from filers to LGB events and LGB organisations. Response rate cannot be calculated	220 Lesbians 172 Gay men	Self ID <i>Therapy (counsellor, psychiatrist, psychologist, social worker). Recent, first, most helpful, worst</i>	Therapist characteristics ■ Sexuality ■ Gender	Mean Helpfulness Ratings (4-point scale [¶]) of: LGB Female Therapist 3.45 LGB Male Therapist 3.51 Non-LGB Female Therapist 3.34 Non-LGB Male Therapist 2.77 Therapist rated unhelpful where inappropriate practices were exhibited. Relative risks range from 3.23 to 4.01

† Four point scale: 1 Destructive, 2 Not helpful, 3 Fairly helpful, 4 Very helpful

Study description Author/Year /Country	Nature of population	Sampling/recruitment technique and response rate	Numbers of participants (LGB/Non-LGB)	Definition of sexual orientation/ gender identity <i>Type of counselling/ therapy</i>	Study outcomes of interest	Prevalence (%)/ Mean (SD)	
Liddle (1999) ³⁵ USA/Canada	Community sample aged 22-71	National community sample recruited from fliers to LGB events and LGB organisations. Control sample recruited from faculty and graduate students. Response rate cannot be calculated	220 Lesbians 172 Gay men	81 matched non-LGB people (77% women)	Self ID <i>Therapy (counsellor, psychiatrist, psychologist, social worker). Recent, first, most helpful, worst</i>	Client characteristics ■ Sexuality ■ Gender Recency of therapy	Helpfulness Ratings (4-point scale ¹¹) 294/392 (75) LGB clients rated therapists very helpful 82/392 (19) LGB clients rated therapists fairly helpful 78/392 (62) Non-LGB clients rated therapists very helpful 94/392 (24) Non-LGB clients rated therapists fairly helpful Correlation b/w year of service delivery and helpfulness of therapist ¹² 0.23 (p < .01)

^k Four point scale: 1 Destructive, 2 Not helpful, 3 Fairly helpful, 4 Very helpful

ⁱ Therapist Satisfaction Scale (TSS) 130

Study description Author/Year /Country	Nature of population	Sampling/recruitment technique and response rate	Numbers of participants (LGB/Non-LGB)	Definition of sexual orientation/ gender identity Type of counselling/ therapy	Study outcomes of interest	Prevalence (%)/ Mean (SD)
Liljestrand, Gerling, and Saliba (1978) ³⁶ USA	Adults who had been in therapy aged 14-49	Convenience sample recruited through professional and friendship networks in San Francisco, USA	15 LGB 9 Non- LGB	CHEER 6-point Sexual Orientation scale	Client characteristics ■ Sexuality	Differences b/w LGB and Non- LGB in success of outcome ¹³ dealing with issues of: - sexual orientation in therapy t=1.989 <.05 - social sex role t=0.170 N/S - general outcomes t=0.929 N/S - all outcomes t=1.736 <.05 Mean therapeutic gains where client and therapist have the: - same sexuality 1.625 - different sexuality 0.75 Mean therapeutic losses where client and therapist have the: - same sexuality 1.250 - different sexuality 1.688 Feminine stereotype non significant except for therapy dealing with issues of sex roles t=3.384 <.005 Masculine stereotype non significant except for dealing with issues of sex roles t=1.866 <.05
				Psychotherapy	Therapist/client characteristics ■ Sexuality	

^m Gains/successful achievements or losses/failures/no change

Study description Author/Year /Country	Nature of population	Sampling/recruitment technique and response rate	Numbers of participants (LGB/Non-LGB)	Definition of sexual orientation/ gender identity Type of counselling/ therapy	Study outcomes of interest	Prevalence (%)/ Mean (SD)
Mapou, Ayres, and Cole (1983) ³⁷ USA	Gay men aged 18-58	Convenience sample recruited through gay organisations	79 Gay men	Self ID Counselling (psychiatrist 34.3%, psychologist 17.1%, social worker 11.4%, pastoral counsellor 8.6%)	Service use Therapist characteristics ■ Sexuality ■ Gender Satisfaction with counselling/ therapy ⁴	Number of gay men that have seen a therapist ever: 35/79 (44) Sessions a week: one a week 16/79 (20) >once a week 5/79 (14) Mean number of sessions: 29 Reported use of Non-LGB therapist 18/26 (69) Male therapist 24/735 (3) Satisfaction (where reported) 11/19 (58) satisfied
Rachlin (2002) ⁴⁰ USA	Convenience sample adults aged 17-57	Sample recruited at Transgender conference and through personal contact and via the Internet. Response rate N/A	93 trans people (70 assigned female at birth, 23 assigned male at birth)	Self ID Psychotherapy	Reason for undertaking counselling/therapy Recency of counselling/therapy Outcome of counselling/therapy ■ Progress in general Satisfaction with counselling/ therapy ¹⁵	Improve relationships 76/150 (51) Reduce emotional discomfort 84/150 (56) Personal growth 76/150 (51) Work/school conflict 45/150 (30) Decision-making 33/150 (22) Comfort with gender 44/150 (29) 'Most recent therapist' rather than first therapist seen for non trans/ gender related issues. 81/93 (87) reported a positive change occurred Satisfaction with therapy increased with client's perception of therapist's gender experience r=0.470, p<.05

ⁿ No scale listed in paper
^o No scale listed in paper

Table 2: Description of the 10 studies with qualitative data including main themes arising

Study description Author/Year/ Country	Nature of population	Sampling/ recruitment technique	Numbers of participants	Definition of sexual orientation	How data was collected	Was there a clear description of data analysis? (Repeatability 0 No – 1 Yes)	Use of supportive quantitative methods (Yes/No)	Study outcomes of interest
Bell and Weinberg (1978) ²⁴ USA	1,914 white and black homosexual men and women, of whom one half to two thirds had had professional help for an emotional problem	Public advertisements, personal contacts, organisations, mailing lists, bars, gay baths and public places	1,914 LG men and women	Rating on Kinsey Scale; same-sex contact in past 12 months; same- sex fantasies; arousal to opposite sex	Interview with structured and open questions	Not for open questions	Yes – study mainly quantitative	Therapist's attitudes and behaviour Self-acceptance as gay or lesbian Distress over homosexuality Referral by others such as family, courts or armed services
Gaigut (2005) ²⁶ UK	Lesbians who had between them seen 104 therapists	Not given	24 Lesbians	Not given but assumed to be self ID	Semi-structured face- to-face interviews	Extraction of themes during transcription with subsequent diagrammatic representation of the themes Repeatability 0	No	Explicitness in the counselling relationship Heterosexual therapist's problems with lesbians
Gambrill, Stein and Brown (1984) ²⁷ USA	Adults, 60% of whom had sought counselling since living in the San Francisco Bay area	Advertisements and personal contacts in LGB centres, bars, restaurants, shops and friendship networks	392 Lesbian and Gay men	Self ID	Questionnaire – respondents could give written responses	No (0)	Some closed questions used	Lack of training/training needs Homophobia Pathologising of homosexuality Preferences for LGBT Gay-affirmative therapy

Study description Author/Year /Country	Nature of population	Sampling/ recruitment technique	Numbers of participants	Definition of sexual orientation	How data was collected	Was there a clear description of data analysis? (Repeatability 0 No – 1 Yes)	Use of supportive quantitative methods (Yes/No)	Study outcomes of interest
Golding (1997) ²⁶ UK	55 LBG adults who had been users of mental health services	Fliers to the 7,500 households who were registered with the mental health association Mind. 97 people responded of whom 55 (54%) eventually participated	20 Lesbians 22 Gay men 5 Bisexual men 8 Bisexual women	Self ID	48-item questionnaire	Extraction of themes from answers to open questions, cross-checked by a volunteer Repeatability 0	Yes – closed questions also analysed	Difficulties disclosing sexuality to mental health service staff Discrimination with regard to sexuality within mainstream mental health services User's ability to challenge heterosexist practice in mental health services Role of same-sex partners in services Homosexuality as a mental disorder Information needs of LBG users of mental health services Equal opportunities policies and complaints procedures for LBG clients Positive experiences of mental health care

Study description Author/Year /Country	Nature of population	Sampling/ recruitment technique	Numbers of participants	Definition of sexual orientation	How data was collected	Was there a clear description of data analysis? (Repeatability 0 No – 1 Yes)	Use of supportive quantitative methods (Yes/No)	Study outcomes of interest
King and McKeown (2004) ³¹ UK	9 men, 14 women, from national study. All had used mental health services	Advertisements plus snowball sample	23	Self ID as LGB	Face-to-face interviews; data transcribed	Yes. Repeatability 0	Yes – nested within a large quantitative study	Trust – empathy/ understanding/respect Training issues/LGB knowledge Therapy as a positive encounter Heteronormativity Coming-out issues
Lebolt (1999) ³² USA	9 adult males	Advertisements in LGB centres and psychotherapy schools and training institutes	9 Gay males	Self ID as gay	Face-to-face interview with interview guide; interviews taped and transcripts reviewed	No but findings fed back to participants and their comments incorporated. Repeatability 0	No	Active gay-affirmative stance in therapy Non-judgmental attitudes by therapist Good sense of boundaries by therapists Therapists need to be familiar with LGB issues Disclosure by gay therapists early in therapy was thought to be helpful Therapists needed to 'normalise, equalise, universalise and humanise the gay experience' Therapist should cultivate: a non-homophobic stance; knowledge of addictive disorders; awareness of issues for gay male couples; group therapy skills; sensitivity to boundaries; and knowledge of HIV/AIDS

Study description Author/Year /Country	Nature of population	Sampling/ recruitment technique	Numbers of participants	Definition of sexual orientation	How data was collected	Was there a clear description of data analysis? (Repeatability 0 No – 1 Yes)	Use of supportive quantitative methods (Yes/No)	Study outcomes of interest
McFarlane (1998) ¹² UK	35 LGB service users	Leaflets, letters, visits, telephone calls, and advertisements to LGB groups, services and organisations	35 Lesbian Gay and Bisexual men and women	Self ID of LGB, heterosexual or 'other'	Face-to-face interviews; telephone interviews; and focus groups	Very brief description of method used in the most general terms: content analysis, themes emerged. Repeatability 0	No	<p>Homophobia, biphobia and heterosexism from staff and other service users was a common experience for clients</p> <p>Prejudice and discrimination in society also occurred in MH services</p> <p>Quality of care depended on awareness and commitment of MH staff</p> <p>Women in particular feared or experienced intimidation, sexual harassment and sexual assault</p> <p>Service users felt unsupported and marginalised – invisibility of LGB in mental health services</p> <p>Users wanted choice, particularly for LGB therapists</p> <p>Training of staff urgently needed</p> <p>LGB specialist services considered to play a key role – more empathetic and understanding and less likely to pathologise</p>

Study description Author/Year/ Country	Nature of population	Sampling/ recruitment technique	Numbers of participants	Definition of sexual orientation	How data was collected	Was there a clear description of data analysis? (Repeatability 0 No – 1 Yes)	Use of supportive quantitative methods (Yes/No)	Study outcomes of interest
Mair (2003) ³⁸ UK	Adult gay males	Gay men recruited through advertisement in Pink Paper and Counselling and Psychotherapy Journal	14 Gay men	Self ID as gay	Face-to-face interviews - Interview schedule	Used the Maykut and Morehouse Constant Comparative Method Repeatability 1	No	<p><i>Main categories:</i> Internalised homophobia Choosing a therapist – how important is sexual orientation The impact of therapist sexual orientation on therapeutic alliance Client evaluation of counselling The paradox of gay self-identity</p> <p><i>Recommendations:</i> Internalised therapist homophobia Talking about sexual orientation Disclosure of therapist sexual orientation What is 'gay-affirmative' counselling? The need for training in gay issues</p>

Study description Author/Year/ Country	Nature of population	Sampling/ recruitment technique	Numbers of participants	Definition of sexual orientation	How data was collected	Was there a clear description of data analysis? (Repeatability 0 No – 1 Yes)	Use of supportive quantitative methods (Yes/No)	Study outcomes of interest
Pixton (2003) ³⁹ USA	White adults aged 17-56 with an experience of gay-affirmative counselling	Questionnaires distributed in community centres in which counselling was available, and personal contacts of a researcher	17	Self ID as LG	Semi-structured questionnaire for 17. Four then chosen for in-depth interview	Grounded theory for questionnaire and interview data. Repeatability 1	Yes	Six main categories: Communicating a non-pathological view of homosexuality The counselling space What the therapist brings to the relationship The counselling relationship The presence of therapist and client humanity Therapist holding a holistic perspective
Ryden and Loewenthal (2001) ⁴¹ UK	6 women	Word of mouth and a newsletter to two lesbian networks. Women who had experienced a minimum of 2 therapy sessions no longer than 2 years ago	6	Self ID as lesbian	Semi-structured questionnaire; reciprocity in interview indicating 'personal involvement' of researcher; interviews taped and transcribed	No – this was specifically rejected in our postmodern world as an illusion of attaining a fixed and complete picture. Repeatability 0	No quantitative data collected to preserve anonymity	Ambivalence about sexuality of the therapist that reflects current lesbian discourse, masculine stereotypes and 'invisible' non- masculine lesbians Fantasies about the sexuality of the therapist and what they mean Knowledge about lesbian life by therapists Safety and support in therapy

6.0 Discussion

6.1 Main findings

This systematic review of studies of counselling and psychotherapy for LGBT people identified 22 studies that met our inclusion criteria. We found very few papers focusing on psychotherapy for transgender people that were not solely concerned with preparing them for gender reassignment or assisting them afterwards to adapt to their new gender role, but none had data suitable for inclusion in the review. Our main finding is that the standard of quantitative research into the benefits of psychotherapy for LGBT people is poor, and there is no published evaluation of its effectiveness in either experimental (randomised trials) or quasi-experimental (cohort of clients) research. Therefore, we could not conduct a meta-analysis of the quantitative data. The qualitative studies provided a rich literature on LGBT clients' perceptions of therapy, the kinds of therapists they prefer, and how the attitudes, training and methods of therapists can determine outcome. However, many of the findings (eg need for therapist acceptance and positive regard) did not seem specific to LGBT issues and might be concerns for anyone entering psychotherapy. In summary:

- LGBT people consult psychotherapists and mental health services more often than do non-LGBT people.
- Research over the past 20 years indicates that the reasons LGBT people seek talking therapies appear to be similar to those of non-LGBT people.
- When clients report experiences of so-called 'gay-affirmative' therapy, they usually describe therapy in which homosexuality and bisexuality are regarded positively, prejudice is avoided, the stress of externalised and internalised anti-homosexual bias is recognised, and there is sensitivity to LGBT development, culture and lifestyles. It was a therapy that 'knows what it is to be LGBT'.
- There was little consistent use of standardised measures of outcome. However, therapists were mostly highly rated in terms of general satisfaction and perceived helpfulness of the therapy.
- Most quantitative studies involved convenience samples of LGBT people, which means that selection bias is likely, and the generalisability of existing results to all LGBT people undergoing therapy is questionable.
- The main factors associated with dissatisfaction or poorer outcome were ignorance or hostility to LGBT issues by therapists.
- Although preferences for LGBT therapists were commonly encountered in the quantitative studies, the qualitative data indicated that this desire was not always present and that LGBT therapists were even sometimes avoided for fear that clients could not be frank or because of fantasies of seduction.
- Any move by therapists or mental health professionals to pathologise and/or attempt to change sexual orientation was regarded as unwelcome, and usually led to dissatisfaction and lower perceived helpfulness of therapy.

6.2 Limitations of the review

Despite our inclusion criteria, selection of papers was often very difficult and sometimes had to be made after careful discussion between the authors. Although there was a great number of papers published on this subject, only a tiny selection of studies had attempted to directly address

the experience of therapy for LGBT people, or its outcomes. Furthermore, despite frequent mention of LGBT 'affirmative' therapy, definitions of the therapy actually delivered were brief⁹⁹ or even non-existent³². The nature of the quantitative results published was so disparate that a combined analysis of data was impossible. This left us to summarise the results in a way that is ultimately subjective, despite the rigour involved in our selection of quantitative papers. The qualitative review was more straightforward, and arguably provided a detailed picture of how people experienced therapy and the nature of the main issues involved. However, they cannot tell us anything about the effectiveness of therapy for LGBT people. The relative lack of studies into therapy for transgender people means that our conclusions can only be tentative.

6.3 The contribution of different research measures, techniques and designs

We can conclude very little about the contribution of research design to these findings, as we found little in the way of imaginative design or use of LGBT-focused instruments – to assess either clients, the process of therapy or its outcome. The majority of quantitative studies were simple, cross-sectional, descriptive studies and few went far in the depth or sophistication of their data analyses. However, the research was detailed as far as it went and provides an overview of how psychotherapy services are perceived by LGBT people and what benefits accrue to them, at least in the opinions of clients. The qualitative studies arguably provide a richer, more nuanced view of therapy for LGBT people, and are generally less optimistic in tone. This may reflect the fact that dissident voices are more likely to be heard in qualitative than quantitative research, simply because of the type of recruitment, numbers of participants and forms of analysis involved in the latter.

6.4 Implications for policy and practice

A literature on psychotherapy that takes a positive account of LGBT people and their life experiences has been emerging over the past 20 years. These therapy models affirm same-sex orientation and take account of the stressful developmental experiences gay, lesbian and bisexual clients may bring to therapy^{14,131–133}. Although focusing mainly on men, Isay in particular has written extensively on maintaining an actively affirmative stance with LGB clients, which, he claims, helps to counteract the impact of anti-homosexual bias in a person's upbringing and early adult life when sexual relationships become important¹³³. Unconditional acceptance by therapists of the client's sexual orientation or gender identity may help the client to accept their identity and express it in normal ways, regardless of the exact nature of the presenting psychological problem. There has been considerable theoretical discussion about the conventional ideas on sexuality in psychoanalysis, and an attempt to incorporate so-called queer theory into a more up-to-date understanding, in which same-sex orientation is no longer by definition pathological^{134–135}. Our data do not help us understand the effectiveness of such new developments, nor can they inform us of how extensive they have become in this country. But our findings do suggest that so-called gay-affirmative psychotherapy is welcomed by LGB clients and that it leads to an increased perception of safety in therapy and to higher satisfaction. It is also clear that if therapists are to be effective, they need to learn more about the personal development of LGBT people, the nature of their relationships and what sort of problems they may encounter in a relatively hostile society. Although LGBT clients appear to prefer to

consult LGBT therapists, this desire is certainly not universal, and for many potential clients, seeing well-informed therapists who do not share the prejudices of many in mainstream society is likely to be a requirement for successful therapy. Our data would suggest that therapists should not rely on their LGBT clients to educate them about gay and lesbian lifestyles. Although many clients in the studies in this review did not appear to find this a problem, others found it made them feel unusual or odd. Training institutes for psychotherapy and counselling need to strive to remove prejudice within training itself⁶, as well as educate trainee therapists about the key issues in sexual orientation and gender identity that may arise in their work. Therapists and counsellors are likely to work with a variety of clients across the range of sexual orientation and gender identities, and will need to be sensitive to these issues in clients who are unclear or confused about their sexual identity or who may relate to key people in their lives who are LGBT. This is not a specialised domain but rather one that may arise commonly in therapy. Thus, we would recommend that promotion of training in LGBT 'cultural competence' should become a required part of accreditation in psychotherapy. This would avoid heteronormative practice and encourage the provision of a safe therapeutic space, which would have a number of positive effects. These include avoiding misattribution of the presenting psychological problems to the client's sexual orientation or gender identity, but, at the same time, allowing issues related to sexuality, gender and relationships to be explored, including the client's own prejudice, guilt or shame. It would minimise the tension around therapists' disclosure of their own sexual orientation and facilitate the client's sexual orientation and/or gender identity being worked with as one part, rather than the whole, of their identity. We should also not underestimate the findings from this review that the general skills of the therapist such as warmth, understanding and respect are basic and vital for a positive experience for any client, whatever their sexual orientation or gender identity.

6.5 Implications for research

Our results demonstrate a clear need for the development of LGBT-specific psychotherapeutic interventions, in which the various strands of LGBT-affirmative psychoanalysis, psychotherapy and counselling and the views of the LGBT people towards therapy – as presented in this document – can be considered. These therapies should be rigorously evaluated in randomised trials. Several LGBT-affirmative therapies are springing up around the western world as responses to local needs and cultures, none of which appear to have been evaluated rigorously. Unfortunately, the results of this review do not yet allow us to recommend such therapies. We suggest that LGBT-affirmative therapy could be evaluated against non-LGBT-affirmative therapy of various sorts (eg usual psychological statutory services, or private counselling or psychotherapy). It is common in psychotherapy trials to evaluate a new intervention (LGBT-affirmative therapy) with standard care (which is not routinely LGBT affirmative).

We also need longitudinal comparative studies of people undergoing psychotherapy, using standardised outcome measures to compare LGBT and non-LGBT people. In addition to formal psychotherapy trials, naturalistic studies might explore and contrast different modalities of psychotherapy for LGBT people. These should over-sample from the LGBT community to enhance statistical power. Such studies should examine the predictors of good and bad outcomes for LGBT people in terms of engagement, psychological wellbeing and functioning, and satisfaction with services. Measurement of outcome will entail the standardised measures that are applied in other psychotherapy research.

However, there may also be a need for the development of LGBT-focused instruments to measure issues such as the degree to which clients found the therapy affirmative of their gender or sexual orientation, degree of change in internalised bias against their own sexual orientation or gender, the quality and strength of same-sex relationships, distress about sexual orientation or gender and ease about being open in different aspects of their lives.

We should draw lessons from the various responses found in our qualitative data to actions taken by therapists that may seem self-evidently positive to LGBT people but which are not always regarded in that light by LGBT clients. Examples include having a therapist matched on sexual orientation or therapists freely disclosing their sexual orientation. All such actions by therapists require evaluation in carefully conducted, sensitive research if we are fully to know their impact and effects on outcomes. If more rigorous studies confirm that LGBT people have some negative experiences of psychotherapy, the nature of these problems needs carefully characterising. There may be simple educational interventions at the level of both the therapist and the client to minimise clients' perceptions that their therapist has a heterosexist outlook or will view non-heterosexual orientation and transgender clients negatively or even with hostility. Such interventions could be developed with LGBT-client input and their acceptability and effect on client satisfaction and engagement tested empirically.

7.0 Recommendations

These studies reveal that LGBT-affirmative talking therapies are becoming mainstream, by normalising their day-to-day experiences, helping them to face and counteract the inherent prejudices against homosexuality, bisexuality and transgender that pervaded their early development, and focusing the therapy appropriately onto the issues brought to therapy, rather than on their sexual orientation or gender identity.

We would recommend that:

- 1) All psychotherapy training institutes regard knowledge of LGBT development and lifestyles as part of core training.
 - a. Heteronormative bias must be recognised and avoided.
 - b. Therapists should increase their knowledge of LGBT issues and keep up to date.
 - c. Psychotherapeutic practice that pathologises homosexuality, bisexuality and transgenderism should be replaced by more modern understandings of sexual identity.
 - d. Therapists should become aware of internalised bias in the LGBT clients themselves.
 - e. Therapists should receive training on the impact of self-disclosure for all clients including the sensitive issue of their own sexual orientation and gender identity.
- 2) All psychotherapy training institutes encourage greater numbers of LGBT people to train as therapists in order to improve knowledge in the professional therapeutic community and enable choice of therapists for clients where possible.
- 3) Psychotherapists consider very carefully the advantages and disadvantages of self-disclosure of their sexual identity, gender identity or lifestyle for each particular client and not expect to follow any general rules.

- 4) Psychotherapists take care to inform themselves about LGBT cultures and lifestyles through their personal or professional lives, rather than expecting their LGBT clients to educate them.
- 5) More services are provided for transgender people that focus on general psychotherapeutic issues rather than exclusively on the pathway to or from gender change.
- 6) Affirmative psychotherapy for LGBT people is operationalised in order for it to be evaluated.
- 7) Funding is made available for the evaluation of the effectiveness of LGBT-affirmative therapy in cohort studies and randomised controlled trials.
- 8) Prospective research should evaluate the degree to which our training recommendations are implemented and determine predictors of their implementation.
- 9) Mental health and psychotherapy services should routinely audit outcomes for LGBT people, including satisfaction, access, engagement, perceived homophobia, and mental health outcomes, including psychological and emotional wellbeing and functioning.

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ISBN: 1-905114-23-0
ISBN: 13: 978-1-905114-21-4