Not in front of the students

Would you send your trainees into the workplace to confront a range of clients about whose issues they know nothing? It’s happening – but is it ethical?

by Dominic Davies

It is my view that British counselling and psychotherapy training institutions are failing to provide an adequate level of training to their students to prepare them for the challenges of working with sexual minority clients. I know of very few exceptions to this generalisation – and feedback from participants in my seminar at the recent BACP Annual Conference confirmed that most courses are still not preparing students for this area of work. Counselling and psychotherapy courses seem to be falling behind the progress made in clinical psychology training programmes, where it would appear many courses are now including sexual minority therapy issues.

This article is based on my 25 years of training other counsellors to work with sexual minority clients. Currently, I direct an extensive training programme and have recently developed a two-year specialist training programme in clinical studies of sexual minority therapy, with the help of my associates – the first post-qualifying training of its kind in the world.

I shall use sexual minorities as a generic term for a wide range of variant sexual and gender identities, including people who identify as lesbian, gay, bisexual, trans (*sexual, *gender and *realign), intersex, queer, questioning, members of the ‘kink’ community, and those in non-dyadic relationships. This list is not exhaustive or exclusive. Whilst many of these groups are very different from each other, they share several commonalities in how their way of being in the world is pathologised due to heterosexist, erotophobic and binary thinking about sex and gender.

My position on the importance of specific training to work with sexual minority clients goes against previously held liberal ideas about equality and diversity which claim that treating everyone the same is equal to treating everyone equally. I believe that sexual minorities are ‘different, therefore equal’ and that teaching about sexual minority therapy is as important as teaching about child development or psychopathology. The attitude of, ‘I’ve got a friend who’s gay,’ is not actually a good enough prerequisite to ensure one is going to be able to offer competent therapy to sexual minority clients. Neither, as it happens, is being a member of a sexual minority. There is a whole cultural history and experience and a different psychology to learn about – and, as we can see from the diverse groups of people who make up sexual minorities, there are many different groups to learn about. Knowledge of one group, say lesbians, does not mean you will be competent or familiar working with, for example, a male to female transsexual.

Sexual minorities have specific mental health issues

There is now extensive
research on the mental health of lesbian, gay and bisexual people who, incidentally, are higher consumers of therapy. The other groups I mentioned above have had very little research attention, but we know from clinical experience that they share some similar experiences and concerns with lesbian, gay and bisexual people (LGBs). In particular, these include aspects connected to living with a stigmatised identity and its impact on self-esteem.

We know, for example, that there are higher levels of drug and alcohol use amongst this population. Lesbians tend to drink more than heterosexual and bisexual men and women and gay men. Many gay men go on taking recreational drugs, as they continue clubbing much longer than their heterosexual peers.

Suicidal ideation and behaviour often extends into adulthood as a result of homophobic bullying during school with a stigmatised and gay youth are between three and seven times more likely to consider or attempt suicide compared to their heterosexual peers.

Depression is higher amongst LGBs, and where SSRI medication is the first treatment of choice for GPs, there are often troubling side effects which can affect treatment compliance, especially amongst gay men (who may experience erectile dysfunction, and difficulty reaching orgasm, which in turn may contribute to low self-esteem and social isolation).

Studies have also found higher levels of childhood sexual abuse amongst lesbians and gay men. In part, this may be due to their isolation from peers, making them easy targets for grooming, as well as heteropatriarchal violence. In one study, male sexual abuse survivors defined as homosexual almost seven times (and as bisexual almost six times) more often than non-abused peers.

Around a third of lesbians and gay men report workplace harassment, and 40 per cent report verbal abuse in going about their daily lives. Despite recent legal advances in civil rights and equalities legislation, homophobic hate crime and violence have increased. The Government reported 1,000 incidents of homophobic hate crime in London in 2005, but even they estimate that 80 per cent of all hate crime goes unreported.

This may lend some to question why sexual minorities have poorer mental health. Is it intrinsic, or a response to living in a society which, to borrow Lady Caroline Lamb’s comment on Lord Byron, treats you as ‘mad, bad and dangerous to know’?

PACE is the leading voluntary sector mental health organisation supporting LGBs. In Diagnosis: Homophobic – their report on their Department of Health commissioned research into the treatment of lesbian and gay people in mental health organisations – they conclude:

‘Lesbians and gay men are not inherently any more prone to mental or emotional distress than anyone else. However, they do face many forms of mistreatment and discrimination. Many find the support and inner resources they need to allow them to deal with this, and are enabled to function well and live fulfilling lives. But some find the effects of the prejudice more problematic, and may need more intensive therapeutic input.’

‘Some of the problems stem directly from external mistreatment. This may take the form of rejection by family or community, harassment, abuse or assault, loss of job or housing. Other problems arise as a consequence of the internalising of negative messages: lack self-esteem, drug and alcohol abuse, self-harm, depression, difficulty with intimacy, neurosis, suicide (rates of suicide attempts continue to be very high among young lesbians and gay men). Some people find it difficult to come to terms with their sexuality, or are confused about their sexual identity. Some may be forced, or may choose, not to disclose their sexuality either at all or only under certain circumstances, and may thus suffer the stresses and psychological damage of such a “split” existence.’

Sexual minorities frequently report poor experiences with professional help. For example, also found 58 per cent of her lesbian interviewees described being pathologised by their heterosexual therapists. One said: ‘My therapist told me my femininity was a passing phase.’ Another said: ‘He had compassion for me, in that I was sexually immature and could evolve into a heterosexual.’

With regard to discrimination within mental health organisations, PACE found:

‘Even where respondents did not observe or experience physical or sexual assault, evidence nevertheless showed that homophobic, heterosexist and biphobic attitudes from both service users and staff create environments which can be abusive, invalidating, marginalising and emotionally damaging for lesbian, gay and bisexual service users.’

Given the poor mental health of sexual minorities and their over-representation as consumers of therapy services from poorly trained, pathologising practitioners, one may wonder why therapy training programmes don’t incorporate sexual minority therapy and prepare their students better for the task ahead.

I have identified five blocks to the inclusion of sexual minority therapy into courses: (i) heterosexism (ii) homophobic (iii) guilt by association (iv) competence (v) commitment.

**Heterosexism**

Heterosexual bias permeates most therapy training programmes and the therapy literature. From developmental theories through to the practice of professional help. The example also found 58 per cent of her lesbian interviewees described being pathologised by their heterosexual therapists. One said: ‘My therapist told me my femininity was a passing phase.’ Another said: ‘He had compassion for me, in that I was sexually immature and could evolve into a heterosexual.’

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'The attitude of, "I've got a friend who's gay," is not actually a good enough prerequisite to ensure one is going to be able to offer competent therapy to sexual minority clients. Neither, as it happens, is being a member of a sexual minority.'
these populations. It’s my view that courses have an ethical responsibility to their students to prepare them for working with sexual minority clients.

Furthermore, I believe the Ethical Framework\(^2\) puts this obligation on us too.

**Training content**

Training should include experiential learning, whereby the attitudes, values and self-awareness of the students are explored. Students also need to work on their internalised heterosexism and homophobia. In my experience, where sexual minority issues are included, this experiential component on attitudes is normally the extent of the training.

However, there is also a need to include knowledge about common clinical issues—working with shame and internalised oppression and self-esteem, issues around coming out, relationship issues, to name just a few.

Finally, it is important that the students understand and are familiar with the social contexts of this diverse population including, of course, perspectives on age, race, class, ability and so on.

**A core skill**

What we should be aiming for is helping students to respond to, and work with, hypervigilance; I would maintain that almost all sexual minorities would be hypervigilant to being perceived as ‘mad, bad and dangerous to know’. We need to help students learn about how this hypervigilance permeates the self-structure of the client.

If it is only possible to include one core skill in preparing students to work with sexual minority clients, it should be working with this hypervigilance, which is one of many normal responses to oppression, heterosexism and growing up feeling different. If a therapist can work constructively and creatively with this issue and form sufficient psychological contact\(^2\), they will probably be able to work with whatever other issues follow.

**Conclusion**

Unfortunately, there are too many therapists graduating from too many poorly considered courses offering incompetent therapy to too many sexual minority clients. I would like to extend an open invitation for trainers to feel free to consult on how they might address Sexual Minority Therapy issues in their courses. Whilst some courses are doing something, we really need to improve in this area of training provision.

Therapists need to be aware of what they do know about working with this diverse population and what they don’t know. However, many therapists seem blissfully unaware of what they don’t know and are only too happy to take the client’s money and expect the client to be the one to teach them, giving them free CPD on sexual minority issues. Is this the best we can manage? At Pink Therapy, we strongly believe otherwise.

**Acknowledgements**

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**References**

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