Revision of GAT in PT1?

Previously called *Gay Affirmative Therapy*: problematic as it might be thought to apply only to gay men, also problematic ‘AFFIRMATIVE’ what is being affirmed and by whom?

Criticised by both Du Plock and Ratigan

- Are we affirming the person’s sexuality or their gay behaviours?
- Is it our place as therapist to affirm some behaviours and not others?
- SMT was more neutral - much of it can apply to all (gender and) sexual diversities (incl members of the KINK community, asexualities, )
- GSMT *was* more inclusive but...
GSDT is our current preferred term adopted in Dec 2011.

‘minorities’ was becoming problematic as a term for some people as when considering prevalence figures of a constituencies which comprise non heteronormative hegemony then we find that life long monogamous heterosexuality which is sustained by a regular and fulfilling sex life of only of ‘vanilla’ sexual practices performed by cis–gendered males and females is out numbered by all the other groups we seek to work with: LGBTIQ, Asexualities, BDsM/Kink practices and lifestyler, Swingers and Polyamorous relationships
Key issue

Gender and sexual diversities are hypervigilant to being pathologised (being seen as ‘mad, bad, or dangerous to know’). This can permeate every aspect of their lives and everyone will have internalised this message to some level.

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Everything goes through a filter/translator.
Judy Grahn’s book “Another Mother Tongue” – Think Pink concept (2nd language)

If time permitted I wanted to get you to look at the impact on Lesbians, Bisexuals and Trans people for being perceived as mad, bad and dangerous to know.

Hillin’s work with gay men...
Work with Individual Clients: on self-esteem, internalised oppression and shame, developing assertiveness skills, relationship and dating skills, congruence in occupational role and work/life balance, decisions about parenting, spirituality, drugs & alcohol issues etc.

Within Organisations: therapists could look at in what ways might we need to change counselling organisations to make them relevant and welcoming to GSD clients (assessment documentation, use of anti-oppressive language, availability of GSD counsellors, visible resources (health ed material, advocacy, networking with LGBT organisations etc.

Within social-cultural context: supporting social and legal changes towards equality etc. i.e. access to services for trans (medical and psychological), trans/homophobic bullying at work/school, same sex parenting/adoption issues. Walk for life, or participation in Pride etc.

Therapy issues

- Consider what part sexual orientation or gender identity plays in the client’s clinical issues.
- These issues maybe core for someone in the early stages of coming out.
- For other clients, sexual/gender identity may be relevant by not central.

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Explain the 3D lenses
Assess the clients level of internalised heterosexism gender dysphoria and/or biphobia

Determine the extent to which internalised negative messages & **shame** influence presenting concerns

Facilitate the exploration of the impact of internalised heterosexism, gender dysphoria and/or biphobia on the client’s life.

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Ask client what they like about being GSM’s i.e. what are the positives for them and then ask what’s bad, troubling, less good.

Sex therapy client (38) whose sex life is limited to oral sex and MM and even that has tapered off a lot over the past 6 years and is causing great tension for him with his “attractive younger b/f” (monogamous relationship). Is his dislike of anal sex due to internalised hph? His parents have refused to acknowledge him since he came out 12 years ago and he’s desperate for reconciliation.
**Psychological Contact**

**Pre-contact**
You may be checked out

**Contact**
What first impressions may someone have of you and your space?

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Internet searches, word of mouth recommendations, referrals from ex lovers and friends. Have you googled yourself? Your therapist? ;)

How can you make your space feel welcoming to sexual minority clients?
Positive Images/art
Reading material in waiting room
Your own bookshelves

My chapter on PCA and Psychological contact is on the website.
Recommendations for effective Gender & Sexual Diversity Therapy

In addition to the recommendations in the GAT chapter (Davies) and Perlman...
Primary Skill

- Be able to respond to and work with hypervigilance. Hypervigilance is one of many normal responses to heterosexism and homophobia and growing up feeling different.
- Therapists able to work constructively and creatively with this will probably be able to work with whatever other issues may follow.
- See Davies & Aykroyd: Psychological Contact chapter.
Recommendations

- Be aware of the historical context around homosexuality and gender variance and therapy’s relationship to homosexuality since Freud. See: LGBT History Month: http://www.lgbthistorymonth.org.uk/ And Stonewall Timeline: http://www.stonewall.org.uk/information_bank/history__lesbian__gay/89.asp

- Avoid treating sexual orientation as a ‘phase’ or minimising the importance of minority sexual orientation (esp when working with young people)

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Clients may be hypervigilant to being pathologised, or perved on as some curiosity.
We’ve had our brains washed by long term psychoanalysis, electro shock therapy, neurosurgery. Homosexuality was only declassified as a mental illness by WHO in 1992 17 years ago. Therefore many experienced practitioners were taught to treat it as a mental illness
A psychoeducational approach is necessary as many sexual minority people lack access to accurate information and knowledge of resources. Also they’re time in the closet is time NOT spent in developing some of the social and relationship skills necessary for health adult relationships. When most straight 16–20 year olds are dating most LGBT people are not. Sometimes this creates a huge developmental lag which they may have trouble making up for for the rest of their lives.

Guided reading – relationship and dating skills books, guides on improving confidence and self-esteem, workbooks on coming out etc can all help speed up the therapy process and help people gain a greater sense of confidence and self-awareness.

What are the implications of a psycho-education approach for the therapeutic relationship? (transference)
Recommendations

- Don’t treat GSD’s clients as if they are ‘the same’ as heterosexual clients (ignoring unique stressors)
- Carefully explore requests to change sexual orientations. Conversion/reparative therapies have been shown to increase self-hate, psychological distress and suicidal ideation.
Therapy Guidelines

- BPS Guidelines (Feb 2012)
- ACA Competencies produced by AGLBIC http://www.aglbic.org/resources/competencies.html
- WPATH Standards of Care v.7 (Sept 2011) http://wpath.org/publications_standards.cfm