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HOMOPHOBIA IN THE SUPERVISORY RELATIONSHIP: AN INVISIBLE INTRUDER

Glenda M. Russell and Ellen M. Greenhouse

The intrusion of homophobia and heterosexism into the supervisory relationship represents the intersection of the personal and the political. It is the intersection at which sociocultural phenomena meet and influence the private world of clinical supervision. In this paper, we will explore the varied manifestations and impacts of homophobia and heterosexism on the practice of supervision.

The terms homophobia and heterosexism have been used in a variety of ways (Forstein, 1988; Herek, 1992; Neisen, 1990; Obear, 1991; Pharr, 1988; Weinberg, 1972). Weinberg (1972) defined homophobia as the irrational fear and hatred of same-sex affectional preferences and people who express them. While Weinberg's definition of homophobia refers to a phenomenon within the individual, the term heterosexism more accurately describes pervasive, culturally shared beliefs that transcend the individual (Neisen, 1990). Heterosexism refers to the general assumption that the heterosexual orientation is preferable or superior to the other sexual orientations. While homophobia and heterosexism represent different vantage points, they are almost invariably found together. Henceforth, we will use the word homonegativity to refer to any cognitive, affective, or social forms of these phenomena (Hudson & Ricketts, 1980; Martin, 1993; Shidlo, 1994).

Homonegativity can exist within the supervisory dyad whatever the sexual orientation of each member (i.e., both supervisor and therapist are heterosexual; neither member is heterosexual; gay/lesbian/bisexual supervisor and heterosexual therapist; heterosexual supervisor and gay/lesbian/bisexual therapist). While much of what

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follows will be applicable to any of these combinations, particular emphasis will be placed on dyads in which the supervisor is heterosexual and the therapist is lesbian. Indeed, we use our own experience as a heterosexual female supervisor working with a lesbian therapist as the basis for many of the clinical observations and all of the vignettes that follow.

Just as homonegativity is ubiquitous in society, it is historically pervasive in the mental-health culture. Despite good intentions in many quarters, homonegativity is not only our legacy, but it permeates the training and practice of both psychotherapy and supervision today (Brown, 1986; Buhrke & Douce, 1991; Flaks, 1992, 1993; Garnets, Hancock, Cochran, Goodchilds & Peplau, 1991; Roughton, 1993). It is our observation that when homonegativity is not considered and explicitly addressed in clinical relationships of any kind, it operates as a covert process, exerting unseen impact on multiple levels.

We know that any important phenomenon that is not explicitly addressed influences clinical relationships. Indeed, much clinical attention typically is directed to rendering such covert processes subject to understanding and discussion. In this context, the failure to regard sexual orientation as a factor worthy of consideration represents homonegativity.

Vignette A

A therapist who had completed her doctoral training considered several factors in her choice of a post-doctoral supervisor: competence, theoretical orientation, reputation, integrity. She was aware of making an informal assessment of the supervisor's homonegativity through the limited information available to her. She knew that the supervisor identified herself as a feminist and had gay and lesbian friends. The therapist also knew that the supervisor had treated gay and lesbian patients. Additionally, the therapist knew that the supervisor was aware that the therapist was a lesbian, which precluded the need to specifically identify her sexual orientation. While the therapist was at least minimally aware that she did not want to work with a highly homonegative supervisor, it did not occur to her that she had the right to ask direct questions. The supervisor based her decision to work with this therapist on the therapist's excellent reputation within her training program and the recommendations of colleagues, including lesbians. She did not believe that the therapist's being a lesbian was worthy of any consideration because of the fact that the therapist did not usually present herself as a lesbian in professional settings.

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Each participant brings her own version of homonegativity to this interaction. The therapist minimizes the legitimacy of sexual orientation as a valid and significant consideration in her choice of supervisor and in the supervisory process itself. Her minimizing sexual orientation reflects both her experience within the mental health profession and her internalized homophobia. Internalized homophobia refers to the negative feelings toward oneself for being lesbian or gay (Corbett, 1993; Gartrell, 1984; Neisen, 1990; Shidlo, 1994). It can be characterized by conscious and unconscious shame and self-hatred. The therapist's avoidance of considering and discussing sexual orientation with her prospective supervisor allows her to defend against the painful feelings associated with internalized homophobia. Internalized homophobia is a phenomenon specific to bisexuals, lesbians, and gays, but has properties in common with or similar to other forms of internalized oppression, such as racism or sexism (Batts, 1989).

The supervisor's failure to regard sexual orientation reflects her membership in the heterosexual majority. As a member of an approbated majority, she typically views the heterosexual experience as the norm, even when she finds herself interacting with someone who is not heterosexual. Therefore, she simply assumes that she can use her own training experiences and perspectives to help a lesbian supervisee just as she would with a heterosexual supervisee. She is also more comfortable in the presence of a lesbian who does not call her attention, or that of her colleagues, to her sexual orientation.

Vignette A illustrates the all-too-common failure to recognize the role that sexual orientation might play in the supervision. Treating it as a nonissue from the beginning sets the stage for ignoring the influence of sexual orientation in both the supervisory relationship and in all the clinical work under supervision. Within the supervisory relationship itself, it introduces a covert system of understandings about what can and cannot be discussed. These prohibitions operate much like a secret in a relationship. Even if/when these prohibitions are initially conscious, the awareness of them gradually fades from consciousness. The unspeakableness of sexual orientation has become an inextricable aspect of the relationship. It alters not only what can be spoken but also what can be thought.

RESISTANCES

The overall constellation of the resistances against overtly discussing sexual orientation in the supervisory relationship is complex. It involves contributions from each member of the dyad as well as their synergistic interplay. We draw our observations from a retrospective analysis of our supervisory relationship. Our analysis also has been informed by experience in other clinical and supervisory relationships. Certainly, many of these dynamics are inherent in nonclinical relationships including friendships, collegial relationships, and intimate relationships. For purposes of clarity, those resistances which each member brings to the dyad are discussed separately. From the moment that the supervisory relationship begins, however, the resistances become a property of the relationship. The interaction and elaboration of these resistances renders them irreducible to either member of the dyad.

The Supervisor's Resistances

One of the most powerful and least conscious resistances to discussing sexual orientation is the supervisor's unresolved conflicts and feelings about her sexuality. Few heterosexual adults have histories that are without homoerotic sexual fantasies, dreams, or actions. Despite the categories for sexual orientation that imply rigid and eternal adherence to a singular mode of sexual expression, many, if not most individuals' sexuality seems to be characterized by a greater degree of fluidity than the categories would suggest (Burch, 1993). Whatever ambiguity about sexuality exists is typically ignored or denied because of the discomfort it evokes. A discussion of sexual orientation represents a potential threat to the certainty about orientation that most heterosexuals find comforting and secure.

A related resistance is the supervisor's anxiety about moving outside of the area in which she feels confident. To the extent that sexual orientation is an anxiety-laden or unfamiliar issue, the supervisor is motivated to avoid its discussion. She is highly invested in appearing competent to herself and to the therapist. She probably has had limited exposure to open dialogue with lesbians about the aspects of their internal and external experiences that are unique

and specific to their being lesbian, and those that are ordinary and mundane. Unless she is unusual in this regard, the supervisor's training background and current professional affiliations have done little to support her competence in dealing with sexual orientation issues. Depending on the era and institution in which she was trained, she may or may not have been taught that homosexuality is pathological. Even if she has discarded traditional views of homosexuality, she may have had limited exposure to more contemporary, less homonegative views of being gay, lesbian, or bisexual. The supervisor's training has prepared her to ask questions of many kinds, perhaps even about sexuality, but probably not about sexual orientation.

The supervisor may need to protect herself from the painful affects that would stem from a full awareness of the therapist's position as a lesbian. Simply because she is a lesbian, the therapist has been denied rights and privileges that heterosexuals take for granted. These rights include those granted by the state: marriage, entitlement to spousal privileges, parental rights. Many lesbians, gays, and bisexuals are denied validation by families of origin and work groups, including the mental-health professions and their representatives in training settings and agencies. A complete recognition of these realities might engender sadness on the part of the supervisor. She may experience guilt and helplessness stemming from the recognition that she derives benefits from being a heterosexual in a homonegative culture that she also feels powerless to change.

One of the difficulties in addressing differences of various kinds is the assumption that differences imply inferiority or superiority. In the tradition of the mental-health professions—as well as in the culture at large—being gay, lesbian, or bisexual occupies at best an inferior position. The supervisor, by virtue of occupying the dominant, heterosexual position, may be reluctant to call attention to a difference that implies her superiority in the relationship. She believes she is being protective of the therapist. While that may be true in the context of a homonegative culture, she may, in fact, also be protecting herself.

The supervisor may be attempting to protect herself from negative feelings directed toward her as a heterosexual by the lesbian therapist. Members of privileged groups sometimes assume that

those in the nondominant group harbor anger or envy at their privilege, or hold them in disdain and contempt. These attributions may represent projections or stereotyped assumptions. They may well have a true basis in the reactions of this therapist, or other bisexuals, lesbians, and gays. However, the supervisor who is not conscious that she may be operating on the basis of stereotypes and projections may be unable to make accurate assessments about the attitudes of the particular therapist with whom she works. Moreover, if it is the case that this particular supervisee does harbor anger or envy toward her heterosexual supervisor, it is essential that this anger, like all important feelings arising in supervision, be explicitly addressed.

There are a variety of ways for the supervisor to defend against painful affects that could emerge in this context. One striking defensive strategy, especially among more politically aware heterosexuals, is a tendency to idealize and eroticize gays, lesbians, and bisexuals. Sometimes, this idealization arises from a mystique that people who do not have access to a particular subculture attach to that subculture. The idealization can focus on any aspect of gays' or lesbians' lives, including relationship dynamics, sex, or even a sense of style. While some of the idealization may, in fact, accurately reflect the lives of some people, idealization is still a form of stereotyping. As such, it fails to address the individuality of any single gay, lesbian, or bisexual. Moreover, the idealization reflects the power of the heterosexual to name, categorize, and define the lesbian, bisexual, or gay person (Sampson, 1993). What is important here is the heterosexual supervisor's motive, which is to protect both herself and the therapist from the awareness and the relational implications of social inequities around sexual orientation.

The Therapist's Resistances

The therapist has her own investment in ignoring sexual orientation. The therapist's minimizing the issue reflects both her homonegativity and internalized homophobia. There is an inevitable interplay between the therapist's internalized homophobia and any aspects of the relationship with the supervisor that are homonegative. While internalized homophobia is an ongoing dynamic within the therapist, it can be activated by any context that she perceives to be homonegative.

Internalized homophobia refers to a process by which the culture's hatred of gays, lesbians, and bisexuals is internalized by the individual through complex processes of identification and introjection occurring over time. Through internalization, the hatred becomes part of the self system of the individual gay, lesbian, or bisexual. Through both conscious and unconscious processes, the gay, lesbian, or bisexual assilimates the negative attitudes and stereotypes about his/her group that exist in the culture at large. This assimilation results in self-attributions that reflect those negative cultural beliefs. Some degree of shame and self-hatred may be inevitable (Neisen, 1993). It is important to recognize these affects. It is equally important to understand that the source of these affects is neither in the individual nor in his or her sexual orientation but rather in the cultural hatred of gays, bisexuals, and lesbians.

Internalized homophobia is an inevitable outcome of growing up and continuing to live in a society in which homonegative messages abound. The therapist's, like the supervisor's, professional training has probably done little to reduce her internalized homophobia and has possibly aggravated it. Internalized oppression is one of the most salient factors in the therapist's resistance to raising the issue of sexual orientation in the supervision.

The dominant heterosexual culture defines what it is acceptable to address about sexual orientation. The lesbian therapist has learned that most heterosexuals would prefer that she keep her sexual orientation invisible. She has also learned that being lesbian is defined as a "private matter" because of the exclusive and reductionistic equation of being gay, lesbian, or bisexual with sexual behavior (Herek, 1992). That equation is, of course, overly reductionistic and misses what being lesbian, bisexual, or gay has to do with identity and personal relationships. The lesbian therapist who remains silent about sexual orientation has, in effect, acquiesced to the cultural definition of being a lesbian at the expense of accurately representing her own experience.

In this way, the therapist's bringing up her sexual orientation contradicts the definition of being a lesbian as being a private matter. In addition, the experience of many gays, lesbians, and bisexuals is that to call attention to anything associated with sexual orientation is to meet with judgments that they are being single-minded, overly self-centered, and excessively concerned with idiosyncratic

subjects. It is thus the case that the lesbian therapist who mentions her being a lesbian invites attention to an aspect of herself that is considered inferior, not only by the supervisor but very likely also by the therapist herself. In light of the supervisor's greater power in the relationship, the therapist may fear that she would suffer from repercussions, a fear that may be rooted in both reality and transference. The supervisory relationship often evokes experiences of dependency and powerlessness, many of which are rooted in the therapist's experiences with her family of origin. Parent-child transference reactions undoubtedly mitigate the sense of collegial equality. If the therapist's experience as a lesbian includes a not uncommon rejection by her family (Martin, 1982), she may bring fears and expectations of similar reactions to the supervisory relationship.

The process of keeping her lesbian identity out of awareness may be syntonic for the therapist. Doing so is both an intrapsychic and an interpersonal resolution. Separating sexual orientation from her experience of herself as a therapist allows her to avoid the charged affects that could interfere with her comfort and sense of competence. It also allows her to follow the implicit cultural rules which serve to protect the heterosexual from discomfort.

Collusion Between the Supervisor and the Therapist

Each participant brings to the supervisory relationship her own motivations to ignore the influence of sexual orientation. Each also is responding to the other's avoidance on a level that is not fully conscious. This avoidance becomes part of the fabric of the supervision, and, by extension, part of the fabric of the clinical work.

Vignette B

> A lesbian therapist recounted to her heterosexual supervisor a troubling interaction with a patient who was also a lesbian. The patient had heard a rumor that the therapist was a lesbian and lived in partnership with another woman. She asked for verification in a highly insistent manner. The therapist reported that she had felt cornered and intruded upon. She had encouraged the patient to explore the meaning to her of the therapist's sexual orientation, but declined to validate the rumor.
>
> The supervisor was very supportive of the therapist's actions, including her refusal to divulge her sexual orientation. Most of the

discussion focused on the dynamics of the patient, including her transference to the therapist. The therapist's countertransference was viewed as an expectable response to the patient's style.

The most striking aspect of this vignette is the collusion between the supervisor and the therapist to obfuscate the relevance of sexual orientation in both the clinical and supervisory interchanges. Both the supervisor and the therapist failed to notice the specific importance and relevance of sexual orientation to both the patient's question and the therapist's countertransference.

The therapist and supervisor analyzed the patient's question in terms of her characterological issues. Their discomfort with including sexual orientation as a factor in the interaction with the patient led them to ignore the relational implications of this interchange. In retrospect, both the therapist and supervisor had experienced uncomfortable affect in response to the patient's question. At the most fundamental level, a thorough and accurate understanding of the meaning of the patient's question would have violated the unspoken taboo shared by the supervisor and therapist against considering sexual orientation. The patient's question challenged the therapist to consider her own identity as a lesbian within a clinical context. This represented a threat to a therapist who had not yet integrated her identity as a lesbian with her professional identity. More broadly, the therapist's internalized homophobia had been activated. In an effort to quell the attendant anxiety, she shifted the focus to the patient's pathology.

In addition to respecting the shared taboo and wanting to protect the therapist, the supervisor's view of the patient reflected her own homophobic biases. The supervisor had been exposed to the stereotypes about lesbians that pervade the society at large. Actual contact with lesbian friends and colleagues had challenged those stereotypes only to a limited degree. She viewed the lesbians with whom the had direct contact as exceptions, while maintaining stereotyped views in reference to lesbians as a class of people. Like most contexts where stereotyping occurs, the process is significantly more affect-laden than cognitive and rational (Batts, 1982, 1983). Stereotypes are sufficiently amorphous to accommodate any negative affective reactions. The supervisor transformed her own negative reactions to the patient into traits and attributes that fit her

stereotypes of lesbians: aggressive, invasive, unfeminine, threatening. In a clinical context, the stereotypes are "elevated" to the status of characterological traits. By assigning these traits to the patient, she simultaneously conveys to the therapist that she does not view her as being "like other lesbians."

What began as an avoidance of sexual orientation in the supervision has now compromised the therapy itself. The patient has rightly felt misunderstood. Three overlapping dimensions contributed to her asking the therapist about her sexual orientation. The first is the meaning of the patient's membership in the lesbian subculture. The second has to do with the relational implications of two members of the same stigmatized subculture who encounter each other in a therapy relationship. The third dimension includes the real and transferential aspects of this particular patient's relationship with any therapist.

The patient's question cannot be understood without addressing her membership in the lesbian subculture. The very nature and size of the lesbian community enhances the likelihood that rumors about inclusion in the community will circulate (Brown, 1985). Lesbians are members of a group that is both stigmatized and largely invisible (Herek, 1992). Finding safety, commonality and models for relationships are among the motives for identifying other members (Gartrell, 1984). Lesbian psychotherapists engender strong, often ambivalent reactions within the lesbian community. Psychotherapists may be seen as participants in a mental-health system that has historically stigmatized and oppressed gays, lesbians, and bisexuals. Despite this legacy, psychotherapy is also an institution that holds more promise for many gays, lesbians, and bisexuals than other traditional institutions which have rejected them, such as families, schools, and churches.

The second dimension, relational implications of shared memberships in the lesbian subculture, cannot be accurately described in isolation from its interplay with the third dimension, that of real and transferential aspects of the patient's relationship to any therapist. One of the patient's motives for asking for verification of the therapist's sexual orientation was to bridge the distance she felt between herself and the therapist, a distance rooted both in the hierarchical nature of the treatment relationship and in the patient's particular history with women. In resorting to role, the therapist has reduced

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her own anxiety. She has conveyed to the patient the limits of what may be discussed. The therapist further communicates to the patent her own unwillingness to be accurately perceived. By not confirming what the patient obviously knows the therapist behaves incongruently. Historical experiences the patient has had with significant others who have behaved incongruently were activated in a context where they cannot be therapeutically explored. Moreover, the therapist demonstrated an unwillingness to be accurately perceived, specifically in regard to sexual orientation. This may have reinforced the patient's own internalized homophobia insofar as it conveyed the message that being a lesbian is unspeakable. It is a tribute to this patient's tenacity that she remained in treatment long enough to repair the disconnection created by the mistakes in the therapy that were reinforced by the supervision.

The foregoing vignette is not meant to suggest that there is a singularly "best" way to respond to questions about the therapist's sexual orientation that arise in psychotherapy. Rather, it is meant to illustrate how prohibitions against the discussion of sexual orientation reverberate far beyond the specific content. Any material that evokes the affective experiences associated with homophobia or internalized homophobia may be unconsciously avoided or distorted. The solution to this avoidance is not to unthinkingly answer the questions about sexual orientation—or, indeed, any questions—simply because a patient asks them. The solution, instead, is to render sexual orientation, homonegativity, and internalized homophobia available for consideration and discussion in an ongoing way.

INTEGRATING SEXUAL ORIENTATION

The next vignette represents the beginning of a shared commitment to include the previously prohibited topics in the supervision.

Vignette C

> In a supervisory session, the therapist describes ongoing work with a heterosexual woman patient who has reported a dream in which the therapist is a lesbian. The therapist acknowledges to the supervisor that she is confused about how to understand and respond to the representation of herself as a lesbian in the patient's dream. The supervisor asks, "Why can't you talk about this the way you

would talk with any patient about any transference?" The supervisor's question galvanized a spontaneous recognition that sexual orientation, in the transference and otherwise, is not like any other issue in psychotherapy. As the supervisor and therapist explored this recognition, they began to understand the unique role that issues around sexual orientation, homonegativity, and internalized oppression play in psychotherapy and supervision, generally, and the specific roles that they played in their supervisory work together. As they continued this exploration over time, they frequently asked, "How is this issue different from all other issues?"

The introduction of several new topics reflected the change in the supervision that resulted from this shared recognition. The therapist and supervisor engaged in a retrospective analysis of the exclusion of sexual orientation from the supervision up to that point. This analysis permitted the reexamination of certain cases in order to determine whether attention to sexual orientation would enhance understanding of dynamic and relational processes. This is not to suggest that sexual orientation became the exclusive, or even the predominant, focus of supervision. The actual proportion of supervision time spent on sexual orientation was far less important that the fundamental shift that allowed sexual orientation to be a topic of discussion at all. This shift catalyzed each participant's working on her own issues around sexual orientation.

Most of each person's work occurred outside of clinical settings, which allowed the dyad to avoid the twin dangers inherent in the introduction of social phenomena into clinical situations. On the one hand, there is the danger that the supervisor might depend on the lesbian therapist or her gay or lesbian patients as a source of information to remediate the supervisor's own lack of knowledge. On the other hand, there is the danger that the therapist might use her work with patients and the supervision to deal with her own issues rather than for the benefit of her patients.

Accordingly, the supervisor sought out other contexts in which to explore the influence of homonegativity and sexual orientation on her life. Significantly, much of this exploration took place in a variety of interpersonal contexts rather than through purely intellectual channels. She became involved in process-oriented peer groups comprised of lesbian and heterosexual women. Some discussions centered on the different ways that heterosexual women and lesbians experienced their positions within the group and within the larger

world. The supervisor became a board member for a city-sponsored educational project on homophobia and heterosexism. Her involvement in the project afforded her the opportunities to develop working relationships with gays, lesbians, and bisexuals outside of her social and professional networks. Actively working with other heterosexual allies reduced her sense of isolation and supported the development of her identity as an ally. The support of others was a factor in her increasing willingness to confront and challenge homonegativity both in her social relationships and in professional settings. Speaking publicly as a heterosexual ally often generates reactions from others similar to those experienced by lesbians, gays, and bisexuals on a daily basis, thereby providing another kind of learning.

The supervisor's consideration of sexual orientation was originally rooted in her professional responsibility to gay, bisexual, and lesbian supervisees and patients. Over time, however, it became an aspect of her own identity. She gradually came to appreciate how homonegativity had constricted and defined her own relational capacities. These effects were apparent in her relationships with heterosexual men and women as well as with lesbians, gays, and bisexuals. In particular, homonegativity had denied her access to a full range of intimate experiences with women. Cultural taboos against homoerotic feelings and behaviors affect intimacy in a broader sense, since it is often impossible to clearly delineate the boundary between affection and eroticism. The confusion between the two is sometimes manifest in the avoidance of any intense affection within relationships with members of the same gender. The need to maintain distance from other women can deprive heterosexual women of both the pleasure inherent in intimate relationships and the reparative value of relating to women who are different in significant ways from female parent figures.

As the supervisor unraveled the effects of homonegativity on her life, she recognized how it had insidiously contributed to gender-role conformity. Taking into account the effects of homonegativity enhanced her earlier feminist analysis of gender roles. This new understanding allowed the supervisor to realize the ways in which she had inadvertently conformed to and perpetuated assumptions within the mental-health professions that contribute to maintenance of stereotypes.

Like the supervisor, the therapist pursued much of her learning about sexual orientation in contexts outside her work as a clinician. She renewed her involvement in political work, focusing on general human-rights issues as well as on issues specifically related to gays, lesbians, and bisexuals. She became increasingly willing to speak out on sexual orientation issues in formal and informal situations, including meetings of mental-health professionals. The therapist had a major role in working with public officials to develop a city-sponsored training program on homophobia and heterosexism. Her involvement in this project represented work toward integrating her identities as a psychologist/educator and a lesbian activist. Her research efforts shifted more and more to lesbian, gay and, bisexual issues. Her relationships with lesbian, gay, bisexual, and heterosexual colleagues and activists provided the context for much of her work in these areas.

Of fundamental importance was the therapist's work on her internalized homophobia. Much of her work was similar to that required of any lesbian. In addition, it was necessary for her to engage in specific work to integrate her identities as a lesbian and as a psychotherapist (Gartrell, 1984). Most therapists in the early stages of their careers confront the question of how to function as a therapist in the face of their own inevitable psychological limitations and struggles. This task is made more difficult and complicated when it has been the very tradition of the profession to label an intrinsic aspect of the therapist's identity as pathological. Until she had moved toward the integration of her identities as a lesbian and as a therapist, this therapist had experienced her lesbian identity as an unwelcome intrusion in any clinical setting. Before the integration between her lesbian and professional identities had occurred, issues related to sexual orientation carried an emotional charge that disrupted the therapist's capacity to respond with evenly hovering attention. Once the integration had occurred, the therapist was able to acknowledge the social disruptiveness of issues related to sexual orientation in the world at large without enacting that disruptiveness within the clinical setting.

The work that the supervisor and therapist had undertaken on their own resulted in substantial changes in the supervisory environment and relationship.

Vignette D

The lesbian therapist was reporting on her work with a heterosexual female patient to the supervisor. She described eroticized aspects of her countertransference to this patient. Together, the therapist and supervisor attempted to understand the therapist's reactions by exploration of the patient's past relational dynamics, and by consideration of their meaning in the therapeutic relationship.

This vignette illustrates the clinical power that can be gained when sexual orientation is no longer forbidden and concealed, and when sexual orientation is no longer so affectively charged as to be disruptive to the supervisory process. Instead, sexual orientation has become one source of information in the treatment and in the supervision. The issue of sexual orientation—like any other phenomenon in the patient, the therapist or the supervisor—can be used by the supervisor and the therapist for the benefit of the patients whom they serve.

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2315 Broadway
Boulder, CO 80304