

Gender and sexuality diversity (GSD): respecting difference

Dominic Davies and Meg John Barker emphasise how a broad understanding and respect for gender and sexual diversity is immensely valuable to all psychotherapists working with sex and relationships

Conversion therapy and normativity

The recent publication of the memorandum of understanding on gay to straight conversion therapyⁱ brought many key psychology, health, counselling, and psychotherapy organisations together for the first time to collaborate on a subject on which they had no disagreement. The memorandum clearly states that efforts to try to change sexual orientation through psychological therapies are unethical and potentially harmful. Clearly, therapy has come a long way since the declassification of homosexuality as a mental disorder in the *American Psychiatric Association Diagnostic and Statistical Manual* (DSM, 1973) and the World Health Organization's *International Classification of Diseases* (ICD, 1992).

What the document left out was conversion therapy as it applies to gender and sexual diversity (GSD) identities and practices beyond gay identities and same sex attractions. For example, in relation to transgender, some therapists still deem it acceptable to try to eliminate behaviour in children that doesn't conform to cultural gender norms or private 'cross-dressing' practices by husbands in a heterosexual marriage. In the case of bisexuality, some still encourage clients to 'pick' homosexuality or heterosexuality, rather than respecting the person holding a bisexual identity.

A heteronormative lens

The problem, as we see it, is that many therapists view human sexuality and relationships through a heteronormative lens. Heteronormativity is a set of social norms about sexuality, gender and relationships, which includes the following assumptions:

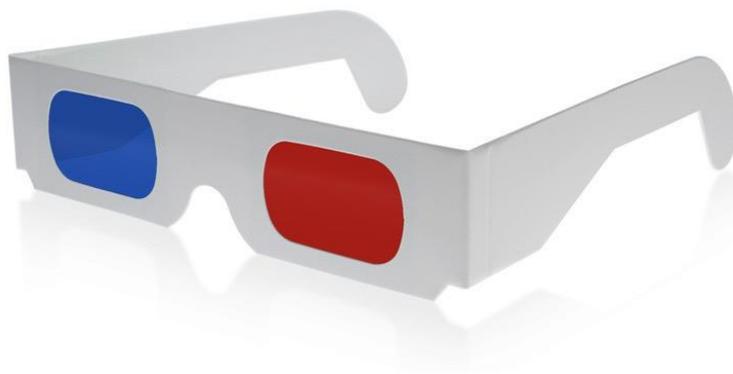
- There are two opposite sexes – male and female – with different associated gender roles – masculinity and femininity

- Normal sexuality is attraction to the ‘opposite sex’; attraction to the ‘same sex’ is possible but not normal, and it is not possible to be attracted to more than one sex
- Normal relationships are monogamous – or at least dyadic – and sex should only take place in the context of that dyad
- Relationships must be sexual, and the normal sexual script consists of foreplay, penis-in-vagina penetration, and orgasm.

People who experience no sexual attraction are thus pathologised by many therapists as having ‘hypoactive sexual desire disorder’ rather than potentially having an asexual orientation.ⁱⁱ Also, people who recognise that one partner cannot meet all their sexual – or relationship – needs often find it impossible to access relationship therapy. Mainstream services generally use the term ‘couple therapy’ rather than ‘relationship therapy’ and are simply not accessible to people in polyamorous or otherwise openly non-monogamous relationships.

Specialist therapy

Often the only option available to those who fall outside heteronormativity in such ways is to access specialist independent therapy (via the Directory of Pink Therapists). This makes therapy for GSD people only available to those who can afford it, and even this is likely to be restricted to certain urban areas. This lacuna has led to Pink Therapy setting up the world’s first postgraduate training in relationship therapy for GSD people.



We could frame the therapeutic task through a pair of 3D glasses. Typically, because of being socialised in a heteronormative world, therapists have been trained to view sex and relationships through the heteronormative lens (the blue lens of the glasses). This often results in the assumption that a client's difficulties are necessarily related to their gender or sexual identity, and in clients getting the message that their sexual or relationship practices are somehow questionable. Alternatively, some GSD therapists may know to eschew that lens and only view their clients through an entirely affirmative queer lens (the red lens of the glasses), which could lead to making collusive alliances and assuming that they know all about the client's experience because they live within similar communities themselves. Viewing the client through both lenses of the 3D glasses allows a three-dimensional perspective: where we recognise the client's lived experience within a heteronormative cultural context and we can remain curious about what is similar and different for each individual client.

Implicit message

The heteronormative lens does not mean that most therapists are overtly homophobic, biphobic or transphobic towards their clients, or even that they give them an explicit message that they are not acceptable as they are (King, Semylen, Killaspy, Nazareth and Osborn, 2007). Rather, research suggests that the impact is much more implicit. For example, Lyndsey Moon (2008) found that heterosexual therapists tended to use more negative and loaded emotion words when describing LGBT clients in comparison to heterosexual clients. And Janet Grove (2014) found that LGBT clients with heterosexual relationship therapists felt that they had to give the impression that they were 'good gays' and felt they couldn't talk openly – for example about kinky or casual sexual encounters.

The uncritical acceptance of the concept and treatment of 'sex addiction' by many in the therapy profession also causes us grave concern when there is a lack of evidence to support it and a lack of agreement over what constitutes it. For example, some of the criteria considered indicative of sex addiction are entirely normative practices among many gay and bisexual men, people with kink identities, swingers, and others.

GSD experiences

It is our experience that three core issues run as threads through most GSD identities and practices which therapists should be aware of. These are hypervigilance, shame and resilience.

Hypervigilance is where clients constantly monitor everything they say and do because of an assumption that the therapist may view them as ‘mad, bad or dangerous to know’. And this – as we’ve seen – is often the case. It is impossible to live in a world which privileges heteronormativity without introjecting negative ideas about oneself that lead to shame. Sex, in particular, is a subject that probably everyone feels some degree of shame about – given the wider sex-negative culture we live in. Within GSD populations, people often feel this more acutely and deeply, given that their sexual experiences are likely to deviate from the normative sexual script. There is also a strong cultural sexual imperative, which can mean that asexual people feel shame and stigma, and indeed may struggle to find relationships in which they aren’t expected – or pressured – to be sexual.

However, of course, not everything to do with GSD identities and practices is problematic. Many GSD people are extraordinarily resilient, as found by the recent Risk and Resilience Explained (RaRE) study by the LGBT charity PACE.ⁱⁱⁱ Moreover, there is much that can be learnt from GSD experience that is valuable for all clients.

Learning from GSD

So far we have been referring to GSD as if we may be talking about a minority of people in comparison to a heteronormative majority. However, it is worth questioning this common assumption. Consider the proportion of the population who are non-monogamous (whether openly or secretly – at least 50 per cent); who have experienced attraction to more than one gender (around 30 per cent); who do not experience their own gender as simply stereotypically masculine or feminine (around 30 per cent); who have periods of no sexual attraction, or who have kinky sex of some kind (up to 50 per cent and perhaps more given the popularity of *Fifty Shades of Grey*). Adding all this together, it would be the heterosexual, monogamous, non-kinky, cisgender^{iv} folk who would be in the minority.

Along with the need to add a queer lens to the heteronormative one, this is another reason to include GSD throughout all therapeutic training, and it is heartening that the memorandum of understanding emphasises the need for such training so that therapists gain cultural competency in working with gender and sexually diverse clients.

Beyond this, there is much of value that can be learnt from GSD people for sex and relationship therapy with all clients. For example, people involved in consensual BDSM (bondage and discipline, dominance and submission, and sadomasochism) communities have had to develop extremely good communication skills and a high degree of self-reflexivity to be able to articulate their desires and communicate these to their partner(s), and they have often had to step outside shame-filled narratives around normative sexual behaviour. Equally, people conducting polyamorous relationships often have highly developed communication skills because they have to negotiate their relationship dynamics and creatively engage with jealousy. One example of this is the development of new language for relationships and emotional states: for example, *metamour* for a partner's partner and *compersion* for a positive feeling on seeing a partner happy with another partner. This radically challenges the assumption of possession in romantic relationships (Ritchie and Barker, 2006).

Summary

In summary, in this article, we have considered how three different understandings of respect might relate to our work as therapists, with a particular focus on sex and relationship therapy. These three understandings are:

- Respecting who a person is rather than trying to change them
- Respecting what their identities and practices will mean for their experience in a world which positions them as outside the norm
- Respecting what we might learn from them.

Further resources

You can find out about the training and CPD on GSD issues on the Pink Therapy website: www.pinktherapy.com/en-gb/training.aspx

Meg John and colleagues provide GSD training for general counselling and psychotherapy courses and organisations:

www.londonsexrelationshiptherapy.com/training

For therapists looking for an accessible overview of the main gender and sexual identities and practices: Richards C and Barker M (2013). *Sexuality and gender for mental health professionals: a practical guide*. London: Sage.

References

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King M, Semylen J, Killaspy H, Nazareth I and Osborn D (2007). *A systematic review of the research on counselling and psychotherapy for lesbian, gay, bisexual & transgender people*. Leicester: BACP.

Moon L (ed) (2008). *Feeling queer or queer feelings*. London: Routledge.

Ritchie A and Barker M (2006). “There aren’t words for what we do or how we feel so we have to make them up”: Constructing polyamorous languages in a culture of compulsory monogamy’. *Sexualities*, 9(5): 584-601.

ⁱ http://www.psychotherapy.org.uk/UKCP_Documents/policy/MoU-conversiontherapy.pdf

ⁱⁱ Thanks to the work of Lori Brotto and others, DSM-5 clearly states that asexual people should not be diagnosed with HSDD.

ⁱⁱⁱ <http://www.pacehealth.org.uk/interact/rare-study/>

^{iv} Cisgender people are those who remain in the gender they were assigned at birth.

Possible pullouts

- What the memorandum left out was conversion therapy as it applies to gender and sexual diversity
- Some encourage clients to ‘pick’ homosexuality or heterosexuality, rather than respecting the person holding a bisexual identity
- Mainstream services generally use the term ‘couple therapy’ rather than ‘relationship therapy’ and are not accessible to people in openly non-monogamous relationships

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- Hypervigilance, shame and resilience
 - There is much that can be learnt from GSD experience that is valuable for all clients