Academic Article

‘That safety of naming’: exploring internalised homonegativity in LGBTQ+ therapists and its impact on therapeutic work

By Neil O’Connor

Abstract:
The lesbian, gay, bisexual, transgender, ‘queer’/‘questioning’ and ‘+’ (LGBTQ+) community is subject to discrimination, prejudice and violence, often resulting in internalised homonegativity (IH). Historical research into IH, described as negative societal attitudes being directed inward in LGBTQ+ people and the resultant impact on psychotherapy was largely concerned with the experiences of the client. This research aimed to increase the understanding of IH, to investigate the impact of IH in LGBTQ+ therapists on therapeutic work, and to establish recommendations for addressing IH in LGBTQ+ therapists.

‘Faggot’ was the worst name you were going to be labelled with

Vincent, an LGBTQ+ therapist

Lesbian, gay, bisexual, transgender, ‘queer’/‘questioning’ and ‘+’ (LGBTQ+) people constitute a worldwide community subject to discrimination, stereotyping, prejudice and violence (Antebi-Gruszka & Schrimshaw, 2018). The introjection of these messages results in internalised homonegativity (IH), described as negative societal attitudes being directed towards the self, leading to inner conflict (Williamson, 2000). Relevant contemporary research was almost exclusively concerned with the experiences of the client as opposed to the therapist, and recommendations for practice consisted of generic advice that was not tailored to IH as a presenting issue. A disproportionately small amount of research explored the subjective experiences of therapist IH, the potential repercussions for therapeutic work, and any measures specifically designed to redress IH.

The present research interviewed five LGBTQ+ identifying therapists with at least three years of experience using a semi-structured format. Data were analysed using Interpretative Phenomenological Analysis (IPA) and uncovered accounts of lived experiences of IH, revealed the oppressive and traumatic effect of IH, and suggested addressing IH through education and therapist self-examination. This research contributed to the understanding of IH by highlighting specific social contexts and personal experiences of IH, by demonstrating the extensive and lifelong felt impact of IH, and by uncovering novel perspectives on the impact of IH on therapeutic

work. This research reiterated the need for the use of appropriate LGBTQ+ related terminology, the need for cultural competency education for therapists, and the central role played by therapist self-assessment and engagement with personal processes.

Internalised homonegativity and therapeutic work

The evolution of related terminology

The term 'homophobia' first appeared in 1971 defined as the dread of, and self-loathing amongst, homosexuals (Desmond, 2016). This has been widely contested since, the most prevalent argument being that the phenomenon is not a classic phobia (Davies & Neal, 1996) but prejudice giving rise to abuse, violence, and discrimination (Dreyer, 2007). Others argued that the word unhelpfully emphasises affective fear, and inaccurately situates prejudice within the individual rather than societal structures (Williamson, 2000). Definitions broadened to include disrespect, disgust, hatred and animosity towards LGBTQ+ people (Desmond, 2016). The term 'homonegativism' emerged in the 1980s to reframe the construct with a keener focus on the value systems and beliefs of prejudiced individuals (Williamson, 2000). 'Heteronormativity' and 'heterosexism', also from this period, refer to societal and political environments which presuppose and prefer the consistent pairing of women and men and ignore or actively suppress any who do not conform (Dreyer, 2007). Definitions were further diversified by the individuation of 'binegativity': the sum of prejudices which aim to invalidate the bisexual experience which is encountered in heterosexual and LGBTQ+ arenas (Israel et al., 2018). The Gay and Lesbian Issues and Psychology reviewed 'queer hate', asserting that the continued use of outdated terminology exacerbates the experiences of the LGBTQ+ community (Fox, 2009).

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Emergent dynamics in therapy

IH impacts on mental and social health in myriad ways (Douglas-Scott, Pringle & Lumsdaine, 2004, Sherry, 2007). This impact will present in the therapeutic space when working with LGBTQ+ clients (Davies & Ackroyd, 2002). The client is not always aware of the influence (Douglas-Scott et al., 2004), but is lured nonetheless into lifelong patterns of chronic self-regulatory coping (Bowers, Plummer & Minichiello, 2005). In the UK Gay Men's Health Network report on health inequalities among LGBTQ+ people (Douglas-Scott et al., 2004), IH was linked to suicidality, self-harm, poor social support, eating disorders, alcohol and substance abuse, chronic stress and denial of sexuality. Further correlates identified included depression, anxiety, lower identity affirmation and well-being, higher risk sexual behaviour and greater difficulty with intimate relating (Antebi-Gruszka & Schrimshaw, 2018). In this same study, it was found that bisexual people report higher levels of IH, that binegativity (where individuated) was positively correlated with psychological distress, and was negatively correlated with life satisfaction, congruence of identity, and social network support specifically related to sexuality (Antebi-Gruszka & Schrimshaw, 2018). IH has been categorised as a minority stressor which places demands on those in disadvantageous social positions borne of inhospitable environments and has been linked to poor outcomes in both romantic relationships and non-romantic intimate relationships for LGBTQ+ people (Frost & Meyer, 2009).

Withholding and disclosing of the therapist's LGBTQ+ nature have both been proven to negatively impact therapeutic work (Silverman, 2001). Unintentional disclosure was recognised as a stressor (Kessler & Waehler, 2005), while research by Riggle, Rostosky, Black and Rosenkrantz (2017) highlighted the LGBTQ+ therapist's dilemma: 'coming out of the closet' (exhibiting high levels of transparency regarding sexuality) was positively correlated with high levels of differential treatment and experience of bigotry, while remaining 'in the closet' was negatively correlated with a satisfactory level of psychosocial wellness. As a parallel, the authors identified that high levels of LGBTQ+ self-congruence and authentic living were positively correlated with high levels of psychosocial wellness while being negatively correlated with self-reported distress.

IH was also associated with negative self-talk about the self and about other sexual minorities, ruminating, self-criticism, lower effectiveness of coping, and

harmful religion-based attempts at coping (Puckett, Mereish, Levitt, Horne & Hayes-Skelton, 2018). It has been argued that societal heterosexism has damaging effects on LGBTQ+ intimate relationships, demanding never ending vigilance from the LGBTQ+ individual to safeguard their interpersonal, physical and psychological safety, with no guarantee of success; moreover, lack of universal legal recognition of LGBTQ+ relationships can lead to perception of less meaning in life than for heterosexuals (Szymanski & Hilton, 2013).

Implications for therapeutic work and recommendations for practice

The first encounters between psychotherapy and the LGBTQ+ community were destructive, and the prevailing theories of the time dictated the value of the person to the detriment of the LGBTQ+ client (Dreyer, 2007). The role of psychotherapy in the modern context, therefore, requires that social norms should be approached with caution, never seen as absolutes, and not assumed to apply to every person in the same way (Dreyer, 2007). Diversity within the LGBTQ+ community was highlighted, reiterating that LGBTQ+ people are not homogenous, but exist with differing experiences and needs (Gottschalk & Newton, 2009). It has been argued that overcoming IH is essential for the development of a healthy LGBTQ+ self-concept, but that it may be impossible to do so entirely (Frost & Meyer, 2009). Any attempt will invariably include working to jettison self-devaluation and to develop strategies for coping with stigma, so therapists must assess their LGBTQ+ clients for IH and (where appropriate) work with increasing assertiveness, communication, skills for facing homonegative adversity, and self-acceptance (Rostosky & Riggle, 2002). Brown (2002) offered a review of literature dealing with suicidality and self-harm in LGBTQ+ youth, advising that mental health professionals should analyse their feelings towards the LGBTQ+ community, and recommended the inclusion of personal attitudes, fears and prejudices in this self-examination.

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Jeffery and Tweed (2015) researched LGBTQ+ therapists who concealed their sexual identity within the therapeutic environment. Feelings of guilt, dishonesty and shame and the sense of being a traitor were reported, even when the therapist based their decision on the benefit to the client and the therapeutic dynamic. A therapist's unwillingness to disclose their sexuality or gender is more acutely experienced when an LGBTQ+ therapist reveals (or considers revealing) their orientation to a heterosexual client (Thomas, 2008). Fears and concerns included that their disclosure would result in a loss of respect for the therapist by the client, or a negative change in the client's feelings towards them. As a corollary, Moore and Jenkins (2012) highlighted that IH is experienced more frequently and more intensely by LGBTQ+ therapists working with heterosexual clients than with their LGBTQ+ fellows.

Bowers, Plummer, and Minichiello asserted that homonegativity is a form of trauma and that lack of acknowledgement of this leads to continual retraumatisation (2005). They proposed that therapeutic redress should take the form of post-trauma recovery in an active way, and that it is not sufficient for therapists to simply tolerate their clients' differing essence (Bowers et al., 2005). Never assuming that couples who have been together and openly LGBTQ+ for a long time are immune to IH was highlighted by Spencer and Brown (2007). IH can be concurrently explored alongside shame and vicarious shame, but, as this exploration can induce feelings of shame, therapeutic sensitivity is paramount (Greene & Britton, 2016). The recognition and acceptance of shame by the therapist can facilitate awareness and processing by the client (Greene & Britton, 2016). The therapeutic intervention of decentering, wherein thoughts and feelings are actively viewed as events rather than immutable truths about the self, was explored by Puckett et al., (2018). The researchers found that decentering can be deployed in therapy to help clients to place emotional distance between themselves and adverse cognitions, with a resulting decrease in automatic maladaptive thinking and schema formation, and an increased detachment from internalised negative messages like IH (Puckett et al., 2018).

Much of the proffered recommendations for practice consisted of generic instruction - for example, the importance of a supportive therapeutic relationship (Bowers et al., 2005), something which is not unique to the needs of LGBTQ+ people presenting with IH. IH is widely acknowledged as a focal point of the literature concerned with, and published by, LGBTQ+ people, while being significantly underrepresented in the research and education of counselling and psychotherapy (Moore & Jenkins, 2012). Lea, Jones and Huws (2010) pointed to the paucity of LGBTQ+ related guidance and course content in education, while a dissertation by Meades (2019) highlighted the need for LGBTQ+ cultural competence training programmes for therapists.

Methodology

IPA was chosen for this research because of its suitability for the exploration of interpersonal and subjective phenomena like IH. This involved creative examination of the participants' lived experiences: in IPA, meaning is interpreted in an active way. IPA is considered a double hermeneutic as the researcher is trying to make sense of the way in which the participant makes sense of what has happened to them (Smith & Osborn, 2003). IPA research is especially interested in how the everyday ebb and flow of life assumes significance for the individual (Smith et al., 2012).

The sample comprised five LGBTQ+ therapists who had been working for at least three years, with gatekeepers and snowball sampling used in recruitment. Semi-structured interviews were carried out which allowed new ideas and topics to emerge. The data gathered was fully anonymised, including the use of pseudonyms and the redaction of identifying features, and the participants were afforded the right to withdraw from participation (Smith et al., 2012). The participants were also afforded the opportunity to request amendments to, or redaction of, any portion of their data after their interviews (Smith et al., 2012). Engagement with academic supervision was central to this research: in order to combat bias, an awareness of a personal connection to the topic was consciously maintained.

The narratives of the participants in this present research were replete with accounts of homonegative slurs, physical assault and differential treatment, recalling

(Dreyer, 2007)

Results

This present research noted gaps in the research with regard to LGBTQ+ specific recommendations for practice, avenues for addressing IH in LGBTQ+ therapists, and the exploration of experiences of IH in LGBTQ+ therapists. Three core themes emerged from the analysis: 'a deeply felt understanding', 'influence of IH on therapeutic work' and 'what needs to be done'.

The narratives of the participants in this present research were replete with accounts of homonegative slurs, physical assault and differential treatment, recalling Dreyer (2007) and Desmond (2016). Szymanski and Hilton (2013) discussed LGBTQ+ safety, and this research uncovered the participants' related experiences of feeling unsafe in social situations, withholding public affection to avoid being victimised, and homonegative assault. Susan used the language of emotion and connection when she sought *'to bring [IH] down to the innate need for belonging, safety and love'*, contrasted with *'other people's prejudices and fears'*. Susan's juxtaposition of intense emotions (*'love'* and *'fear'*) demonstrated the polarity of her sense of the phenomenon.

Williamson (2000) and Cornish (2012) were recalled by this present research when the participants reported IH encountered in families, communities, schools, universities and work environments: Peter spoke about how he internalised that *'Queers are and gays are that, faggots and dykes… all of this language in schools and families'.* Williamson posited that IH belies the beliefs and value systems of prejudiced individuals (2000): this research found that IH is more keenly felt with clients who hold overly religious and dogmatic values or a rigid heteronormative worldview.

The detrimental effect of IH on mental and psychosocial health was highlighted throughout this research, with each of the participants discussing the harmful impact and naming related morbidities and symptomologies. This finding agreed with the totality of historical research into LGBTQ+ lives (Antebi-Gruszka & Schrimshaw, 2018, Sherry, 2007, Puckett et al., 2018). This includes health inequalities such as suicidality (Douglas-Scott et al., 2004), poor romantic and non-romantic relationship outcomes (Frost & Meyer, 2009), and poor

quality of life, reflected in the participants' accounts of sadness, despair and trauma (Antebi-Gruszka & Schrimshaw, 2018). Marcus described how he was *'a confident child… I used to break my own heart with why I'm not sharing this*'. He was held back by something. stronger, something *'heartbreaking'* for which he took full responsibility: he would *'break [his] own heart'.* Vincent reflected on visibility management and his own sadness at years of *'filtering'* (the active process of avoiding revealing his LGBTQ+ nature). Rita also recalled filtering and using discreet pronouns to hide her partner's gender. Peter concluded by succinctly stating, *'We've internalised [that] there's something wrong with these people. And then we turn out to be one of these people'*.

Israel et al. (2018) noted the presence of binegativity in LGBTQ+ arenas. This echoed two female participants' experiences of negative reactions from within the LGBTQ+ community, and their sexual histories with men marring their 'gold standard' status as 'true homosexual[s]'. Exploring work with clients who seemingly lack an internal struggle regarding their sexuality, Rita stated, *'When I'm sitting with somebody who has been the 'gold standard'… it brings up with me the fact that that wasn't my experience.'* Upon probing the idea of the *'gold standard',* Rita responded:

It doesn't bother me [pause]. Maybe it does… it feels good, this idea that you can only be a true homosexual person if you have never been with somebody of the opposite sex… it's my experience that I'm not a good lesbian because I was married to a man.

Rita yearned to be a *'good lesbian'* and *'a true homosexual'*, qualifying the source of this

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wish by saying, *'It's almost as if I'm not good enough for the LGBTQ+ community'.* This suggested the potential existence of 'heteronegative' sentiments amongst LGBTQ+ people.

This research revealed several accounts of experiencing heteronormativity (Dreyer, 2007), including incidents from childhood, adolescence and adult working life. The conscious use of up-to-date terminology in carrying out this research was informed by Fox's assertion (2009) that the use of inaccurate historical terms aggravates the experiences of LGBTQ+ people.

The current research identified the incidence of IH in therapeutic work, such as client's use of slur words, and the mechanisms employed by the participants and their clients to cope, such as Peter's unconscious dismissal of all male clients (Douglas-Scott et al., 2004, Bowers et al., 2005, Davies & Ackroyd, 2002). Susan explored her somatic reaction to an experience with a client who reminded her of one of her parents: '*There was an increase in heart rate… I've noticed that I held my breath… that being taken away, that safety of naming, of being, of voicing, of proclaiming.*' As her response was probed, Susan alluded to trauma recovery work: *'You remind yourself that you are safe'*. Recounting a similar experience, Peter acknowledged that he was challenged by *'every single male I ever met. Every single male I ever met'*, his use of repetition emphasising his sense of the impact.

This research agreed with the finding that IH leads to negative self-talk and self-criticism (Puckett et al., 2018). The participants described current and historical incidents of harsh internal dialogue with resultant professional shame, loss of faith in self, and anticipating blocks to therapeutic work arising out of the clients' discovery of their LGBTQ+ nature.

Intentional and unintentional disclosures were discussed in this research, in agreement with the literature (Kessler & Waehler, 2005): the participants recounted both scenarios from their histories, identifying somatic and psychological effects including shame, fear and anger. The participants also described their more recent constructive attitudes to client inquisitiveness and self-disclosure, echoing Riggle et al. (2017). IH impacts more profoundly on therapists who disclose (or consider disclosing) their LGBTQ+ nature to a heterosexual client (Thomas, 2008) while Moore and Jenkins (2012) asserted that IH arises more frequently and intensely in all aspects of work with heterosexual clients. The participants in this research named this increased incidence of IH in their work. Thomas' work uncovered fears that disclosure would result in a negative change in the client's feelings towards the therapist, echoed in this present research. Both withholding and disclosing are known to have a negative impact on therapeutic work (Silverman, 2001) and this research agreed, with both approaches being described alongside the resultant detrimental

impact. Jeffery and Tweed (2015) found that guilt and shame resulted from the withholding of the therapist's sexuality, reflected here by participants recalling clients going unchallenged when using homonegative slurs. The reframing of homonegative adversity and IH experiences into positives and strengths by four of the participants recalled decentering (Puckett et al., 2018).

The literature regarding the addressing of IH in therapeutic work was noted to proffer only generic recommendations, and the participants in this research discussed the lack of recognition of the LGBTQ+ community in education and practice. Gottschalk and Newton (2009) highlighted the importance of recognising the distinctions between the LGBTQ+ community and the heteronormative world, and this was reflected in the current research when the participants expressed their *'heartbreaking'* experiences of heteronormativity or having their *'nuanced'* lifestyles eroded or diminished. Reporting lesser degrees of IH than in younger life was a common thread amongst the narratives in this research, but the participants uncovered contemporary experiences and hitherto unconscious aspects of their IH during their interviews, recalling Frost & Meyer (2009). Rostosky and Riggle (2002) proposed that an attempt to overcome IH includes acceptance of self and letting go of previously held negative perceptions. Avoiding the assumption that being openly LGBTQ+ makes one immune to IH (Spencer & Brown, 2007) was also echoed herein.

Bowers et al. (2005) argued that IH is a form of trauma, and this was echoed in the current research when the participants discussed their experiences as traumatic or described traumatic soma. Narratives of trauma and resultant defenses within this research also hinted at the possibility of defensive reactions in the form of heteronegativity and homonormativity. Susan's recollection of experiencing a negative side of the LGBTQ+ community was similar to Rita's experience of not being a 'good lesbian'; Susan recalled *'being told how to be, how to dress… the best way to look lesbian enough, or gay enough'*.

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>
> *(Moore & Jenkins, 2012)*

IH and the LGBTQ+ experience has been significantly underrepresented in the education of counselling and psychotherapy (Moore & Jenkins, 2012). This research agreed, with four participants describing their disappointment with their experiences in the educational arena. Meades (2019) pointed to the need for cultural competence training for therapists working with LGBTQ+ clients, and the four participants in this research who focused on education unanimously highlighted the need for this type of training.

The response offered by one participant underscored the therapist's personal accountability and the individual process of those in counselling education, similar to Brown (2002). Peter's singular response outlined a different approach: '*The first thing is to get an awareness… there is this part of me, and I know it. It's about really embracing that there has been damage done. What we need, it's inside already.*' Exploring this further, Peter posed a rhetorical question: *'What could a college do that would help us to work through our own internal defense?'*

Limitations

All of the participants were Caucasian and cisgender, which may have resulted in overlooking the experiences of therapists from different ethnocultural backgrounds and differing gender identities, as well as the opportunity to examine the concurrent effects of those types of oppression and discrimination. Four out of five of the participants in this research were Irish, and the South African participant trained and worked in Ireland, meaning that the Irish context of counselling and psychotherapy may be overrepresented. It cannot be certain that the results are applicable to the international LGBTQ+ community, but the subjective nature of both IH and IPA analysis may go some way in mitigating this limitation. The limitations identified in this research suggested that avenues for further research could include the experiences of therapists from ethnocultural and educational backgrounds outside of the Irish context, as well as those of gender identity other than cisgender. Furthermore, an inquiry into the applicability of the results of this research in the context of the international LGBTQ+ community could uncover valuable insights. Finally, the suggestion of a potential heteronegative and homonormative culture in the LGBTQ+ community warrants further exploration.

Clinical significance

This research contributed to the current knowledge of IH by identifying a range of specific societal arenas and personal dimensions where IH and causative homonegativity is found. The findings of this research contributed to the understanding of IH by emphasising the pervasive and lifelong effect of IH, the merit of embracing diverse descriptors in accounts of homonegativity and IH, and the value of challenging outdated terms with conscious use of up-to-date LGBTQ+-related language. This research contributed to the understanding of the impact of IH on therapeutic work by revealing novel accounts and perspectives, building upon the existing literature. This research underlined the need for cultural competency education for therapists, and the central role played by therapist self-examination and engagement with personal processes.

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