Gender and Sexual Diversity Therapy (GSDT)

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Gender and sexual diversities

This chapter will focus on working with gender and sexual diversities (GSD). This is a more inclusive term for the more traditionally used LGBT (IQ) (lesbian, gay, bisexual, transgender/ sexual, intersex, questioning). It encompasses a wider range of gender and sexual diversity identities including, but not restricted to, people who either engage in Kink/BDSM (bondage, dominance, discipline, submission, sadism and masochism) practices or lifestyle - irrespective of sexual orientation (Langdridge and Barker 2007) - as well as people who may identify anywhere across the gender spectrum and not simply intersex or transgender.

Gender and sexual diversities (GSD) are also opening up the debate on different possibilities in relationships such as asexuality (Rothblum and Brehony 1993) and celibacy or polyamory, swingers and other forms of consensual non-monogamy (Barker and Langdridge 2010).

Recent theories (Diamond 2008) around sexual orientation elaborate on its natural fluidity. Sexual preference is best thought of as a continuum and may vary according to the social context and over time: some same sex attractions may occur at various points in one's life, whilst libido or desire for sex may also vary in degree. Diamond's research indicates that women are more fluid than men as they tend to be attracted to an individual rather than a sexual object. Gay men tend to be more rigid in their choice of partner-type (Diamond 2008) (see also Davies 2012). Individuals often identify their gender or sexuality differently from one stage of their life to another; for instance gender variance may manifest late in adult life (Lev 2004).

Clients present with different ways of experiencing romantic and/or sexual relationships. Often the issues are about interpersonal rather than intrapsychic factors. The asexual population (whether in romantic relationships or not) is struggling to be out and accepted: individuals not engaging in sexual activities are frequently pathologised and discriminated against. When disclosing their asexuality they face social opprobrium and pressure to partner up and have sex (Cormier-Otaño forthcoming). At the other end of the spectrum are polyamorous relationships, where individuals are concurrently having more than one romantic and sexual relationship. Polyamory - like asexuality - embraces heterosexual, homosexual or bisexual individuals.

The possible combinations of sexual preferences, sexual orientation, gender identity, gender preferences and relationship choices are varied and each becomes an individual narrative. Some of these narratives come with varying degree of difficulties, but of course most GSD's never present for therapy and lead happy and fulfilled lives. Helping clients to identify and name their own sexuality highlights the complexity faced by gender-variant clients, who challenge society's definition both of gender and of sexual orientation: is a lesbian couple still in a same sex relationship when one of them transitions to become a man? (Lev 2004)

Gender and Sexual Diversity Therapy

Gender and Sexual Diversity Therapy (GSDT) is a recent and deliberate move away from *Gay Affirmative Therapy* (GAT) to encompass and support all forms, aspects and issues around gender and sexual diversities. It is a trans-theoretical approach where all theoretical models (Psychodynamic, Humanistic, Behavioural) can operate within their central organising principles and tenets (Davies and Neal 2000).

The name Gay Affirmative Therapy was problematic in a number of ways. On a political level it may appear to exclude (amongst others) lesbians and bisexuals or the gender-variant. It also ignores subcultures and groups where opposite sex attractions are present (kink, fetishism,

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swingers, etc…). Finally the concept of "gay affirmation" implies an agenda for clients' self-actualisation.

Hypervigilance - a key concept

GSDs have a long history of being considered 'mad, bad or dangerous to know'. This results in hypervigilance against pathologisation or negative judgements and GSDs will scan their environment for signs of hostility or safety: am I going to be (mis)read? Am I going to be accepted or understood? Is it safe to reveal myself? (Carroll 2010). This very sensitive state is a source of anxiety and distress that will also be present in the counselling room. GSD clients will often unconsciously or directly question their therapists around their understanding of gender and sexual differences. Consequently, some clients may benefit from or request to work with a therapist who is also from a gender or sexual diversity; others may benefit from, or prefer to work with, someone from outside of their community. The client's choice of therapist is charged with meaning and well worth exploring the assumptions that lie behind the request for a minority therapist or indeed a non-minority therapist. However, the clients' wishes need to be respected and accommodated where possible. This issue also raises the question of whether GSD therapists are comfortable and willing to reveal their sexual orientation or gender history.

Good Practice:

Most counsellors and psychotherapists are unlikely to be specifically trained to work with GSD's (Davies 2007). Virtually all developmental models and many counselling theories privilege heterosexuality, both as a social norm and as a sign of psychological health. Recent UK research found that 17% of counsellors would agree to help a client suppress their same sex attractions (Bartlett et al 2008). So-called "conversion" or reparative therapies are not only unethical because they collude with social and internal oppression that same sex desire equals pathology and have been shown to be harmful to individuals who undergo them. (Daniel 2009).

Good practice in GSDT requires a subtle curiosity and interest in the client's life, and an ability to work sensitively with their hypervigilance. It is not the client's place to educate the therapist with regard to the social context of their experience. However, the client's own perspective on that social context is, of course, entirely relevant and appropriate. This requires therapists to have a wide understanding of the social context in which gender and sexual diversities are living their lives, as well as how multiple identities can interact and sometimes conflict. There are a wealth of books and information online that deal with gender and sexual diversity clients. Much of the current literature is American, although the UK is now making a good contribution to the field.

It is also paramount for any therapists to develop their awareness of their own prejudices, beliefs and assumptions about what is 'healthy' and 'normal' in terms of sex, gender role, relationships etc. As all of us have been socialised within mainstream culture, in which heteronormative beliefs are an inherent and perpetuated given, and therefore none of us is entirely free of heterosexism and homophobia - in the same way as it is hard to be free of racist or sexist attitudes.

UK therapy trainings rarely offer adequate training around gender and sexual diversity issues. Often these issues are included in a single lecture on diversity and rarely exceed three hours of teaching. A common training experience is that GSD issues are included only upon the demand of LGBT trainees and these students are expected to facilitate their peers' learning. This can result in their own learning needs (to work effectively within their own communities) unattended to, and they are forced to seek post qualification specialist training elsewhere (Davies 2007).

A third area for learning and developing good practice is to understand more about gender and sexual diversity psychology, and the impact of stigma on the development of the self. Therapists should not fall into the trap of denying the very real differences that exist between

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those of a diversity identity and those of the heterosexual mainstream or majority. Lesbian relationships are quite different from gay male relationships, which differ again from heterosexual couplings. There are many differences between each of the GSD identities as well as some sharing of common features. It is the authors' view that training is essential to have a sufficient understanding of the intrapsychic, as well as socially constructed, elements of GSD experience.

Personal experience and clinical practice are helpful ways of gaining knowledge. Volunteering as a counsellor in GSD charities is a unique way to learn but these organisations may require their counsellors to identify as GSD. Meeting with other therapists and sharing information, books, supervision and support is another way to maintain good practice. Just having a gay friend is not enough, nor is it sufficient simply to hold a GSD identity. Training is essential for all wanting to work in this area.

Supervision is undoubtedly a key factor to good practice – as it is in all other aspects of the therapist's work. Although it can be difficult to make enquiries of a long-term supervisor, or to challenge their knowledge and awareness, therapists working with gender and sexual diversity clients are best served if their supervisor has had some specific training in this area as well. A therapist reflecting on his/her own prejudices around issues affecting gender and sexual diversity clients needs a supervisor who has worked on his/her own prejudices as well. Otherwise, issues such as erotic transference/countertransference or angry feelings in the counselling room will remain unexplored or ill advised (Pope, Sonne and Holroyd 2000). An uncomfortable example would be a kink-aware therapist wanting to think about their work with a client whose sexual practices usually involve domination, faced with a supervisor who understands BDSM as the acting out of self-harming tendencies, resulting from childhood abuse or pathology.

Understanding social context and particular issues:

GSD clients may well come to therapy with issues not so different from those presented by all clients, but the social context will bring an extra dimension and different layers to their narrative.

It is important to consider the power of the heteronormative, patriarchal and Eurocentric society in which we have evolved. External oppression and negative messages around sexual orientation, gender and ethnicity lead to internalised oppression. A young boy pressured to behave in a way stereotypical of his own gender (e.g. wearing blue or having short hair) can lead to the internalised belief that it is wrong for a man to dress in pink or have long hair. Such beliefs, if not challenged, may lead to this adult man accepting the idea that a feminine side to himself is wrong or socially unacceptable. Similarly, messages that sex and its expression should be limited to heterosexual, procreative activities, remote from consensual experimentation, can lead to feelings of guilt and shame. This kind of internalised oppression can result in self-loathing, low self-esteem, isolation, fear of rejection and other psychological difficulties.

Gender and sexual diversities experience higher levels of mental health distress, depression, self -harm and substance misuse than heterosexuals (King et al 2008).

In urban environments the majority of socialising between individuals of gender or sexual diversity groups takes place in clubs and bars. Many new designer drugs have been introduced on the gay club scene first, thus becoming a very common ingredient to a night out - prior to becoming mainstream on the general club scene.

This use of drugs and alcohol among gender and sexual diversity groups can be understood in part as a response to pressure and oppression. There is an urge to escape from external pressures, to lower inhibitions, and to experience a sense of community with one's peers. The misuse of drugs and alcohol can also lead to unsafe sexual practices or risky situations.

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Isolation, hiding and shame are common amongst GSD clients and can lead to a lack of access to accurate information. This means that the counsellor may need to employ psycho-educational methods and bibliotherapy, homework etc to help with relationship skills, sex education and other issues. In cases where the therapist's sexual orientation matches the client's and is disclosed, the therapist can sometimes be seen as a role model whether they want that or not. This of course is one of the dynamics to be discussed in supervision.

Identity and belonging:

Individuals carrying such strongly internalised self-oppressive thoughts may well question their own identity and sense of belonging. Only by exploring their own narratives or in finding kindred spirits does the client experience an integration of these different parts. The GSD-aware therapist can help to empower clients to find the words to describe and make sense of their own sexuality and sexual expression. Having gained a sense of their own sexual identity, clients will often move to a position where the need to belong to a community then becomes more important. However, difficulties can arise when the pressure to embrace cultural norms within the GSD communities is very strong and oppressive (fashion, lifestyle, peer pressure) and lead to the development of a false self where the client again feels only conditionally accepted.

Many GSD individuals want to marry (civil partnership) and adopt children, thus recreating a lifestyle more attuned to the heterosexual mainstream. For some people this is looking towards the dominant majority for a seal of approval; for others they might see their 'minority' identity as an insignificant feature in their lives.

GSD clients belong to many communities (spiritual, cultural, professional, political, families, gender etc.) and may experience the impact of conflicting beliefs or ideologies. Most religions or faiths do not tolerate same sex relationships. Similarly within the various GSD communities, not all individualities, ethnicities, sexual practices or gender identities are embraced. Ableism, ageism and racism are just some of the very real discriminations operating from within a broadly GSD culture.

Moving times and olden days:

Historically, in order to negotiate a place in society, gender and sexual diversity individuals had to 'pass' as heterosexual or to come out: either to pretend to be what they were not (reinforcing external and internal oppression) or to disclose to self and others their own sexual preferences or gender identity and put themselves at great risk. This is a process of self-acceptance and exposure that heterosexual individuals do not have to undergo.

Coming out is a process and not a single event. It is complex and recurrent, there is a well-founded fear of being rejected, victimised or abused (trans and homophobic hate crime is on the rise) and the constant decision of whether to come out or not in each new social or professional situation (work, friends, family, neighbours, authorities, institutions, GP's etc) is very stressful and anxiety provoking for some individuals particularly where the level of internalised and externalised oppression is too high. (Carroll 2010).

Universal 'coming out' is also a western concept that may have little relevance for people from other social and ethnic groups. Coming out can result in exclusion from the family and community - especially for members of black and minority ethnic communities where other ways of negotiating the integration of minority sexual identities are more relevant (das Nair and Thomas 2012, Beckett 2010). das Nair describes a process of stepping in and out of the closet, sometimes having to manage their gay identity more covertly and alongside cultural expectations to marry and have children. Beckett, eloquently describes, in her work with a young Muslim man the process of 'inviting in' rather than coming out, where significant people are selectively invited into knowing more about the client's life and sexuality.

Fortunately, the coming out experience (or 'emerging' as it has come to be known for trans people, Lev 2004) and acceptance of GSD by significant others and society has (for a larger

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number of people) changed for the better in recent years. New generations may be more comfortable with a "queer" identity rather than a gay or lesbian one and may be completely at ease with their identity as "other". The notion of making a declaration of a fixed sexual or gender identity is breaking down amongst many young people for whom nailing their sexuality to a post is irrelevant. This so-called 'Rainbow Generation' may experience their identities more fluidly.

On the other hand, the older GSD population might still be struggling with internalised oppression and repression from past experience (electro-convulsive therapy, criminalisation of same sex practices, public naming and shaming etc)

Active listening and empathy are key skills to allow the client to develop their narrative in order to realise the impact of the social context on their identity. The difficulties experienced by people with GSD identities will often have common causes, but as ever it is the reflective, aware, respectful and non-judgemental clinical approach to each client's unique situation that is at the core of a good practice and will ultimately support their well-being and mental health (Davies 1996).

The skilled and ethical GSD practitioner needs to be flexible enough to work with all clients regardless of the client's stage of accepting their sexuality. Therapeutic work around sexual or gender identity may well help the client work through unease about difference, but does not take on an agenda to alter this integral part of a person's lived experience.

Finally GSD therapists should be ready to work with clients presenting with requests for 'cure' or reduction of their same sex attractions, or who have been damaged or abused by 'reparative' therapies.

Sexual practices

Pleasure, procreation and play are the three aims for sex and imagination can be fertile when it comes to sexual practices. It is the therapist's responsibility to have an open mind and an understanding of diverse sexual practices should they choose to work with gender and sexual diversity clients.

Language and communication between client and therapist should be on a similar level or register; the therapist's vocabulary should mirror the client's and unfamiliar words be congruently explored by the therapist. The impact of using medical or anatomical terms by the therapist in response to informal, colloquial, or slang terms used by the client may well send messages of discomfort or disapproval from the therapist.

It is also helpful for the therapist to have reasonably current knowledge of sexual health, HIV awareness, treatments and safer sex.

Conclusion

Gender and Sexual Diversity Therapy is cognisant of the social context in which gender and sexual diversities live as well as the particular concerns of each individual. It works with the hypervigilance and consequences of living within a society which is biased towards heteronormativity and binary conception of gender. It helps clients understand their experiences and the impact of external oppressions, how they are internalised and a range of issues specific to these populations and communities. It stresses the need for clients to self-define and for developing personally relevant values and moral codes.

GSDT good practice requires a thorough working through of the therapist's prejudices around sex and gender and a minimum knowledge of how these diversities live, not only in a western, heteronormative and patriarchal society but also in different settings around the world.

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Therapists will continuously be challenged, provoked and educated by clients whose presenting issues confront two of the world's biggest and most sacred taboos: sexuality and gender.

References:

Barker, M. and Langdridge, D. (eds) (2010) *Understanding Non-Monogamies.* Hove: Routledge.

Bartlett, A., Smith, G. and King, M. (2009) The response of mental health professionals to clients seeking help to change or redirect sexual orientation. *BMC Psychiatry* 9 (11) available online: http://www.biomedcentral.com/1471-244X/9/11

Beckett, S. (2010) Azima ila Hayati: An Invitation into My Life: Narrative Conversations about Sexual Identity. In Lyndsey Moon (ed) *Counselling Ideologies: Queer Challenges to Heteronormativity.* Farnham: Ashgate.

Carroll, L. (2010) *Counselling Sexual and Gender Minorities.* Columbus: Merrill.

Daniel, J. (2009) The Gay Cure? *Therapy Today.* October: 10-14

das Nair, R. & Thomas, S. (2012). Race and Ethnicity. In R. das Nair & C. Butler (eds.) *Intersectionality, Sexuality, & Psychological Therapies: exploring lesbian, gay, and bisexual diversity.* London: Wiley Blackwell/BPS-Blackwell imprint. Pp59-88.

Davies, D (1996) Towards a Model of Gay Affirmative Therapy in D. Davies and C Neal (eds) *Pink Therapy: a Guide for Counsellors and Therapists Working with Lesbian, Gay and Bisexual Clients.* Buckingham: Open University Press.

Davies, D. and Neal, C. (eds) (1996) *Pink Therapy: a Guide for Counsellors and Therapists Working with Lesbian, Gay and Bisexual Clients.* Buckingham: Open University Press

Davies, D. and Neal, C. (eds) (2000) *Therapeutic Perspectives on Working with Lesbian, Gay and Bisexual Clients.* Buckingham: Open University Press

Davies, D. (2007) Not in front of the Students. *Therapy Today*. February 2007

Davies, D (2012) Sexual Orientation in C. Feltham & I. Horton (eds) *The Sage Handbook of Counselling and Psychotherapy* 3rd edition. London: Sage Publications

Diamond, L. (2008) *Sexual Fluidity: Understanding Women's Love and Desire.* Massachusetts: Harvard University Press.

Langdridge, D. and Barker, M. (eds) (2007) *Safe, Sane and Consensual.* Basingstoke: Palgrave.

King, M., Semlyen, J., Tai, S.S., Killaspy, H., Osborn, D., Popely, D. and Nazareth, I. (2008) A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. *BMC Psychiatry* 8 (70) http://www.biomedcentral.com/1471-244X/8/70

Lev, A. I. (2004) *Transgender Emergence: Therapeutic Guidelines for working with Gender-Variant People and Their Families.* New York: Haworth.

Pope, K.S., Sonne, J. L. and Holroyd, J (2000) *Sexual Feelings In Psychotherapy.* Washington: American Psychological Association.

Rothblum, E.D. and Brehony K. A. (1993) *Boston Marriages: Romantic but Asexual Relationships among Contemporary Lesbians.* Amherst: University of Massachusetts Press

Reading Suggestions:

Finnegan, D.G. and McNally, E. B. (2002) *Counseling Lesbian, Gay, Bisexual, and Transgender Substance Abusers: Dual Identities.* New York: Haworth

Moon, L. (2008) *Feeling Queer or Queer Feelings: Radical Approaches to Counselling Sex, Sexualities and Genders.* Hove: Routledge

Pattatucci Aragón. A. (2006) *Challenging Lesbian Norms: Intersex, Transgender, Intersectional and Queer Perspectives.* New York: Haworth

Sue, D. W. (2010) *Microaggressions in Everyday Life: Race, Gender and Sexual Orientation.* New Jersey: Wiley.

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Pink Therapy is the UK's largest independent therapy and training organisation to specialise in working with a broad range of gender and sexual diversities. Founded by Dominic Davies in 1999, we are regarded by all UK therapy organisations as the lead agency in this area. We run the only university accredited specialist Diploma in Gender and Sexual Diversity Therapy in Europe, which has attracted therapists from the UK, Netherlands, Singapore and Australia. We also run a six day intensive **International Summer School** where therapists from around the world come to study with us. Pink Therapy offers training, clinical consultation, supervision and consultancy to therapists overseas in person or via Skype.

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