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Family preservation is generally viewed in terms of a rather narrow practice definition. However, it's underlying philosophy offers a strong framework for building a positive, non-biased helping alliance with lesbian clients in a therapeutic setting.

The family preservation philosophy offers a unique heuristic for helping professionals to work with lesbians. Family preservation values teach that the therapist must start with the client's reality, recognize the particular needs of that client, and use the client's strengths in treatment. Also inherent in this perspective is respect and sensitivity to the lesbian client's "cultural context, experience, and history" (Family Preservation Institute, 1995). In other words, in the family preservation philosophy there is no assumption of heterosexuality in the therapeutic relationship; rather there is an assumption of unconditional positive regard. Further, clients are engaged in a dialogue and encouraged to name the challenges they encounter in their own words, from their own perspective. All of these principles will help empower lesbian clients.

Lesbians may avoid traditional mental health services in times of need, preferring to depend on alternative services or friendship support networks. The choice not to seek help through mainstream agencies may be based on previous negative experience or on an assumption of the homophobic attitudes which are often inherent in such services. Traditional services are usually based on the medical model. Services based on the family preservation philosophy, however, have the capability of creating therapeutic relationships in which there is no assumption of heterosexuality, where the lesbian client is respected and viewed as a whole, healthy individual.

Lucas (1992) estimates that 2-6% of American women are exclusively lesbian and that 20% of all women in the United States have had some lesbian experience prior to the age of 40. Factoring in family, friend and collegial relationships of the identified lesbian population results in an even larger segment of the population in which therapists are likely to encounter lesbian issues. This is a significant prospective client base which is, in fact, increasing (Laird, 1993). Therapists may be involved in a direct practice relationship with a lesbian client or her family members. And, increasingly lesbian couples are having or adopting children.

The social work mission addresses many facets of the profession, particularly values and ethics, diversity, social justice, at-risk populations, and individual empowerment. Each of these tenets is an essential consideration for therapists engaged with lesbian clients. This is especially important when viewed in terms of the philosophy of family preservation, which focuses on

practice "guided by values which uphold the uniqueness, dignity, and essential role which families play in the health and well being of their members" (Family Preservation Institute, 1994). Therapists possess biases which they would do well to acknowledge and process to be effective in the helping alliance. This requires self-exploration and "identification of personal homophobia" (Falco, 1991), acquisition of accurate, factual knowledge, and use of affirming language which does not assign negative, clinical labels.

Increased insight gleaned from client's experiences may help improve services and treatment modalities for lesbians from a cross-cultural perspective. Understanding and validating the lesbian client's views and incorporating them into practice may significantly enhance service provision to this significant nonethnic minority group.

Defining Lesbian

There is no single definition of lesbianism. Removing it from the typically accepted context of strictly sexuality, Tully (1995) states that it also encompasses "a more comprehensive view of women-identified women that can include spirituality, politics, emotions and intellect" (p. 1591). Ferguson defines a lesbian as "a woman who has sexual and erotic-emotional ties primarily with women or who sees herself as centrally involved with a community of self-identified lesbians . . . and who is herself a self-identified lesbian" (Golden, 1987, p. 21).

Nor is there one all-encompassing descriptive profile of a lesbian; lesbians run the gamut of ethnicities, socioeconomic levels, disabilities, religious upbringing, age, education, and so forth (Falco, 1991; Tully, 1995). Lesbians are also engaged in a wide variety of professions and activities, and a great proportion do not fit the physical stereotype which is imposed on them. Lesbians are, however, different from nongay women in many ways, in terms of the reality of living with internal, institutional and societal oppression, discrimination, hate and fear.

Lesbian Mental Health

While prior to 1973 the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association categorized homosexuality as a mental disorder, studies show no significant differences in psychological adjustment and well-being of lesbians and nongay women (Wayment & Peplau, 1995; Rothblum, 1994). Lesbian clients bring to the counseling process many of the same problems as nongay clients. However, the therapist must not ignore the client's lesbian orientation; leaving this important information out will impede the therapeutic process and may keep the client from progressing by not dealing directly with who she is. And, even when the client's issues are not related to sexual orientation, the therapist needs to remember that the impact is heightened by the fact of living in a homophobic society.

Viewing the lesbian client as healthy will focus treatment on the presenting problem and not on finding the cause of gayness (Kaplan & Saperstein, 1985). This will also help put the client's

sexual orientation more appropriately in context, helping dispel the idea that gayness is always a choice, and reminding the therapist of Kinsey's perspective that sexual orientation is fluid over a continuum and not fixed (Goodman, 1985). Falcos states, "Lesbian affirmative practice is a frame of reference, not a technique" which "involves the knowledge, skills and attitudes of the therapist" (1991, p. 31-32).

Reframing Fusion

Nichols and Schwartz define fusion in terms of family therapy processes as "a blurring of psychological boundaries between self and others" (1995, p. 592); the traditional therapeutic view has been that fusion is a symptom of dysfunction in family relationships. However, lesbian psychologists have identified fusion not as a sign of dysfunction, but rather as an outgrowth of a relationship between two women, behavior which accommodates the probable reduced social structure of lesbian family life and lack of acceptance of the family by society. If a therapist is able to reframe fusion to a positive interpretation, one of adaptation, perhaps, work with lesbian clients is likely to be more successful. By viewing fusion in a lesbian couple from a perspective of strength and understanding of it's function, the therapist may help affirm the relationship, acknowledge the impact of societal homophobia on the family, and thereby enhance the strength of the therapeutic alliance.

Coming Out

It is often assumed that a lesbian's psychological well-being is directly connected to her level of outness (Falco, 1991). Spaulding (1993) describes a lesbian's coming out as the development of a new definition of self, a sense and image of self, behavior patterns within and outside the lesbian community, and a redefinition of self in the context of family of origin. Variations in the process depend on many factors, including family, religious background, health, previous hetero- and lesbian sexual experience, age at recognition of lesbian orientation, and even political climate. It involves resocialization and, to some extent, a return to adolescence (Spaulding, 1993; Browning, Reynolds & Dworkin, 1991).

It is also a time when existing familial and friendship relationships are tested. As a result of coming out, a woman's lesbian identity may be embraced, accepted, or, she may be rejected.

While adult lesbians are generally on their own and not dependent on family for basic needs, becoming invisible in the family of origin deprives them of their most basic human connection and nurturing environment. Fear of this loss often keeps lesbians from coming out completely; with selective, ongoing assessment of how friends and relations will react. This "secret" becomes a complex juggling act for the woman, who must keep on her guard and remember who "knows" and who does not. All of this may take a toll on her sense of self worth and security.

Lesbians and Traditional Mental Health Services

Lesbians have been called the invisible minority in a system of care which assumes heterosexual orientation (Robertson, 1992). Traditional mental health services are problematic for lesbians for several reasons: open gayness is still socially stigmatized, practitioners often lack accurate information about gayness, and, because of their own fears, therapists may provide misinformation to both lesbian and nongay clients (Child Welfare League of America, 1991). Falco (1991) reports that in a 1988 study by Jensen and Bergin of 425 therapists (including psychologists, psychiatrists, clinical social workers and marriage and family therapists), 57% of those responding defined a healthy lifestyle as one which included a heterosexual relationship.

Many lesbians hesitate to reveal their sexual orientation to practitioners because of the personal risk involved, emotionally, physically and professionally. A recent study showed "a repertoire of strategies" for safety, including seeking practitioners of similar orientation and experience, and becoming "attuned to subtleties in language, manner, and emotional atmosphere, monitoring for signs of ignorance, [and] prejudice" (Stevens, 1994, p. 222). Falco (1991) cites 1973 findings by the Boston Women's Health Book Collective wherein the lesbian community referred to therapists as "the rapists of the lesbian identity" (p. 20). Therapists have responded to disclosure of lesbian orientation by avoidance, ignoring the client's lesbian identity, with lectures about an unhealthy lifestyle, and even exhorting the client, "You're not a lesbian!" (Falco, 1991, p. 43-44). Further supporting the lesbian client's hesitancy to divulge her orientation, Klein (1986) notes a variety of techniques historically used to cure homosexuality, including incarceration, hospitalization, aversion therapy, electric shock, frontal lobotomy, drug therapy, and psychotherapy. Lesbians have also been subjected to treatments such as hysterectomy, removal of ovaries, and clitorectomy (Falco, 1991).

There are, however, beneficial aspects to lesbians using traditional mental health services. Encounter with a lesbian affirmative agency or therapist may help a lesbian feel validated. And, the experience therapists gain may help them become more aware and more comfortable with this population. It is hoped that increased contact will motive the agency to advocate for better services and training (Grace, 1984).

In 1986, the American Psychological Association Task Force on Heterosexual Bias in Psychotherapy conducted a survey of members and results showed that the 1,481 psychologists in the sample differed widely in terms of gay affirmative practice. Ninety-nine percent of respondents had treated at least one gay or lesbian client. The study found gay affirmative practice but also considerable bias, inappropriate and inadequate practices, and lack of understanding of lesbian issues in terms of both assessment and intervention; 58% had personal knowledge of cases where therapists had provided biased treatment (Garnets, Hancock, Cochran, Goodchilds and Peplau, 1991). Findings indicated that a significant percentage of the therapists saw sexual orientation as a problem, provided wrong information on lesbian issues, held negative views on lesbian parenting, and lacked an understanding of the impact of

homophobia on the gay or lesbian client (Corey, Corey & Callanan, 1993, p. 271). Certainly, lesbians suffer from real psychiatric disorders just as nongays do, but primary treatment issues frequently relate to difficulties caused by misconceptions and the societal hostility and fear directed toward them, resulting in self-esteem problems, feelings of rejection, isolation and anger (Klein, 1986; Browning, Reynolds & Dworkin, 1991), and a hesitancy to rely on traditional treatment systems.

In the therapeutic milieu, lesbians may face double discrimination due to their gender and their sexual orientation (Spaulding, 1993). And, for lesbians of color, there may be triple discrimination (Falco, 1991). This is, to a great extent, a result of the entrenched institutional sexism inherent in many therapeutic theoretical frameworks, and a system which labels male-identified characteristics as healthy but devalues them when seen in women (Brooks, 1981). Much of the traditional mental health system is based to some extent on Freudian theory which is detrimental to women in general, and lesbians in particular. Freud considered lesbians to be immature and incomplete. Lesbianism, by definition, is in opposition to the stereotypical expectations of women which are ingrained in the patriarchy-based American society (Falco, 1991). Power is an issue in the traditional therapeutic relationship. "In traditional therapy, therapists have power, and this power can be used to push lesbians back into the closet and away from a positive, integrated, woman-identified life" (Girard & Collett, 1983, p. 48).

The commonality to be found among these studies is the reality of discrimination and homophobia faced by lesbians in day to day life, including in securing mental health services. The studies also illustrate the resiliency of lesbians and their level of commitment to each other, their families, and their community.

Family Preservation Philosophy and Lesbian Clients

Sophie states that "the therapeutic relationship is itself a treatment modality" (1988, p. 54). The implications of homophobic therapists treating lesbians are far-reaching, particularly in view of a study of 140 mental health professionals which reported social workers to be the most homophobic, while psychologists were shown to be the least (DeCrescenzo, 1985). Homophobia on the part of a therapist has a negative impact on the therapist/lesbian client relationship through stigmatization and unequal treatment and restricted ability of the agency to provide appropriate services (Moses & Hawkins, 1985, p.155-156).

The Code of Ethics of the National Association of Social Workers (NASW) clearly mandates member practitioners to work against oppression and provide unbiased, empowering assistance and advocacy to all clients, regardless of status or sexual orientation. Social work's mission addresses values and ethics, diversity, social and economic justice, and respect for the individual (ie, start where the client is). The basic philosophy of social work, and in particular family preservation's strengths perspective and emphasis on cultural competency, support lesbian affirmative practice.

Even more specifically applicable to work with lesbians is the philosophy of family preservation, which is "guided by values which uphold the uniqueness, dignity and essential role which families play in the health and well being of their members" (Family Preservation Institute, 1995). Also central to the philosophy is an expanded definition of family and respect for the dignity and privacy of each family member. Finally, traditional models see the therapist as the expert; family preservation regards the client as the expert about itself, and, as stated above, approaches the process from a strengths perspective rather than the traditional deficit model.

These principles are of critical importance when working with lesbian clients because of the institutional homophobia this population often faces when seeking services. Service providers must respect the efficacy of the lesbian and her family, also integrating the reality of the changing profile of the American family into practice paradigms. They would do well to recognize the special strengths lesbians possess which enable them to overcome the constant negative messages they encounter, and use these strengths in treatment plans and helping relationships. It is also beneficial for therapists to view lesbianism in a holistic sense. Lesbianism is more than merely sexual behavior; it encompasses all facets of the individual woman's life. This client is a complete person, grounded in her own reality, possessing exceptional strength and courage.

Nevertheless, regardless of the prescribed ethical guidelines, many helping professionals still view homosexuality as a disease which must be cured, and, while conversion therapy is less prevalent today, use of this modality still occurs. A 1984 study of 112 psychotherapists in Cincinnati, Ohio by Graham, Rawlings, Halpen and Hermes showed that 62% believed therapy could change sexual orientation (Falco, 1991). Inadequate knowledge about lesbians is still a major factor in the homophobic attitudes of therapists. Lesbian affirmative practice recognizes that lesbianism is a valid expression of sexuality, that most lesbians are emotionally healthy, and that oppression is an every day occurrence in a lesbian's life (DeCrescenzo, 1985). Goodman (1985) proposes that agencies could greatly enhance gay affirmative practice by helping therapists recognize, assess and acknowledge their own attitudes, offering appropriate training, and providing factual information to dispel myths and wrong assumptions.

Expanded Definition of Family

The family preservation model uses a definition of family which embraces not only the traditionally accepted stereotype of family, but also all possible combinations and descriptions. The most important defining factor is that the unit views itself as a family. This has been an area of great distress for lesbians, lesbian couples, and lesbians with children, in that society generally does not recognize, accept or define them as families. In fact, around 3.5 million gays and lesbians have children (Women's Action Coalition, 1993), and this number is steadily increasing. Again, the lesbian family may be invisible in society, which sometimes strips away

support systems which are assumed by heterosexual families. The family may, in fact, be viewed wrongly as a single parent family. (Crawford, 1987). Kirkpatrick (1988) cites Lewin's findings that lesbian mothers depend on family supports more than supports from within the lesbian community; the lesbian community tends to be more adult focused and mothers may feel out of place.

Wayment and Peplau (1995) discuss a study by Aura of 664 women in southern California in which lesbian and nongay women reported similar levels of social support, and showed that a higher level of social support was correlated with increased feelings of well-being. In this study, lesbians indicated a greater need for "reassurance of worth," defined as "receiving respect and praise, having people know 'the real you,' and receiving support for behaviors that are nontraditional for women" (p. 1198). This seems logical in the context of the differing social roles of lesbians and nongay women.

Recognition of an expanded definition of family is an essential ingredient in working with this population. Validating the lesbian family as a viable unit worthy of respect and support can lay the groundwork for establishing a strong, healthy family unit.

Strengths Perspective

Lesbians have many special strengths. They must possess well-honed survival skills to flourish in an environment of homonegativity and to overcome the illness model by which they have historically been judged. Lesbians are all but invisible, without identity, in traditional paradigms (Muzio, 1993). The family preservation philosophy fosters a redefinition of the traditional view and emphasizes instead the strengths which enable lesbians to create and maintain families.

Gergen and Kaye state that people who enter therapy "have a story to tell" (1992, p. 166), and the strengths perspective encourages reframing of experience. Such restorying can have a significant impact on work with a lesbian client, providing an opportunity to place her story in a positive context rather than adhering to the old version with its negative connotations.

Cross-Cultural Competence

Another important aspect of the family preservation philosophy is cross-cultural competence. The lesbian community is often referred to as a subculture and lesbians may be considered a nonethnic minority (Atkinson & Hackett, 1988). Studies show that client perceptions of the attitudes and beliefs of the therapist may have a significant impact on the process and outcome of service. Kaplan and Girard (1994) note that "lack of understanding can create barriers to service delivery" resulting in client dropout (p. 89), and Allen (1993) states that "it is the ethical responsibility of the clinician to . . . foster an atmosphere of respect for a multiplicity of views" (p. 38). Axelson (1985) discusses the idea of "synergetic counseling" (p.336-7), a blending of

helping behaviors and therapist reality with the reality of the client. He believes that in an effective therapeutic relationship the therapist accepts and validates the client's reality of self, not society's.

Hardy (1989) discusses the problems created by the "neglect of context" in family therapy with minority group families, where the therapeutic relationship may be seriously compromised by inattention to cultural issues. In addition, the idea of the "theoretical myth of sameness" is introduced, referring to the tendency of therapists to attempt to incorporate all clients into the dominant paradigm, and, further, to stereotype them within an alternative paradigm as well. This issue is of particular importance in working with lesbian families, especially in terms of the low level of societal acceptance and support they experience; formerly married lesbians may be faced with harassment and legal battles to retain custody of their children. They fear losing the battle - and their children - despite evidence that children raised in lesbian households tend to be more flexible and more accepting of differences in other people (Laird, 1993).

The homophobic experiences and the vulnerability of lesbian clients must be understood clearly by helping professionals and not underestimated. The undercurrent of fear and oppression that lesbians must deal with in every aspect of their lives is heard in the voices in this study and must not be minimized.

The overwhelming strength of lesbians - no matter what their level of outness - must also be recognized and integrated into the helping process. The fact that most lesbians are able to function and thrive despite their societal status as a feared, hated and often ignored minority, with the courage to live and love as they must, displays remarkable resilience. These ego-strengths may be further enhanced by lesbian affirmative therapists and agencies; such positive experiences may help break down not only institutional homophobia but also the personal homophobia of therapists and the internalized homophobia of the individual lesbian herself.

Lesbian Affirmative Practice

Therapists must remember that many of the accepted views about sexual orientation, gender identity and masculine and feminine roles are created and defined by society; it is society which has labeled gayness as deviant. Therapists must also recognize the extent to which their own views are biased by the dominant culture; biases and personal uncertainty must be dealt with in order to work successfully with lesbian clients. This internal work by the therapist should be done outside the therapeutic milieu, and it is the first, most vital step in developing a lesbian affirmative practice modality.

A client centered approach seems most beneficial with lesbians, with treatment based on the principles that lesbians are basically healthy and happy, that sexual identity is just one aspect of an individual, and that the counseling environment is supportive and non-judgmental (Klein, 1986).

While there is without question a need for more openly lesbian therapists, it must be remembered, too, that certain clients will be uncomfortable with an openly lesbian therapist, who must be sensitive to this issue. Lesbian therapists, just as those who are nongay, must also come to terms with their own sexuality and their internalized homophobia.

In practice, in addition to honest self-assessment of personal beliefs, value systems, and sexuality, the therapist must also acquire at least basic information on homosexuality to dispel possible myths and misconceptions. A knowledge and understanding of the history of oppression which lesbians have experienced is also important.

Further, the therapist should become familiar with local, statewide and nationwide resources. Creating a resource list is imperative in view of the isolation and discrimination which make it difficult for lesbian clients to access many services. It is a critical order of business for the therapist to research lesbian-friendly providers such as physicians, attorneys, and spiritual guides.

Goodman (1985) suggests that traditional mental health agencies may become more gay affirmative if administrators are attentive to helping therapists recognize homophobic attitudes, encourage self-assessment, and increase level of sensitivity to gay and lesbian issues. Intra-agency training programs may provide concrete information and an opportunity for values clarification to reframe stereotypes and portray lesbian clients as healthy people.

Conclusion

Lesbians live in a world where heterosexuality is assumed not only by friends, family, and coworkers, but also by service providers. By recognizing the special needs - but at the same time removing the stigma of difference imposed by society - therapists may help lesbian clients to more fully view themselves from a positive, empowered stance.

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