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Working with depression in lesbians

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Working with Depression in Lesbians

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Dedication

This project is dedicated to my mother, June Allyn Jobson Colvin Alvins, who influenced and motivated me to get to where I am today.

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Abstract

Competency in multicultural counseling is one of the challenges counselors face. Women are twice as likely as males to be diagnosed with depression, and some of these women are lesbians. Vulnerability factors for the development of depression in lesbians include internalized homophobia, disclosure issues, minority stress, family rejection, and lack of a sense of belonging. Effective counseling for depression in lesbians combines multicultural competency and awareness of the stages of identity development, along with exploration of both the lesbian's level of disclosure and her degree of internalized homophobia.

Introduction

Gender inequality is fueled by stereotypes and ignorance about gender identity and gender roles, both of which are taught through socialization to young children. The gender rules and pressure to meet gender expectations are transmitted first by the family and then by the culture. Gender differences, values, norms, expressions, behavior, assumptions, status, interaction styles, and patterns are all communicated and modeled to children, who absorb the information and behave accordingly (Berk, 2007). Rigid ideas about gender identity roles cause people to attempt to conform to behaviors that may or may not resonate with their true nature. Historically, females were socialized to be submissive homemakers in order to fulfill their social role of wife and mother (Aldrich, 2006). Social pressure to be heterosexual remains invisible while children follow the silent rules, but when sexual preferences diverge, the previously unseen expectations suddenly become glaringly obvious, and the rule breaker becomes responsible for breaking the silence and disclosing his or her divergent sexual preference. Studies have shown the risk for depression in lesbians is one and a half times higher than in heterosexual females (King, Semnlyen, Tai, Killaspy, Osborn, Popelyuk, & Nazareth, 2008). This paper explores risk factors for depression in lesbians, along with appropriate therapeutic treatment to help lesbians navigate through life in a minority status.

History of Same-Sex Relationships

In ancient times lesbians were called tribades (from the Greek tribo, tribein, which means to rub or fret). One of the ways of determining if a female was a tribade was based on her anatomy - if she had a clitoris that was enlarged and resembled a penis. Another way to identify a tribade was to ascertain the sexual acts in which she participated. The first writer to use the word lesbian as a synonym for tribade was Brantome (1540?-1614), but this term did not gain wide acceptance until the nineteenth century (Crompton, 2003). The word, *lesbian*, originates from Lesbos, the Greek island upon which Sappho was born in the sixth century BCE. Sappho, considered the most highly regarded female poet of Greek and Roman antiquity, wrote of her passionate love for other women. She was a contemporary of Jeremiah and Nebuchadnezzar (Robinson, 1963). Whether the lesbian was accepted by society depended on the social mores of the day (Spencer, 1995). We can find evidence of this by looking at how lesbians were treated around the world in 1655. In that year lesbianism, heterosexual anal intercourse, and masturbation were added to homosexuality as acts punishable by death in the Massachusetts Colonies (Katz, 1976). In China, literature reflected individualism, challenging Confucianism. One play called Pitying the Perfumed Companion by Li Yu (1611-1680), considered to be imperial China's most remarkable writer of short stories, focuses on lesbian love and is the most famous play on that topic in Chinese literature (Crompton, 2003). Meanwhile, the Swedish Queen Christina abdicated the throne in 1654, went to Denmark, cut her hair short, began dressing like a man, and relocated to Rome (Stern, 2009). Famous gay men born in the late 1600s abounded in England: James I, Francis Bacon, Christopher Marlowe, William Shakespeare, and three famous lesbian poetesses: Katherine Phillips,

the duchess of Newcastle, and Aphra Behn. Katherine Phillips was known as the

"English Sappho." Between 1680 and 1709, Japan produced more literature on male love

than any culture since ancient Greece (Crompton, 2003). Lack of cultural acceptance

creates risk factors for depression.

Risk Factors for Depression

Internalized Homophobia

Homophobia is defined as the fear, hatred, and intolerance of gay men and women (Margolies, Becker, & Jackson-Brewer, 1987). One of the effects of social mores on the lesbian in our society is internalized homophobia. Internalized homophobia can also be referred to as the internalization of heterosexism, sexual prejudice, and sexual stigma. The lesbian who suffers from internalized homophobia is unable to accept herself because she is conflicted between feeling she should be heterosexual and feeling sexually attracted to other women. As a result, internalized homophobia may lead to depression (Frost & Meyer, 2009).

"Coming Out"

Coming out is a process, and some researchers have found that lesbians who disclose their sexual orientation to family and friends have less anxiety and negative affect, along with greater self-esteem, compared to those who do not disclose their sexual orientation (Bosker, 2002; Cassidy, 2007). The ability to disclose one's divergent sexual orientation takes courage and exposes the discloser to the possibility of rejection by family, friends, and/or society. Staying "closeted" and remaining invisible allows one to be presumed heterosexual, but this also has consequences. One of the consequences of not disclosing is that the lesbian is forced to live a double life, where she has to conceal her true feelings and cope with the consequences of appearing available to males. Living with this conflict puts her at risk for depression (Rothblum, 1990).

Coming out to family may be beneficial or problematic. Both disclosing and not disclosing can be stressful and provoke anxiety. Family reactions can alleviate stress or

exacerbate it. To help decide whether to disclose to the family or not, the lesbian can assess the family in the following areas:

- the preexisting levels of closeness, openness, and conflict

- the amount of shared time experienced

- the importance of the family as a source of social identity and economic support

- the availability of alternate support systems

- the cost/benefit estimate of the anticipated responses of the family members.

If potential consequences are assessed negatively, not coming out may be the better decision. Maintaining safety is of paramount importance, and in order to do that, assessment of conflict, distance, support, and potential for violence are critical (Connolly, 2006).

Minority Stress

Stress has been shown to demonstrate a strong association with negative physical and psychological health outcomes. Major life events have been quantified as to the severity of their impact on one's level of stress. Lesbians have the additional stressor of gay-related stress. Minority stress theory states that for a lesbian, gay, or bisexual person, antigay stereotypes, prejudice, and discrimination constitute varying degrees of threat, resulting in fear of rejection and concealment of one's sexual orientation. Minority stressors can cause mental health problems, such as depression (Frost & Meyer, 2009). Gay-related stress is associated with psychological distress in general and with depression specifically (Lewis, Derlega, Griffin & Krowinski, 2003).

Lesbians by their nature suffer the effects of the minority stress of being female and the additive minority stress of being non-heterosexual. Each episode of oppression has direct effects and combines together to impact psychological health in a negative way (Szymanski & Owens, 2009). The combined effects of the stressors imposed on lesbians from the consequences of disclosing their sexual orientation and the resulting depression can elevate the risk of substance abuse for this population (Bostwick, Hughes, & Johnson, 2005). Women treated unfairly on the basis of their sex understand discrimination as reflecting negative societal views of women and of themselves. This perception can decrease their self-esteem, both as a woman and as an individual, and can increase psychological distress (Fischer & Holz, 2007). The lesbian who desires to pass as a heterosexual must deny her true identity and behave like a member of the dominant culture. She must live with the daily risk of exposure. She is isolated from her peers, and knows her acceptance is based on a lie. The amount of damage to the self is proportional to the amount of self-preservation that motivated her to lie (Margolies, et al., 1987).

Family of Origin

One of our unexamined expectations is that our family is our primary support system and will be on our side in times of conflict. Unfortunately, for members of the lesbian population, the family, formerly perceived to represent refuge, may behave more like the enemy at the time of sexual disclosure. Instead of defending the lesbian against the oppression of homophobia, heterosexism, and discrimination, the family may side with the oppressive beliefs, attitudes, and behaviors of society, expecting their daughter

to marry a man and have children. Coming out to one's family requires thoughtful assessment of the importance and impact of the family on the individual and how dependent or independent the lesbian is from a physical, emotional, financial, and social point of view (Connolly, 2006).

Sense of Belonging

A sense of belonging is a basic human need as identified by Maslow (1970) and is necessary for psychological well being and self-actualization. Studies have shown that individuals who report a lesser sense of belonging are more likely to report higher levels of depression, while those who report a higher sense of belonging report lower levels of depression. Lesbians who report that they felt valued and that they fit into the lesbian community also reported feeling a greater sense of belonging to the general community, and this was associated with lower levels of depression (McLaren, 2009).

History of Therapy

Homosexuality was not removed from the official list of psychopathologies until 1973 (Strommen, 1993), and it was not until 1975 that the American Psychological Association voted to oppose discrimination against homosexuals, urging psychologists "to take the lead in removing the stigma of mental illness long associated with homosexual orientations" (APA, 2000, p. 964). Until that time, the therapy of choice for this population was conversion therapy. As its name implies, the goal of this therapy was to convert the lesbian or gay male into a heterosexual. This therapy was based on Freud's opinion that homosexuality was the result of arrested sexual development, an expression of an infantile sexual wish. Therefore, altering one's same-sex orientation to an opposite sex orientation was thought to assist the lesbian or gay male to achieve a higher level of psychosexual development (Drescher, 1998).

After Freud's death in 1938, the psychoanalytic theories about homosexuality widened, but still remained within the mainstream of the psychoanalytic movement. The theory of Sandor Rado put forth in 1969 laid the foundation for what was later called reparative therapy. His theory, called adaptational psychodynamics, was based on how one interacts with one's cultural environment and the theory of evolution. Since the core belief of the theory of evolution is survival of the species, the concept of reproduction is of paramount importance. Because same-sex relationships do not support reproduction, Rado viewed these relationships as a deficient adaptation. Bieber supported Rado's theory, claiming his study in 1962 confirmed that parental psychopathology caused females to be lesbians and males to be gay. In 1968 Socarides broke away from Freud's theory that homosexuality is reflective of a developmental arrest and defined it as a

conflict between the ego and the id, which creates a compromise formation that is acceptable to the superego. Ovesey recommended a behavioral approach in 1969, which is said to be representative of reparative therapy. In his method he assumed the role of dating consultant, where he advised the patient on how to conduct her love life so that eventually the patient was able to have sex with a member of the opposite sex. Reparative therapists have formed an organization called the National Association for Research and Therapy of Homosexuality (NARTH), whose position is that it is unacceptable for members to question the group's belief that homosexuality is an illness (Drescher, 1998).

Psychology of Women

Freud's psychoanalytic theories of female sexuality developed from 1923-1932 centered around his opinion that the female focuses her attention on the fact that the male's anatomy is different from hers. Freud declared that in order for a woman to be feminine, she needed to give up her self-assertive drives. His view was that women had weaker superegos, less interest in the outside world, and fewer moral convictions. His theories reflect his idea that men were more valuable than women, so that women had a secondary, subservient role to men. He thought women were doomed to a life of penis envy and passive masochism (Moulton, 1975).

Karen Horney pointed out in 1922 that psychoanalysis was discriminatory against women, having been created by a man. She objected to the idea that all women were subject to penis envy, and pointed out that women should not be measured by male standards. Horney felt that motherhood, though providing strong satisfaction to women, made it necessary for the female to postpone her individual creative fulfillment until her motherhood duties were fulfilled. She argued that a woman's sense of inferiority was enhanced by social disadvantages, such as the preference for boys in many families, the restriction of women's activity, and the monopoly of many professions by men (Moulton, 1975).

Clara Thompson contributed significantly to the new psychology of women between 1941 and 1950. She met Harry Stack Sullivan in 1923, who was instrumental in sending her to Sandor Ferenczi for analysis. (Ferenczi was a contemporary of Freud, but he had a more positive attitude toward women.) For several years Thompson and Sullivan met weekly with Karen Horney and Erich Fromm to exchange and develop their ideas.

Ferenczi and Sullivan disagreed with the coolness and lack of empathy of classical

psychoanalysis. Both Thompson and Sullivan believed in using simple and clear

language that patients understood. Thompson's papers written about women highlighted

how women were dealing with increasing awareness of their cultural inferiority.

Thompson talked about how women were able to enter almost every field of work, but

were not accepted on equal terms with men. Thompson pointed out how women were

subject to both external obstacles, such as lower wages, and internal obstacles, such as

emotional pressure from family and society to prioritize her family before her aspirations.

Thompson depicted the wife's desire to work as a threat to the husband's traditional role

of sole provider, which could be interpreted as a slur on his manhood, and society might

be equally disapproving. Thompson maintained that women were trained to be insincere

about their sexuality, ashamed of menstruation, self-conscious about their bodies, and

expected to spend much time on their appearance. As far as the psychoanalytic concept of

penis envy, Thompson asserted that women may suffer feelings of inadequacy as long as

they remain unassertive and dependent on men, with a resultant unclear sense of

themselves (Moulton, 1975).

Historically, sex-role expectations for women are related to warmth and

emotional expressiveness. Women are expected to be supportive, nurturing, and non-

competitive. Girls are conditioned to be more responsive to interpersonal cues than boys,

and often girls see themselves as supporting others by the time they are in kindergarten.

During adolescence, females tend to define themselves in terms of their social skills and

acceptance by others, while males define themselves in terms of their competence, status, and power in relationship to others. As a result, women are socialized to be sensitive to the acceptance or rejection of others, which translates into an evaluation on her self-worth. Women see themselves as supporting others' lives, rather than fulfilling their own needs (Riddle & Sang, 1978).

Since masculine traits are more socially desirable than feminine traits, females who are more masculine than feminine (cross-sex-typed) or high on both sets of characteristics (androgynous) are better adjusted, having higher self-esteem, more flexible adaptive behavior, and more personal achievements. Studies have shown that when females exhibit aggressive and dominant behavior, they are judged as more aggressive than males and in need of therapy. Sex education for girls centers around reproduction. While boys are encouraged to explore and enjoy their sexuality, girls are taught to set limits on sexual behavior, since they will be held responsible for the consequences of their sexual encounter. Three specific components of women's socialization that have particular implications for lesbians are: defining oneself in terms of others; valuing male characteristics as more socially desirable; and valuing sexuality for pleasure, rather than for procreation (Riddle & Sang, 1978).

Multi-culturally Competent Therapy

Lesbians have experienced discrimination related to being women and being gay.

Therefore, it behooves the practitioner to avoid discrimination in psychotherapy. To help

with this, guidelines have been developed by the Committee on Lesbian and Gay

Concerns, which is sponsored jointly by the Board of Social and Ethical Responsibility in

Psychology and the Board of Professional Affairs. The views held by therapists that were

considered to be biased or inappropriate include:

1. the belief that the lesbian is mentally ill

2. the assumption that a lesbian's problems are because of her sexual orientation

3. the failure to recognize that a lesbian may have negative attitudes about her
   sexual orientation

4. the assumption that a client is heterosexual

5. the assumption that a client is seeking to change her sexual orientation

6. the expression of beliefs that demean the gay lifestyle

7. the lack of understanding of the nature of lesbianism

8. the lack of knowledge about the coming out process

9. the underestimation of the importance of intimate relationships

10. the presumption that the lesbian is a poor parent because of her sexual
    orientation (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991).

A multi-culturally competent counselor who applies the principles of client-centered

therapy would avoid the above pitfalls. Carl Rogers believed the ultimate goal of

psychotherapy was to free the individual from whatever prevented him or her from fully

actualizing themselves, "to be that self which one truly is" (Rogers, 1961, p. 163). In

alignment with that belief, person-centered therapy allows the client to select his or her own goal and choose the path to accomplish that goal (Rogers, 1965). In order to be in congruence with the client-centered approach, a counselor would not act on assumptions and would explore the client's belief system to root out any maladaptive beliefs or self-defeating behaviors preventing the client from achieving his or her goal. The multi-culturally competent counselor would have undergone training that would dispell belief that being a lesbian was a mental illness, extricated opinions that demean lesbianism, acquired an understanding of the nature of lesbianism, gained knowledge about the coming out process, become aware of the importance of intimate relationships, and realized that a lesbian can be as good a parent as a heterosexual. Although this may sound like a daunting task, this is the reason Multicultural Counseling is a required class in the curriculum of counselors-in-training.

Stages of Identity Development

The therapist must not assume that the client is seeking therapy for an issue related to her sexual orientation. Lesbians seek therapy for depression, anxiety, and relationship issues, just like other women. These concerns may be intertwined with issues specific to lesbians, such as discrimination, disclosure concerns, anti-gay violence, or lack of role models. The therapist ferrets out the extent to which the problem is related to the client's lesbian identity according to the Cass Stage of Identity Development model. Assessing the stage of identity development is useful in conceptualizing the client to determine how the developmental stage interacts with the client's professional, ethnic/cultural, and religious stage of development, along with how much support the client is receiving from the lesbian community, the degree of discrimination the client is tolerating in housing or her job, and how safe her neighborhood is (Scrivner & Eldridge, 1995). By assessing the client's stage of identity development, the therapist can facilitate the client's exploration of the issues that correlate with that stage to assist the client in moving to the next stage. Studies exploring the relationship between phase of lesbian identity and self-esteem have been done, and it was found that chronic depression was common in women in the "pre-coming out" stage, since that is when the female is repressing her sexual orientation and lacking self-acceptance and social support (Bosker, 2002). According to Cass' Stage of Identity Development model, women have higher self-esteem and less depression the closer they get to the completion of the stages. Therefore, helping the client to move through these stages would be beneficial (Cassidy, 2007). The stages of identity development include: Identity Confusion, Identity

Comparison, Identity Tolerance, Identity Acceptance, Identity Pride, and Identity

Synthesis (Degges-White, Rice, & Myers, 2000).

- Stage One, Identity Confusion, is when one has the first conscious awareness of a thought, feeling, or behavior related to lesbianism.

- Stage Two, Identity Comparison, is the time that one reaches a tentative commitment to one's lesbianism. Handling social alienation is the main task of this stage. If one is unsuccessful in accepting that she is different and chooses to change her perception of herself as a lesbian, identity foreclosure occurs, and no further progress is made in the lesbian identity formation progress. In this case scenario, there is usually a dangerous amount of self-hatred and an increased risk of self-harm.

- Stage 3, Identity Tolerance – The critical factor in this stage is the emotional quality of the contact with other lesbian women. A positive contact can change one's negative self-image, and a negative contact can increase one's negative self-image. If identity foreclosure is avoided, one's commitment to a lesbian identity is enhanced, and Stage 4 is achieved.

- Stage 4, Identity Acceptance, is the stage during which the lesbian begins to feel normal.

- Stage 5, Identity Pride, is when the lesbian has nearly completely accepted her lesbianism, and at the same time, she is acutely aware of her rejection by society. In this stage her disclosure of her sexual orientation is increased. When

she discloses and receives an unexpected positive response from a heterosexual, she recognizes the inconsistency of her thoughts and moves into Stage 6.

- Stage 6, Identity Synthesis, is the point at which she integrates her sexuality with other aspects of her identity. It is at this time that being lesbian is no longer seen as her sole identity, but as a part of the whole picture of who she is (Degges-White, et al., 2000).

Advantages of "Coming Out"

Studies find that self-esteem and self-image increase in proportion to increased visibility and openness about a female's lesbianism. For this reason, the therapist is encouraged to explore the risks and benefits of coming out with lesbian clients. Closeted lesbians, who are disclosing their sexual orientation, often use defense mechanisms to justify their continued non-disclosure. They deny that disclosure is necessary, saying they never engage in intimate conversations with family members or work associates. Sometimes they boast about how they can avoid questions about their personal lives and deny that their lack of honesty has any negative impact on their relationships. Eventually, the enormous effort it takes to conceal their lesbianism becomes obvious, and they admit extreme anxiety whenever anyone mentions boyfriends, marriage, and children. They become aware of how painful it is to keep their relationships invisible and realize how much energy they expend in maintaining their invisibility (Gartrell, 1984; Cassidy, 2007). Coming out, however, is not without its risks, not the least of which are the psychological effects of declaring one's minority status in the face of a predominantly heterosexual society. Lesbians can experience emotional difficulties such as depression, anxiety, low self-esteem, hopelessness, feelings of isolation, grief and loss, self-hatred, and even suicide attempts (Bosker, 2002). Other risks of disclosure include the possibility of rejection, verbal abuse, being fired from their jobs, custody battles, and physical violence. As a result, a lesbian has to be constantly vigilant to evaluate those in her environment in order to judge who would be safe to whom to disclose her sexual orientation (Earle, 1999).

The Insidious Nature of Internalized Homophobia

Internalized homophobia is the internal acceptance of irrational fear, hatred, and intolerance of homosexuals. Internalized homophobia consists of erotophobia, fear of or discomfort with one's sexuality, and xenophobia, the discomfort with one's strangeness. Erotophobia is fairly pervasive in our society, where the openly sexual woman is thought of as a "bad girl," but it becomes even more potent for lesbians who are participating in sex for pleasure, not for procreation. Xenophobia is experienced as fear of rejection because of differentness from perceived expectations and social isolation or punishment. Social and family rules are stored in the superego, and tampering with established patterns often results in shame, guilt, fear, and anxiety. Lesbians often do not fulfill their parents' dreams, which causes them to lose their "good girl" status. This loss results in plummeting self-esteem (Margolies, et al., 1987). The therapeutic goal in this conceptualization where the superego experiences anxiety due to social deviance would be to expand the superego, so that it is capable of accepting the sexual orientation of choice (Igartua, Gill, & Montoro, 2003). Engaging in Socratic dialogue utilizing open questions could be useful in stretching the superego (Gilbert, 2007).

Internalized homophobia can be expressed overtly and also can be expressed covertly, taking insidious forms that are unconscious and difficult to identity. Some of the covert expressions of internalized homophobia are: fear of discovery; discomfort with obvious "dykes;" rejection of all heterosexuals (heterophobia); expressing superiority to heterosexuals or exaggerated gay pride; belief that lesbians are not different from non-gay women; uneasiness with children being raised in a lesbian home; limiting

attractions to unavailable women, heterosexuals, or those already partnered; and short-term relationships (Margolies, et al., 1987).

Internalized Homophobia Treatment Goals

Internalized homophobia manifests from the ego's struggle between rules and desires. It is the role of the therapist to differentiate between when homophobia is helping the client to navigate through discrimination and when it is sabotaging the client's efforts to deal with a hostile environment: Does the defense allow the client to hide, remain in denial, and shield her from dealing with reality? Does it protect her from achieving intimacy with her partner and disallow her from attaining a satisfying relationship? Does it support sexual rigidity or behaving in ways that sabotage sexual fulfillment? (Margolies, et al., 1987).

The role of the therapist is crucial, in that this relationship can be the client's first building block of a support system, and clients internalize the acceptance of the therapist. After the therapist and client become aware of the homophobia, the treatment goal is to reconcile the conflict between sexual feelings and shame or guilt. This work involves routing out homophobic beliefs, feelings, and behaviors (Margolies, et al., 1987).

Cognitive behavioral therapy addresses irrational beliefs and maladaptive thinking, which generate negative feelings and self-defeating behaviors. Sometimes depression is a combination of negative core beliefs about the self, world, and future, along with ruminating on these thoughts, avoiding problems, and withdrawing from activities. Therefore, it is important to explore with the client how she thinks and feels about

herself, the world, and the future, as well as her coping behaviors and her use of social

support. During this exploration, automatic thoughts, rules and assumptions, core beliefs,

rumination styles, and safety strategies can be examined and reframed if necessary

(Gilbert, 2007). Helpful questions in this exploration would be:

- How does that thought make you feel about yourself (the world, the future)?

- If you were to address this problem, how would you do it?

- What would be another way you could deal with that problem?

Once a client becomes aware of rumination on negative thoughts, thought-stopping

techniques could be taught, so that when the client finds herself engaging in this activity,

she can visualize a "Stop" sign or a red light to help her disengage from these thoughts.

Identifying favorite activities is helpful in teaching coping behaviors to replace

maladaptive ones with healthy ones. Rules and assumptions can be challenged in a non-

confrontational way, just by questioning them: "How did you come to that conclusion?"

"Help me understand how looking at this situation in this way helps you achieve your

goal" (Gilbert, 2007).

Safety strategies are the behaviors we put in place to protect ourselves from harm,

injury, or rejection. People evolve their own protective system based on their childhood

experiences with their parents and continue using the same strategies in an effort to stay

safe. Exploring a depressed client's reaction of avoidance or withdrawal in the context of

how she is trying to protect herself from something that she perceives as potentially

harmful allows the client to see her behavior as adaptive, rather than maladaptive

(Gilbert, 2007). Also, families' responses to lesbianism should be dealt with, and an important part of the therapeutic process is to mourn the loss of the "good girl" identification (Margolies, et al., 1987) and the inability to meet the family's expectations (Igartua, et al., 2003).

One study identified seven issues that participants identified as crucial for their acceptance of their sexual orientation:

- work within clients' religious values

- explore options and create alternatives

- enhance self-esteem, self-acceptance, and self-control

- break compulsive cycles and replace ineffective coping mechanisms

- strengthen honesty, authenticity, and assertiveness within relationships

- maximize gender identity congruence

- utilize support groups (Beckstead, 2001).

To develop strategies to decrease internalized homophobia, it is helpful to take into account the influence of the client's gender, culture, religion, locus of control, social networks, and personal upbringing. Exploring internalized homophobia to assess psychological distress is essential. Statements that indicate unconscious internalized homophobia include:

- "I have no problems with my sexuality."

- "I don't think others need to know I'm gay."

- "I don't know why those drag queens have to parade around."

- "Telling my mother I'm gay would kill her." (Igartua, et al., 2003)

Internalized homophobia can be treated as a dysfunctional cognition due to maladaptive assumptions in cognitive therapy. Brainstorming on the meaning of the words gay, lesbian, or bisexual can reveal negative beliefs about homosexuality. At McGill University Sexual Identity Centre, a multi-modal group approach is used, combining psychoeducation, work on defense mechanisms, along with challenging maladaptive assumptions and providing a corrective emotional experience of belonging to a group of peers (Igartua, et al., 2003).

<center>**Motivational Interviewing**</center>

Motivational Interviewing (MI) is a way of being with people that seeks to understand and experience that person's way of being as a style of counseling and psychotherapy. Its key components are collaboration, evocation, and autonomy. The collaborative approach employs a conducive method, rather than a coercive method. The evocation style draws on the client's perceptions, goals, and values, which supports the resources and motivation for change that reside within the client. The component of autonomy affirms the client's right to make his or her own choices and facilitates the capacity for self-direction. The focus of MI is to build motivation to change by helping the client identify what is getting in the way of achieving his or her goal, including discrepant self beliefs and/or contradictions between values, thoughts, feelings, and actions. By doing this, the client becomes aware of the difference between where he or she is and where he or she wants to be (Miller & Rollnick, 2002).

The four guiding principles underlying MI are:

- Express empathy – Reflective listening as described by Carl Rogers (1965) is the foundation on which skillfulness in MI is based. Underlying reflective listening or accurate empathy is acceptance, so the client does not feel judged, criticized, or blamed. This kind of acceptance frees clients to change, while nonacceptance immobilizes the client's change process. This attitude of acceptance builds the therapeutic alliance and enhances the client's self-esteem.

- Develop discrepancy – Developing discrepancy is a tool to help the client move past ambivalence. The use of this directive technique is where MI begins to move

away from non-directive client-centered counseling. Building discrepancy between present behavior as opposed to values and goals, enables the client to identify reasons for change and move towards positive behavior change.

- Roll with resistance – This concept is an approach to use when the client argues against change. Reflective listening creates an environment of unconditional positive regard. In this listening method, the therapist forms a hypothesis about what the client thinks and/or feels and responds with that hypothesis in the form of a statement. If the client clarifies it, the therapist restates the hypothesis with the clarified content. If reflections continue to generate resistance, the therapist can explore the client's perception, affirm the client's choice, support the client's self-efficacy, shift focus, reframe, or side with the negative to re-establish collaboration.

- Support self-efficacy – A client's belief in his or her ability to succeed is a good predictor of treatment outcome. Thus, enhancing the client's confidence of success is one of the goals of MI.

The pairing of intervention with the client's stage of change is crucial to maximize the effectiveness of MI (see Table 1) (Miller & Rollnick, 2002).

Table 1

Stages of Change

STAGE	CHARACTERIZED BY	INTERVENTION
Precontemplation	Client not considering the possibility of change although others might identify the problem.	"How can I be of help to you?" (What is individual motivated to do?)
Contemplation	Client recognizes there might be some reason for concern, but vacillates between reasons to change and reasons to stay the same.	"On one hand you feel you would like to stop smoking, but on the other, you feel you would like to continue."
Preparation	Client accepts the need to make a change and is ready to develop a plan	Develop effective plan using "piecemeal" or baby steps approach.
Action	The client is in process of engaging in actions to bring about the desired change.	"How did you get yourself to do that?" Reinforce client's new behavior by expressing enthusiasm and excitement, along with asking for details.
Maintenance	The goal is to sustain the changed behavior and prevent relapse.	Teach coping skills. Explore anticipated obstacles and unforeseen circumstances.

Conclusion

Effectiveness of treatment for depression in the lesbian population is enhanced by multicultural competency training and knowledge of specific risk factors for depression in lesbians, such as internalized homophobia, the issues around coming out, and stress factors. Additionally, familiarity with the stages of identity development would be helpful in conceptualizing the client. In order to dislodge maladaptive coping mechanisms, irrational thoughts, and core conflicted beliefs, cognitive-behavioral therapy can be used in a client-centered approach. Along with that, the application of MI principles and determining the client's Stage of Change will facilitate the process.

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