

Attaining and Maintaining Positive Lesbian Self-Identity: A Cognitive Therapy Approach

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INTRODUCTION

While lesbians experience a high degree of satisfaction in their relationships (Peplau, Cochran, Rook & Padesky, 1978; Peplau, Padesky & Hamilton, 1983), the route to positive self-identity may be rocky for newly identified lesbians. Cultural, familial and societal attitudes toward lesbians are often very negative. In social context, therefore, a woman may feel confused when trying to reconcile her positive feelings for women with negative reactions from others and her own negative stereotypes of what it means to be lesbian.

Gilbert (1980) has outlined two principles of feminist therapy: (1) “the personal is political,” and (2) an egalitarian client-therapist relationship. She details aspects of these principles which seem crucial to helping lesbian women attain a positive self-identity: “The client learns to differentiate between what she has been taught and has accepted as socially appropriate for her from what might actually be appropriate. . . . [she] learns she is not crazy” (p. 248). An egalitarian therapy relationship includes encouraging the client “to be more self-directed and autonomous.” The client is encouraged

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to become self-nurturant, “learning to value oneself as a woman, learning to value other women as women, and receiving mutual support and nurturance from other women” (p. 249).

While all feminist therapists would undoubtedly agree with these goals for helping lesbians attain and maintain positive self-identity, the therapeutic methods by which these goals can most easily be attained are not so clear. One therapy approach which therapists might find especially compatible with feminist therapy is cognitive therapy (Beck, Rush, Shaw & Emery, 1979). As will be illustrated below, cognitive therapy approaches are well suited to helping lesbians develop a positive sense of self, even within negative social environments.

COGNITIVE THERAPY

First, how is cognitive therapy a feminist therapy? Two features of cognitive therapy are primary: a collaborative therapy relationship and guided discovery. These two features can help form a feminist therapy relationship and provide a methodology that helps women learn to take control of their own emotional and mental well-being.

Collaboration in cognitive therapy implies a team approach with an emphasis on “working on problems rather than on correcting defects or changing personality” (Beck & Emery, 1985, p. 175). Beck and Emery’s explanation of methods used to achieve collaboration further illustrates feminist values in this therapy:

Neither therapist nor patient takes a superior role. The therapist can ask a patient to listen to tape recordings of a session to see if the latter can learn more from the session or provide the therapist with useful feedback. . . . All procedures are open and clearly explained to a patient. Treatment manuals or sections of them are often given to a patient as suggested reading so that he [*sic*] can become more aware of treatment strategies. (p. 176)

Aside from the language use of “patient” and “he,” it is clear these therapy processes are consistent with feminist principles. Davis and Padesky (in press) have argued that cognitive therapy is

consistent with feminist therapy models. They also suggest cognitive therapy can be enhanced by a feminist analysis of socio-cultural factors and their impact on women’s self-identity.

Guided discovery is the main therapeutic process in cognitive therapy. Through Socratic questioning and experiments designed to gather information, the therapist helps the client begin to test her own beliefs and assumptions about herself, other people and the world. The use of these methods with lesbian clients is best described with some case examples (see below).

The advantage of guided discovery therapy methods is that the client is assisted in the process of learning to evaluate her experiences and draw her own conclusions. This can help clients distinguish between what they have been taught (cultural and familial schemas, or core beliefs) and what has been their actual experience. It can also provide an organized way for clients to test out their own automatic thoughts (perceptions of specific events) and underlying assumptions (cross-situational expectations and rules).

For example, a woman exploring relationships with other women for the first time had the following thoughts and beliefs: “All gay women are tough and masculine” (cultural schema), “If I become gay, I’ll have to give up all my old friends” (underlying assumption), and “She just wants to go to bed with me” (automatic thought following a friendly conversation with a woman in a bar).

In cognitive therapy this lesbian client learned: (1) her thoughts may or may not be true, (2) she can learn to test her thoughts by gathering evidence based on her own experience, and (3) she can take some control over her reality by trying to change her environment or herself to better meet her needs. Through a process of collaborative guided discovery, she was able to ease her anxieties about the meaning of becoming lesbian. More importantly, she learned a process of evaluating beliefs which can help her solve future difficulties such as relationship misunderstandings.

HOMOPHOBIC BELIEFS IN LESBIAN CLIENTS

One of the greatest sources of distress for the newly identified lesbian is her own homophobic beliefs. She may tell the therapist

she is concerned only with what others may think. The client may be right that family members and friends will be prejudiced; however, before a lesbian can cope with others' beliefs, she must confront her own.

It is often difficult for a new lesbian to admit she has prejudiced beliefs. The therapist can facilitate her awareness and expression of these by saying, "Most of us don't like to admit to having prejudices but it is nearly impossible to grow up in the world without being taught negative things about lesbians and other minority groups. What are some of the things you've been taught about lesbians?"

With this introduction by the therapist, the woman is able to acknowledge (with some psychological distance, if needed) the homophobic beliefs she learned from her family and cultural group. Then the therapist can propose that they evaluate together how much she believes each idea. For example, she might believe 50% that lesbians are masculine, 98% that being lesbian eliminates her chance of having children, and 10% that lesbians are uptight sexually.

In these ways, the therapist is helping the client see that she does have negative beliefs about what it means to be lesbian and that she holds these beliefs with different levels of conviction. The next important step is to help her identify which beliefs are negatively affecting her comfort in labeling herself a lesbian. For example, if she does not wish to have children, the belief she cannot have children (even though strongly held and probably erroneous) will not be a primary focus of the therapy.

Once distressing negative beliefs about lesbians have been identified, the task of therapy is to help the client test these beliefs and evaluate their validity for her. There are a wealth of cognitive therapy methods designed to facilitate this process (Beck et al., 1979). A case example will illustrate one possible approach.

Marissa, age 25, sought therapy for depression following the breakup of a brief first relationship with a woman. A primary concern for her was the belief that becoming lesbian was going to ruin her life. She felt certain of her lesbian identity and yet was equally certain this ruined her life prospects for success. Her summary of

the first half hour of therapy was "Why does this have to happen to me?"

Marissa identified several beliefs she held about lesbians and rated her conviction these were true: (1) lesbians hate men (85%), (2) lesbians live on the edge of society (95%), (3) it is not safe to let anyone know you are lesbian (90%), (4) most lesbians drink a lot of alcohol (75%), (5) you cannot have a child if you are lesbian (100%), and (6) you cannot dress or keep your hair feminine if you are lesbian (90%). Each of these was a great concern to Marissa because she was not sure she could or wanted to live a life with these qualities.

Marissa and her therapist came to a collaborative agreement that the second belief, "lesbians live on the edge of society," might be a good starting point for testing out these stereotypes. Prior to entering therapy, Marissa's only contact with lesbians had been with her ex-lover whom she had met at work and with lesbians she met on two occasions in a local gay bar.

Although currently working as a receptionist in a beauty shop, Marissa hoped to enter a professional field and she doubted she could comfortably do this as a lesbian. The following dialogue with her therapist illustrates how Marissa was helped to begin considering the limits of her current experience:

Therapist: OK, let's begin looking at this belief. What makes you think all lesbians live on the edge of society?

Marissa: Well, Amanda worked all by herself in a sales job and the women I met at that bar all seemed pretty tough.

T: What type of bar was it?

M: Well, it was a cowboy bar. Mostly men, but some women. Amanda thought I'd get a kick out of it.

T: Do you think those few gay women you've met represent a pretty good cross section of lesbians?

M: Yes. Well, I guess so - I don't know.

T: If you were the type of lesbian you'd like to meet where would you go - to meet with other women?

M: I don't know.

T: Well, where do straight women who you like go to meet other women?

M: I guess at work, and out to dinner, and at parties and clubs, health clubs—that sort of thing.

T: Do you think it's possible that lesbians might meet at similar types of places and events?

M: Maybe. But how would I know where to go or how to recognize them?

(Note: At this point, Marissa is allowing herself to consider that her belief may not be totally true. She is beginning to reformulate the problem as one of meeting the kind of women she enjoys rather than as the hopeless absence of such women.)

T: Well, those are good questions. If you were new to town, which in a way you are to the lesbian community, how would you find out about such groups?

M: I would look in the phone book or a neighborhood guide.

T: OK. Do you know if such a thing exists for lesbians here?

M: No.

T: There are several places you can check. First, there is a woman's bookstore that has a listing of women's events and an information sheet for local lesbian groups....

In this therapy excerpt, the therapist did not simply reassure Marissa that there were lesbians she would like. It is a tenet of cognitive therapy that new learning has much greater impact if it comes from Socratic nudging of the client's own knowledge base. In this case, Marissa was reminded through the questioning that she had skills for finding other women when she was new to a community.

In the rest of the interview, Marissa and her therapist role-played how she might comfortably get the information about women's and lesbian events. She agreed to go to the bookstore and collect what-ever information was easily available as a first step. In this way,

cognitive therapy is action-oriented and helps the client increase her sense of personal power.

HOMOPHOBIA IN OTHERS

Once a lesbian has evaluated her own experience and developed more balanced beliefs about lesbians, she is in a better position to cope with negative attitudes in others. A helpful feature of the cognitive approach is that she has also learned methods to test out beliefs which can help her talk with others she knows.

Alice's mother cried about her lesbian relationship and said, "you'll never be able to have a happy, normal life." Rather than engage in a "Yes I will - No you won't" argument that Alice said characterized past discussions about these things, she tried using the skills she had learned in cognitive therapy. First she clarified that, for her mother, "normal" meant doing things with heterosexuals.

Next, Alice reminded her mother about a female couple she had known in their small Indiana town. Her mother was in a bridge group that they attended. Alice's mother was reminded through Alice's questions that these women did seem to be happy. "But they didn't tell everyone about their relationship!" her mother declared. Alice was then able to talk with her mother about how she decided when to tell people about her relationship.

Using these methods with others requires some emotional distance on the part of the client. The therapist can facilitate the client's ability to tolerate negative attitudes in people who are important to her in the following way:

Client: I can't understand why my parents are so bigoted. They have known me for 30 years.

Therapist: When you first began to think you were lesbian, were you 100% positive about the idea?

C: No, not 100%. But when I got more experience I could see it was good for me and not everything I feared was true.

T: How many experiences have your parents had to help them evaluate their beliefs about lesbians?

C: They know me and they should know I'm not weird!

T: Yes. And are they convinced you are a lesbian?

C: No! They keep telling me I can't be or don't have to be.

T: So what they know about you doesn't necessarily affect what they believe about lesbians—because they aren't sure you are “really” a lesbian.

C: I guess not.

T: So, if you want to change their ideas about lesbians, what things do you suppose might help? For instance, thinking back on your own transformation experience, how long did it take? What kinds of experiences helped you change your negative attitudes?

By helping the client recall her own process of coming to terms with lesbianism, the therapist facilitates her willingness to see attitude changes in others as a developmental process as well. The therapist suggests the client consider *experience* as a change tool rather than argumentation or simply expecting others to be accepting.

In some cases, important people in a lesbian's life will be so completely rejecting or unwilling to change attitudes that she will have to cope with this rejection. In these cases, the therapy task becomes one of helping her deal with these negative experiences without permanent damage to her own positive self-identity.

In coping with negative reactions, it is important the therapist find out the idiosyncratic meaning of these for the client. Some possible meanings might be:

- “I'll never be able to be with them again.”
- “This means I was wrong to have them as a friend.”
- “I guess I can't trust anyone. I should stay closeted.”
- “Being lesbian is just too difficult to handle.”
- “If my parents can't accept it, maybe it is wrong.”

A period of mourning following losses of relationships or trust is very important at this stage of therapy. Then, the therapist can be-

gin helping the client see where her conclusions might be distorted. For example, a friendship is not totally wrong because one person cannot accept everything about another.

A final stage of helping a client cope with homophobic attitudes in others often is encouraging her to take some steps to change attitudes in her broader community or society. As she identifies her anger at social prejudice against lesbians, the therapist can explore with the client things she can do to reduce this prejudice. Depending upon the client and community these steps may include: speaking out to correct prejudice on the job or with people in the community, joining a group which combats prejudice against lesbians or other minority groups, or helping other lesbians gain greater positive self-acceptance.

COPING WITH SOCIAL PRESSURES

Even the most positive self-identity does not protect a woman from the special pressures and social stresses lesbians face. To name a few, these may include: constraints on physical affection shown to a lover in public situations, expectations of heterosexuality in relationships at work or in the neighborhood, financial and legal constraints on lesbian couples, family pressures to appear at holidays without one's lover, and decisions about when, how and to whom she will “come out.”

Each lesbian must work out her own solutions to these problems depending upon her own values, environment, and tolerance for risk. A cognitive therapist can help her clarify values and evaluate the advantages and disadvantages of different responses in these various situations. Role-playing possible coping strategies can help in this evaluation process.

Maria was quite distressed following a dinner with her lover and old friends who did not know she was lesbian. It was one of the first nonlesbian social events she had attended with Alma since their relationship began four months earlier. Part of Maria's Latina heritage was comfortable physical touching and yet she felt self-conscious and refrained from touching or making eye contact with Alma for fear her friends would notice their love. As a result, she

felt disloyal to Alma and painfully alienated from the positive lesbian identity she had achieved over the past year.

Her therapist reviewed with Maria the ways in which she touched and looked at others during this evening. Then they reviewed her history of affection with women friends before she identified as lesbian. Maria began to see she was putting extreme limits on her public closeness with Alma.

In a couple's session, Maria and Alma role-played with some hilarity the range of physical touching that would be normal between women of their culture in public. They then experimented with different levels of touching in public situations to test out Maria's assumptions that any form of touching would lead to social disapproval. These social experiments led to much greater comfort for both of them.

EXPLORATION OF THERAPIST ATTITUDES

It is important in cognitive therapy, as in all therapies, that the therapist evaluate her own values and beliefs in addition to the client's beliefs. The same cognitive methods that are used with the client can aid the therapist's self-exploration.

Therapists need to identify their own distorted biases for and against different aspects of lesbianism and keep an open mind to the client's personal experiences. It is obvious how a therapist's negative stereotypes can harm the therapy process, but it is equally important to avoid overly positive stereotypes.

For example, a therapist who has attained a positive and open lesbian life-style among family and friends with a great deal of social support must be careful not to disregard the possibility that the client's social environment may be much less accepting. By keeping grounded in the client's experience and actively testing out beliefs and assumptions as cognitive therapy requires, a therapist can help avoid her own biases from impeding the therapy process.

Marissa's therapist thought she knew what Marissa meant when she said, "lesbians live on the edge of society." The therapist's mother had once said this to her and had been referring to an image of lesbians in black leather jackets. Fortunately, the therapist directly asked Marissa what she meant by the phrase. It turned out

Marissa meant working in professions which were more solitary or masculine.

CONCLUSION

Cognitive therapy seems an ideal therapy approach for helping lesbians develop a positive self-identity because of the influence of individual and social beliefs on this process. By helping women test out these beliefs, based on their own prior experience and carefully constructed social experiments, they can come to more balanced views of the possibilities in lesbian relationships. This process is best accomplished through a collaborative relationship according to the tenets of both feminist and cognitive therapies.

In addition, cognitive therapy helps women achieve a greater sense of control over their reality by incorporating an analysis of social attitudes into the therapy and showing that even culturally held beliefs can be tested and modified. To this end, it is often therapeutic for the woman to not simply alter her own negative beliefs but also to work at a personal or community level to change negative beliefs in the community at large. Each step of cognitive therapy helps enhance the client's sense of personal power by teaching her therapeutic processes so she can apply them to future problems.

The basic structure and process of cognitive therapy is consistent with the principles of feminist therapy. It is collaborative, helps the client separate the internal from the external, and emphasizes change rather than adjustment. Furthermore, it is an empowering therapy which offers skills and consistently emphasizes the importance of personal meaning of experience. Despite the name "cognitive," it is a therapy that deals with the whole person and includes an analysis of social and environmental influences.

As demonstrated above, cognitive therapy can help lesbians gain a more positive identity by testing and changing maladaptive beliefs. Given the high levels of satisfaction experienced by most lesbians (Peplau et al., 1983), this foundation is then likely to be maintained by positive experiences and continued practice of the cognitive methods learned in therapy.

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