Working Relationally with LGBT Clients in Clinical Practice: Client and Clinician in Context

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Introduction

"Since this is a gay clinic, you probably want me to be gay, out, and proud," said Tom in our first session. Conflicted about his sexual orientation, recently diagnosed with HIV, still living in the closet at 40 years old, and suspicious of my motives, Tom spoke volumes with that one statement. He also brought us right into the fact that we were already in a relationship, one filled with expectation, hope, and dread. He further illustrated, as will be discussed, the clinical challenges and necessary relational theory elements for effective clinical social work practice.

Relational social work is particularly suited for intervention with oppressed populations, such as lesbian, gay, bisexual, and transgender (LGBT) clients, who are vulnerable to pathological labeling (Glassgold 1995; Lewes 2005). Relational therapy directs the clinician away from unidirectional diagnostic labeling and toward a mutual articulation of problems and goal setting for clinical work (Orange et al. 1997). Deconstruction of pathogenic narratives applied to any population is a core clinical element of relational theory's basis in constructivism and its techniques of mutual exploration and co-created strategies of addressing problems that are both individual and generic for marginalized or maligned groups (Berzoff 2011). The relational social worker strives to normalize and thereby depathologize

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the client's experience. In this way the worker helps to alleviate the experience of shame and the stigmatization inflicted by hegemony of a homophobic and heterosexist society (Glassgold 2004). The relational social worker does not pursue trying to know the etiology of the client's sexual orientation or gender identity. Instead of asking "why?" the relational clinician is more interested in the "how" of the client's present lived experience. She is curious about the many ways that the client's sexual orientation and gender identity have had an impact on his relationships with others and the self.

Unlike some earlier, psychoanalytically informed models of practice, relational theory does not have a tradition that seeks to find the origin of sexual orientation and gender identity in the client's developmental history (Drescher 1998). The focus is on the individual's particular subjectivity and not upon the etiology of sexual orientation or gender identity. Subjective experience is the departure point for clinical exploration (Ganzer 2007). This can include an examination of the impact of sexual orientation and gender expression upon personality development across the lifespan.

LGBT Identity and the Mental Health Professions

Historically, within the mental health professions, LGBT orientations have been deemed pathological and diagnosed as mental illnesses and perversions. In American psychiatry, which has shaped American clinical practice in general, homosexuality was considered a mental illness to be cured. Clinical social work was heavily impacted by the diagnostic categories and descriptions of mental illnesses, being in most public service sectors required to legitimize clinical treatment based on an approved diagnosis. In 1973, through the lobbying efforts of the LGBT community, the American Psychiatric Association (APA) removed homosexuality as a diagnosis from the Diagnostic and Statistical Manual (DSM) III (Drescher 2010). From 1980 to 1986, a new diagnosis appeared in the DSM-III, viz., ego-dystonic homosexuality (American Psychiatric Association 1980). Some argue that this was a compromise to appease prominent segments of the APA who persisted in conceptualizing homosexuality as the result of pathological personality development and that this diagnosis perpetuated the homophobic treatment of gays and lesbians by the mental health professions (Bayer 1987), including clinical social workers as primary providers of public mental health care.

The pathologizing of transgender experience in particular remains entrenched in the current version of the diagnostic manual, *DSM-IV-TR* (APA 2000). Gender identity disorder (GID) is routinely assigned as a diagnosis to transgender clients seeking help from the mental health professions (Sennott 2011). Medical practitioners often require a psychiatrically assigned diagnosis of GID as a prerequisite for access to gender-confirming medical treatments such as hormone therapy or surgery (Drescher 2010). The planned fifth edition of the DSM strikes GID from its list of

disorders; however, it contains a diagnostic compromise similar to one used by the APA in the 1980s – gender incongruence. While sidestepping the issue of individual pathology and the etiology of transgender experience, this diagnosis persists in labeling persons of transgender experience as prone to dysphoria in ways in which no other identity is described in the DSM (Bennett 2010). Activists, including many prominent providers of transgender health-care services, have decried this addition to the DSM-5 (Davis et al. 2010).

The long-held notion that lesbian, gay, bisexual, and transgender subjectivities are inherently pathological reflects our society's tendency to segment human diversity into "good" and "bad," "us" and "them" (Berreby 2005). This dichotomous thinking about sexuality has been the case among many mental health professionals for more than a century (Carlson 2005), even though the founder of psychodynamic thinking and practice, Sigmund Freud, wrote explicitly that psychoanalysis "is decidedly opposed to any attempt at separating off homosexuals from the rest of mankind as a group of special character" (Freud 1949). While Freud supported gay rights and believed that homosexuals were fit to be trained as psychoanalysts, his theories on sexuality, which generally held up heterosexuality as the norm, provided a basis for anti-LGBT bias in the mental health field (Drescher 2008).

Prominent LGB theorists (transgender-identified theorists were not publishing until very recently) have left their mark on relational theory, affecting more than just the relationship between psychoanalysis and sexuality. In addition to changes in the DSM, in the 1990s, there was a convergence of relational psychoanalysis, feminism, and queer theory. Queer theory, which emerged from feminism and LGBT studies, is the analysis of text and theory from an LGBT perspective. This convergence of these theories led to the depathologizing of homosexuality (Kassoff 2004) and created a path by which openly gay, lesbian, and bisexual people could enter psychoanalytic training, previously forbidden to them (Drescher 2008). While psychoanalytic training per se was not the central issue, its influence pervaded the perspectives on mental health and qualifications for providers. The end of the twentieth century saw more and more lesbian, gay, and bisexual (LGB) people enter into the fields of social work, psychology, and psychiatry, doing research and publishing in those professional capacities, which has furthered the de-stigmatization of LGB people (transgender people remain stigmatized by the mental health professions) and broadened the focus of psychoanalytic thinking.

Most recently, relational theory has taken up the question of transgender subjectivity, positioning transgender identity not as pathology but as variance (Goldner 2011), just as was done previously with homosexuality. Transgender clinicians, in social work and other health arenas, are entering the field, publishing their clinical experiences and theories on this topic (Hansbury 2011). As relational theory continues to integrate LGBT orientations into the framework of normal variation, rather than pathology, thereby altering the thinking in the field, the relational approach can do the same work between clinician and client, altering the way LGBT clients think and feel about themselves in relation to others and the world around them.

Clinical Social Work Understanding of Homophobia, Transphobia, and Biphobia

LGBT clients seek the assistance of clinical social workers with the usual goals and problems common to non-LGBT clients. They want to find meaningful and stable work, improve their relationships, feel less depressed and anxious, increase their self-esteem, etc. In a mutual working alliance, client and clinician collaborate to work on the interpersonal and developmental issues that can underlie many presenting issues. The piece that complicates clinical social work with LGBT clients is accurate apprehension of the experience of growing up and continuing to be a diverse individual in an environment marked by the oppression and marginalization of homophobia, transphobia, and biphobia. Homophobia refers to the hatred and fear of homosexuals, transphobia to the hatred and fear of transgender people, and, similarly, biphobia is the hatred and fear of bisexuals (Elze 2006). However, many transgender people are the victims of homophobia, and many gay, lesbian, and bisexual people experience a kind of transphobia if we recognize the word to include the fear and hatred of gender-nonconforming individuals. Just as diversity of all kinds challenges the clinician, and thereby potentially evokes powerful countertransference reactions, understanding the issues and relational social work practice solutions with the LGBT population enhances all clinical social work practice.

It is important to note that sexual orientation, gender identity, and biological sex are three different aspects of the self (Morrow 2006). Sexual orientation refers to one's preference in sexual and/or romantic partners. Gender identity refers to a person's sense of self as a man, woman, both, or neither. And biological sex refers to physiological aspects of maleness, femaleness, and combinations of the two, including gonads, genitals, and chromosomes. Keeping these differences in mind, a transgender man, who began life as female, may be primarily attracted to men and identify as gay. He would experience both transphobia and homophobia. A butch lesbian experiences homophobia, but she also may be subject to a kind of transphobia due to her masculine appearance and demeanor. Bisexual people experience homophobia when expressing their same-sex desires and relationships, and they also experience biphobia.

Despite much of Western culture's advancements, these LGBT phobias have not gone away. In their grip, LGBT clients continue to come into therapy with related presenting problems. For example, gay male clients may seek treatment for deep shame about sex and the "feminine" aspects of their gender identities (Shelby 2000). Many lesbian clients continue to struggle in intimate partnerships where they subjugate their own needs and desires to those of their partner (Buloff and Osterman 1995). Many transgender women clients suffer anxiety and depression due to daily harassment in the streets, and the loss of family, friends, and jobs (Sánchez and Vilain 2009), while many transgender men clients struggle with the pressures of being male in the world and may often hold themselves back from realizing life goals (Hansbury 2011). Bisexual and genderqueer clients often find they are getting lost in the shuffle, rejected by gay and trans groups, without adequate social support (Weiss 2003). These are generalizations, but they are included here

to alert the relational clinician to the diversity of presenting problems with which LGBT clients struggle and to the likely transference stance to clinical services that may represent the problems that stem from heteronormative society's pressure on the LGBT person to conform to rigid ways of being.

Whether or not the client is being seen in an LGBT-specific setting, with an LGBT clinician or the most liberal-minded straight social worker, homophobia and transphobia are in the room, in both members of the dyad. In a homophobic society, all persons harbor homophobia to one extent or another, just as racism exists in any member of a racist society, regardless of background, politics, personal intention, and the like. As feminist psychoanalyst Young-Bruehl (1997) writes, "Homophobes hate acts that they themselves can and usually do engage in, so, to repudiate these acts they must assign them clearly to another category of people. The category is all that stands between them and those acts" (p. 143). Homophobia, whether internalized or externalized, is repudiation, a splitting off, of the homosexual parts of the self. We could say the same for transphobia, since all human beings are a combination of masculine and feminine, male and female aspects (Knights and Kerfoot 2004). It is this split, in LGBT clients, which relational therapy can help to heal. To do so requires that the clinician be aware of her own sex and gender splits and that she be willing to work through them. A clinician who is unwilling to confront her own homophobia and transphobia, who believes that homosexuality, bisexuality, or transgender identity is a curable disease, must get ample supervision from an LGBT-affirmative clinician. If these issues cannot be worked through, then it would be unethical for the clinician to continue working with LGBT clients (Rosik 2003), and she must refer them to more qualified colleagues or risk retraumatizing the clients with her own unprocessed fear, envy, and hate.

Clinician Sameness and Difference

In clinical social work practice with diverse client populations, the sameness or difference of the clinician's population of identification comes into play overtly and covertly. Two primary issues need to be in the forefront of the social work practitioner's awareness as she engages, assesses, and constructs a working treatment plan with any client. First, to designate as "diverse," only those peoples who are from marginalized and oppressed groups, privileges the dominant group in insidious ways which may cloak transference and countertransference elements, among other clinical elements. Second, identification with one's own group, be it dominant or oppressed, when meeting a client of the same group, can equally obscure individual assessment and treatment option considerations. While sameness and difference may not be readily apparent, being a member of any population of identification is a strong force in the self-experience of both client and clinician. In relational theory thinking, discovery of such forces is a central feature of both client assessment and clinician self-regulation, including most significantly factors that can rupture the attunement process.

LGBT clinicians are not immune to homophobia, transphobia, and biphobia. For example, a gay male therapist who had been working with gay and lesbian clients for many years found himself face to face with his own transphobia when he began working with his first transgender client. He had difficulty accepting that the client, a transwoman, was not a man, and he continually referred to the client inappropriately with male pronouns, unwittingly shaming and erasing her each time. In supervision, he discovered his own deep feelings of shame and rage around thwarted childhood longings to express his femininity. Unable to work quickly through his envy of the client, he rightly referred her to a colleague. Another example might be a feminine-presenting lesbian therapist who is prejudiced against lesbian clients whom she perceives as being too masculine. A transgender therapist might be prejudiced against a genderqueer client, a transgender person whose gender expression challenges the boundaries between male and female. There are many hypothetical clinician and client pairings that, due to apparent sameness, could appear on the surface to be a good match but underneath reveal entrenched prejudices that could have the potential to deeply impair clinical work.

These examples of internal barriers to successful clinical social work practice are not the norm and are offered as cautions to point up the need for clinical social workers to master the methods that allow such barriers to become integrated and useful in the treatment process. While similar biases exist in all people and all clinicians to some extent, use of the relational approach can foster open dialogue and self-examination, and they can use these biases in a productive way to help LGBT clients work through the traumas of both internalized and external homophobia and transphobia. Some key techniques, reflecting the relational model, are essential in this work and are described here to provide clinical social work students with tools to orient their practice with LGBT clients.

The Clinical Process: A Case Example

Beginning with Transference and Countertransference

While clinical social workers typically are not introduced to clinical process starting with transference and countertransference, work with diverse populations elevates the significance of this dimension of the relationship to a primary position. As noted in the introductory chapter of this book, the very designation of diversity population creates an anticipatory separation of the client group from an implicit norm. Therefore, the clinical social worker needs to reflect on the implications of a population's diversity identification in the service of distinguishing collective expectations in the transference and especially the countertransference from her readiness to meet the client as an individual.

Regarding assessment, it is important to remember that this is a process in which both clinician and client engage. Before the clinician can begin to assess the client, the client has already begun assessing the clinician. This is assumed in the two-way

dynamics of intersubjectivity that is the hallmark of relational therapy (Goldstein et al. 2009). The client's and clinician's own diversity identifications also are among many factors at play in the preliminary development of the intersubjectivity between client and clinician. In our current Information Age, the client has access not only to impressionistic information and predictions based on agency context; he also has access to powerful information sources, such as agency websites. These sources frequently contain information about services as well as service provider photographs and professional profiles. Additionally, the client will often identify the clinician with qualities inherent in the agency environment, such as the tidiness of the facility, or the professionalism and client-centeredness of agency administrative staff. A clinician in private practice might also have a professional website, online published papers, or other caches of information, personal and professional, available to anyone who knows how to use Google.

The client, Tom, cited at the beginning of this chapter, offers a good example of the power of predictive transference based on the client's first impressions of the clinical encounter. His first relational statement of "you probably want me to be gay, out, and proud," in which he imagined that I wanted something for him, quickly conveyed that Tom was expecting coercion from me, a kind of brainwashing in which my desires would attempt to wipe out his own. His worry, and perhaps also his hope, about what I might want came from the setting in which we met. We were meeting at the Callen-Lorde Community Health Center, an agency in New York City with the specific mission to meet the medical and mental health needs of the LGBT and HIV-affected populations. To reach my office, Tom had walked through a lobby decorated with rainbow flags, flyers offering transgender name-change workshops, and posters about safer sex between men. He was in a setting that clearly valued being "out and proud," and he understandably assumed that his clinician's values would be in line with those of the clinic. Tom's transference was not just to me but also to the agency as a whole.

This illustrates how, in the two-person psychology of the relational approach, the social services agency acts as a third entity, co-creating the clinical relationship along with client and clinician. This further demonstrates how a relationship takes shape before client and clinical social worker even meet face to face. Each agency setting and client pairing will elicit a different sort of predictive transference. It is neither advantageous nor possible for an agency setting to be completely neutral. Relational theory posits that it is equally impossible and not by definition advantageous for the clinician to be free of transference triggers. Instead, awareness of the messages conveyed and received provides a wealth of clinical material regarding client attitudes, internalizations, and experiences to be explored in relationship with the relational social work practitioner.

LGBT clients in smaller cities and rural settings across the country receive treatment in settings not designated as LGBT focused (Foster 1997). This has practice implications for the social worker in such settings, who must create a relationship of trust where the absence of LGBT service identification reflects the broader society in which sexual and gender diversity is unwelcome. In the absence of overt recognition, a population of diversity might be expected to predict lack of recognition,

ignorance, or, even worse, intolerance. The clinical social worker cannot know in advance how the client will forecast the agency climate and the clinician's perspective. His presence in a generically identified service setting calls for special alertness to how a client of a diverse population configures the relational baseline.

These are examples of how transference and countertransference elements merit clinical reflection from the outset. The clinician in a generic practice setting is not less influenced by the agency culture than one in a population-identified setting. From a relational practice viewpoint, the clinical social worker needs to be mindful of what communications are taking place and what their influences are on her and on the clients entering the practice setting. In agencies where LGBT clients don't see obvious reflections of themselves in the waiting room, they may well believe that the agency does not employ persons like themselves, and expectations that LGBT prohibitions exist are predictable. Therefore, an absence of open LGBT presence surrounding the clinical encounter places the onus of trust building more completely on the clinician. All populations, where diversity is fused with rejection or marginalization, identify social work services with the dominant and therefore negating social order (Ferguson and Woodward 2009).

As the transference relationship has already begun, the client waiting to meet the clinical social worker may wonder, "How will my sexuality be received? How will the social worker respond to my gender presentation? Will I be judged? Will I be shamed? Can I be understood?" Of course, similar worries are typical of any client beginning work with a new clinician and come up throughout the treatment. However, LGBT clients are entering the relationship having endured a history of homophobia and transphobia imposed by family and culture, and thereby, internalization may be anticipated at conscious and unconscious levels. As Cabaj (2000) states "All gay people have internalized homophobia, having been brought up in a homophobic society that either tends to promote prejudicial myths about gay people or negates the existence of gay people in general" (p. 9). To this should be added that all bisexual and transgender people have internalized bi- and transphobia for the same reasons. No matter what the setting, the LGBT client can be expected, at least preliminarily, to enter the clinician's office with a lack of trust, expecting the same negative treatment from the clinician that he has received from the world at large and that he might continue to receive from inside himself.

Assessment with LGBT Clients

Assessment is an ongoing process, one that continually unfolds during the course of treatment. The clinician thinks about the person as a whole and from within the context of the individual in their particular social environment. The DSM should be used with careful reflection. In a clinic setting and in the current age of managed care, a diagnosis code is often required. The relational clinician should consider diagnoses that address the underlying psychological situation of the whole person, such as dysthymia or anxiety, rather than diagnoses that are based upon identity.

For transgender clients, clinicians must keep in mind that the DSM's gender identity disorder diagnosis is controversial. Similar to earlier diagnostic categories related to homosexuality, long since removed from the DSM, the gender identity disorder diagnosis stigmatizes the individual's identity, rather than describing the individual's particular emotional or psychological distress (Sennott 2011). Indeed, in recognition of the perils of diagnosis by identity, gender identity disorder is slated to be removed in the next revision of the DSM (Lawrence 2010).

While the clinician's assessment continues throughout the entire treatment, the first session often sets the tone for the qualities of the transference that the client brings in. While any first session with a clinician is intensified by anticipation of confronting the presenting problem, and does not therefore reflect the client's highest level of functioning, it nonetheless reveals patterns of relating, problem conceptualization, hopes for clinical assistance, and the like. In the first session, the clinician should also pay attention to her own countertransferential responses. These can provide the clinician with plentiful information about the client's relational world. Transference often explains how he experienced his early caregivers and how they experienced him. Its thread continues through his current relationships today.

The social worker is well schooled in starting where the client is, and the clinical social worker is additionally alerted to the relational meaning in all of the initial transactions. The clinician pays attention to body language. How does the client walk into the office? Does he give a deferential greeting and sit stiffly in the chair, waiting silently for the clinician to begin? Or, does he robustly shake the clinician's hand, then scatter his coat, gloves, and bag, flop down in the chair and launch into it? What are the client's first words? Does he answer the question, "What brings you here?" with a list of specific and concrete goals (to get a new job, to stop using drugs, to improve his relationship with his husband) or with a shrug and a mumbled, "I don't know. I just want to feel better." These opening remarks may be along the lines of "Nobody listens to me," or "Everybody wants me to take care of them," or "I just want everyone to leave me alone." The relational clinician wonders how the dominant themes in that first session might shape the contours of the entire treatment. One client might feel that the clinician never listens, the next might take care of the clinician's feelings, and another might continually present as withdrawn. Each of these situations not only describes what is happening in a session but provides the clinician a summary of the experience that the client brings to the relationship with the clinician, often foreshadowing the course of explorations, resistances, interpersonal exchanges, and other elements of the treatment relationship.

Simultaneously, the relational social worker is listening to her countertransference. Maybe the clinician notices her attention is wandering or else feels riveted to every word the client is saying, as if watching a thrilling blockbuster movie. Maybe the clinician feels something in her body, a flush of sexual heat, a discomfort that sends her fidgeting, or a heavy tiredness that threatens to come out in a yawn. This information sets in motion a means of problem analysis, in that the relational expectations and reactions reflect the worldview that the client is bringing to his overall functioning. All of this countertransferential information provides an overview to the clinician of how a relational matrix is being co-created by client and clinician.

Tom's case provides an example of how this initial and open-ended assessment process creates a dialogue wherein conflicts, strengths and liabilities, and patterns that may pertain to the core problem can emerge.

The Course of Treatment

Remembering that assessment spans the entire treatment, from initial intake to termination, the relational social worker constantly interrogates her internal response to the client and her participation in the relationship that emerges between client and clinician. Specifically in the model of relational treatment, she does not view the client's statements about her as mere projections but as part of the mutually created field of interaction. The client who perceives the clinician with suspicion and guardedness may evoke a parallel carefulness in the clinician. The relational clinician is observant of this interactive pattern and may proactively comment on it and ask the client's observations as a means of promoting mutuality in the working process (McWilliams 1999). Therefore, I had to wonder aloud about Tom's statement in our first meeting and invite him to join in this exploration. I noted that he stated that I wanted him to be "gay, out and proud." On the manifest level, this was his expectation. On the interpersonal level, he was declaring his expectation of our interactional hierarchy, including who was in charge of what he should be. On an intrapsychic level, this topic was clearly on his mind and therefore a target of clinical attention. Was this also a statement of his ambivalence and perhaps confusion about what I should want for him? Did he want me to replicate the shaming he had received from important figures in his life such as family, friends, Church, and State, or was he daring me to push him toward self-acceptance? These were questions, which, with tact and timing, would form a central part of our clinical practice dialogue.

Relational theory recognizes that meaning is co-created (Mitchell 1988). Both perception and expression contain material from the client and clinician. Tom, as is often the case and recognized as such in relational practice, was partially right about me. While I did not imagine him marching in gay pride parades or becoming an HIV activist, I did harbor the hope that he could eventually live without internalized homophobia. I did hope that he could stop blunting his emotions with, as I came to learn, drugs and dangerous sex. I did hope that he could feel less shame about his sexuality and his longing for intimacy with men. It was, as revealed as the clinical practice proceeded, a hope that Tom and I shared, and that would, over the course of our relationship, develop into a reality. In relational work, the trajectory of the client's hope is elicited and shared. Its specific content and the real-life ramifications are first lived out in the dialogue of the clinical social work relationship. The client then can begin to bring this orientation of hopefulness to his daily life (Mitchell 1993).

The process of relational assessment would be the same with non-LGBT clients. From the first moments of the first encounter with a client, the clinician is assessing defenses and resistances, ego strengths, attachment style, and the like (McWilliams 1999). With LGBT clients, however, it is key that the clinician listen especially for

two things: (1) the reverberations of gender trauma from early experiences when the client's gender presentation was corrected or punished, a common experience for LGBT persons (Bailey and Zucker 1995; Hiestand and Levitt 2005), and (2) internalized homophobia or transphobia and its impact on the client's psychosocial functioning (Elze 2006). Both of these phenomena can manifest at any point in the clinical relationship.

Mirroring. LGBT clients often grow up without adequate mirroring. The LGBT child typically has heterosexual, cisgender (non-transgender) parents, teachers, and friends. Unlike the offspring of other marginalized and oppressed minorities, such as the African-American or Hispanic child and the Muslim or Orthodox Jewish child, all of whom typically have some opportunity to see themselves reflected in important others, the LGBT child is an outsider from early life. The LGBT child is typically un-mirrored in his identity formation (Beard and Glickauf-Hughes 1994; Gair 2004) and must make meaning out of a selfhood that is more likely to experience shame and censorship, even assault, than it is to be supported. In adolescence, when the LGBT client is first expressing his sexuality and gender identity, the lack of mirroring often comes from peers and society, as he moves outward from the sphere of family. The most prevalent problem faced by lesbian and gay adolescents, especially those with nonconforming gender expressions, is isolation, which Hetrick and Martin (1987) break down into three types: (1) cognitive isolation, "the almost total lack of accurate information"; (2) social isolation, "the negative self-view enforced by the denial of accurate information"; and (3) emotional isolation, "feelings of being alone, of being the only who feels this way" (pp. 165–171). In a time when peer identifications are so crucial, the gay, lesbian, and/or non-gender-normative adolescent may find him or herself without the opportunity to develop a group identity, a sense of the "we." Without self-sustaining models and mirrors, this cognitive isolation may lead to a "cognitive dissonance that will radically affect the young person's sense of self" (Hetrick and Martin 1987, p. 167).

What is the impact of a lack of mirroring on the developing self? Relational theory, drawing on the key interpersonal precepts of many psychodynamic bodies of theory, describes several powerful repercussions of mirroring failures that must be addressed in the treatment process. Without adequate empathic responses from early caregivers, the individual may develop narcissistic traits and relational dynamics. According to self psychology, the lack may also lead to what is called a vertical split in the psyche, "the side-by-side, conscious existence of otherwise incompatible psychological attitudes" (Kohut 2009, p. 177). A client with a vertical split alternates between grandiose feelings and states of low self-esteem. He may feel like a superstar 1 day and a miserable wretch the next, an oscillation that generates, and is generated by, deeply unbearable shame and rage. Lack of mirroring may also lead to the child's development of a formidable false self. As Winnicott (1956) explained throughout much of his work, the false self is a defensive structure the child uses to comply with external demands and to get basic needs met by caregivers and the environment. It is like a mask used to protect the true self, which remains hidden. These and other concepts from Kohut and Winnicott, though they predated the

development of relational theory as the basis of clinical social work practice, focus on the relational matrix and are often used by clinicians who follow this approach to working with clients. They are useful when working with LGBT clients who, due to the lack of mirroring discussed here, often keep their true selves hidden for fear of being shunned or shamed. Inviting those hidden parts out into the light, where they can be seen and mirrored without judgment, is part of the relational clinician's task.

Active Attunement. As Buloff and Osterman (1995) write in *Lesbians and Psychoanalysis*, "Peering into the face of society, much as a child looks into the face of her parent, the lesbian looks for a reflection of her self" (p. 95). The young lesbian searches to find mirrors that reflect her emerging self; she sees instead "grotesque and distorted images reflected back in words like: perverse, sinful, immoral, infantile, arrested, inadequate, or she sees no reflection at all – a peculiar silence – an invisibility" (Buloff and Osterman 1995, p. 95). This idea can be expanded to include all LGBT expressions of selfhood in relation to others. The mother of a young female child who will grow up to be a transgender man might look with distaste or turn her gaze away from a "daughter" with more masculine expressions, sending a message to the child that her/his self and strivings are not loveable. A gay male's mother, worrying that her son might be socially punished for having more feminine characteristics, might hold the child close, smothering him with protectiveness, sending the message that it is not safe to be himself. These and other unstated relational messages resulting from distorted or absent attunement to the reality of the growing self are often internalized and frequently emerge in the relational matrix of the clinical situation.

The clinical social work practitioner is well aware that events of the past may not be directly remembered but present themselves as derivatives in the client's struggles with problems in treatment (Goldstein 2001). In adulthood, the client may exhibit conflicted attachment styles bred from such earliest maternal interactions (Ainsworth 1989; Hazan and Shaver 1987). For the LGBT-aware clinician, it is important to explore these attachment issues in themselves and determine how, if so, they are connected to the client's gender identity and sexual orientation (Mohr 2008). Recognizing with the client the impact of attachment anxieties in his relationships to self and others, including the clinician, allows the clinical social worker to reflect back to the client the presented material in a manner that confirms its emotional significance. A client, for example, who presents distress, not about developmental misinterpretation or disapproval but about present reactivity to misinterpretation or disapproval by others, can be helped by the relational clinician to address the emotional depth of experience, not only its factual profile.

Pursuing active attunement with previously unrecognized suffering and conflict can be the crux of the therapeutic process. I have invited transgender clients preparing to transition from male to female, who have been ambivalent about their gender expression, to come to their sessions dressed in women's clothing or to bring photographs of themselves in women's clothing. The clinical intention of these sessions was to actively engage and affirm the gender identity the client wishes to express in the greater world. In this way the client can begin to share this aspect of self with

another and experience doing so without the shaming received from earlier objects. In addition to the direct relational interchange of being present with another person in the new form, the client and clinician talk about the details of this identity expression experience. In inviting direct practice and interaction with identity expression, the clinician and client collaborate in the creation of a corrective emotional experience. The corrective emotional experience, a concept first proposed by Franz Alexander (McCarthy 2010), was an early relational innovation in psychoanalytic theory and persists in contemporary relational theory (McWilliams 1999). The clinician fosters this correction in creating a favorable emotional environment in which previously distressing material, such as shamed or thwarted attempts at female gender expression, is validated and the traumatic influence is diminished.

Self-Disclosure as an Aspect of Relational Treatment. Self-disclosure is a broad topic. It can mean any revelation about the clinician, verbal or nonverbal. The clinician who blushes when the client talks about sex is self-disclosing. So is the clinician who decorates her office with expensive art. Deliberate self-disclosure for therapeutic purposes, however, includes the revelation of the clinician's affects, conflicts, and thought processes about the client and the work (Hanson 2005). What is revealed, ultimately, is a clinician who is a human being with human feelings, rather than a robot or a computer that spits out data analyses. McWilliams (1999) encourages inclusion of self-disclosure of the clinician's experiences or observations, particularly for clients who lack reference points for alternative perspectives; her caveat is that the clinical social worker scrupulously determines if the disclosure is targeted to a client's needs and interests.

Although controversial in relational work (Sparks 2009), judicious disclosure of the clinician's countertransference is another hallmark of relational therapy and can be useful in mitigating shame. Morrison (2007) writes, "I consider self-disclosure generally to be a useful antidote to shame, both as part of our acceptance and soothing of personal shame, and as a potent procedure from clinician to client as a means to 'level the playing field' and humanize the shame experience" (pp. 106–107). Many LGBT clinicians today routinely disclose their sexual orientation and/or gender identity to their LGBT clients for the purpose of providing a model and to detoxify the client's shame. In addition, HIV-positive clinicians sometimes disclose their serostatus to HIV-positive clients for the same reasons (Cole 2001).

Rupture and Repair. Ruptures in empathy, also known as empathic failures, and their repair through mutual exploration by client and clinician are a significant aspect of relational social work practice. The clinician's empathic failure is inevitable, although never intentional, and profoundly important to the work. Kohut (2009) was among the first to underscore the significance of rupture and repair as a therapeutic element. The erasure, shaming, and punishment LGBT clients have endured often make them exquisitely sensitive to empathic failure from the therapist. The relational clinician should realize that although these ruptures are inevitable, they also represent clinical opportunities to not only repair the clinical relationship but also mitigate the effects of previous empathic failures by significant figures in the client's past.

Regarding my client Tom's early statement "you probably want me to be gay, out, and proud," his words "you probably want me to be" reveal a parental order: Be this; don't be that. We can imagine that this order, to be and not to be, generated shame, as well as rage, in Tom from a young age. LGBT clients have been ordered to be silent throughout life, keeping parts of their true selves hidden from the homophobia and transphobia of the environment. This internalized homophobia and transphobia become part of the ego or self where, as Malyon (1981) explains, "it influences identity formation, self-esteem, the elaboration of defenses, patterns of cognition, psychological integrity and object relations" (p. 60). It is hardly unexpected that LGBT clients enter therapy with the expectation that they will be bullied, coerced, and judged by the clinician. They expect rupture to happen, but they expect the outcome to be without repair. Unfortunately, in too many cases, the client's expectations turn out to be correct. It is the clinical social worker's role, and opportunity, to allow voice for the client's narcissistic wounding of rupture to be met with empathy, open exploration, and reparative attunement to the sequelae of the original rupture in the any ongoing relational issues the client may bring.

Gair (2004) calls attachment ruptures for LGBT children a "silent traumatization." "Narcissistic rage" is a term coined by Kohut (1972) as arising "when self or object fail to live up to the absolutarian expectations which are directed at their function" (p. 386). It is often provoked in response to psychological injuries such as "ridicule, contempt, and conspicuous defeat" (Kohut 1972, p. 380). It is important for the clinical social worker to not only explore this rage as a reaction to environmental oppression but also to explore ways in which this rage continues to shape relational as well as internal functioning.

Termination. Shelby (2000) reminds us that "If we focus on gays and lesbians as the 'victims' of social prejudice, we tend to minimize narcissistic rage" (p. 278). Helping the client to work through his narcissistic rage related to repeated empathic failures by important figures across his lifetime, including through ruptures in the clinical practice process, is often a key component of relational work with LGBT persons. The decision to terminate in a clinical case such as Tom's is reached through a mutually agreed-upon decision that the difficulties that brought him into treatment, known and unknown at the time, were adequately addressed in the clinical social work process. Adequacy in the face of inevitably ongoing conflict means having sufficient tools to handle interpersonal misunderstandings without their triggering dysfunction or disproportionate internal distress. Not insignificant among these tools is the internal representation of his relational experience with an empathic social work clinician who has offered respect and understanding of his struggle.

Conclusion

LGBT persons represent a community of diversity that intersects all segments of society. As such, LGBT persons can be expected to present at almost any setting in which clinical social workers are engaged. It is important that the relational social

worker be prepared to engage in a mutual dialogue, informed in part by the clinician's attempts to grapple with her own countertransference, toward opening pathways of remedy with the client.

Relational clinical practice is an approach of choice when working with LGBT clients because it provides an empathic and open exchange in which clinician and client can collaborate, using the here-and-now relationship to work through relational difficulties from the past and outside of the treatment. Due to homophobia and transphobia in society, and a lack or mirroring in the immediate environment, LGBT clients come to therapy with traumas large and small, an abundance of shame, and rage. Using relational techniques, highlighting mirroring, listening for transference, monitoring countertransference, self-disclosure, the repair of empathic ruptures, and the exploration of narcissistic rage, the clinician can provide a corrective emotional experience that can help the client work through these issues and improve self-esteem, intimate relationships, and overall psychosocial functioning.

Study Questions

1. What makes relational social work particularly well suited for LGBT clients?
2. How does stigmatization within the mental health profession affect the treatment relationship? Discuss how stigmatization illustrates client and clinician in context and how relational social work might address this when working with a client.
3. Provide a brief explanation of the differences between sexual orientation, gender identity, and biological sex. Write a paragraph illustrating encounters with confusion about these distinctions and how clarification would improve your practice.
4. Give an example of how lack of affirmative mirroring in early development of LGBT adults can be addressed through relational practices to enhance coherent sense of self.
5. Identify two strategies of relational social work that can provide a corrective emotional experience for LGBT clients. Describe how these strategies can pertain to other marginalized populations.
6. Identify a personal quality that impacts your work with LGBT clients. Give an example from your own practice in which this quality played a role.

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