Charles Neal

WELCOMING DIVERSITY IN PRACTICE

Psychotherapy and minority sexualities - Moving together into a New Century

These are exciting times for relations between sexual minorities and the cultures of psychotherapy in the West. Profound structural and attitudinal changes in society are fast moving and offer new possibilities for health. Therapists must take up opportunities to learn and grow if their practices are to become more equitable.

There are many forms of oppression which harm individuals and our whole culture- sexism, heterosexism, homophobia, for example- and these are embedded in our history and forms of thought. While not generated by us, we are responsible for their operation in and around us now. Working to end the oppression and domination of others is lifelong. Individuals, communities and whole cultures can, and do, grow and change for the better. Societies in which each person is respected and valued equally are worth working hard to achieve.

A brief history of the world!

In the 1500s and 1600s 'sexual minorities' were seen as inhabited by demons, in the 1800s we were morbid and deranged, mentally ill, by the 1900s criminal sybaritesand, more recently, genetic oddities. I use the term 'queer' to describe a complex of transgressive positions, first thus labelled in 1508.

In 1601 lesbians were labelled; bisexuals had to wait until 1824. 'Gay' generally meant 'prostitute' in the 19th century and, most modern of all, is 'homosexual' (1869).
The sexually different have been scapegoated with all kinds of evil and disease over the centuries. When queers and faeries were witches, the taboos against queer sex, or erotic sex. were deep rooted. Worst of all was any sex which could not result in pregnancy! Female enjoyment of sex was believed to challenge nature. Millions of women unable or unwilling to conform to societal demands about how they should live and love were burned as witches over 4oo years!

The invention of homosexuality in 1869 to separate certain people from others is located in the midst of urbanisation and the rise of industrial capitalism when sexual relations and the family were radically restructured. It's interesting to note that it was at more or less the same time that 'housewife', 'childhood' and 'prostitute' were invented. It is also when psychology was invented, with its gradual pretensions to science. Capitalism overtly extols individualism yet is truly about reproduction, multiples of the same, categories. Too much of psychology came to be about these things, too.

For me, psychotherapy is a queer activity - or should be. At the outset it was highly transgressive, perhaps especially in relation to sex and gender. Freud's 'Three Essays on Sexuality' in 1905 was a groundbreaking attempt to distinguish sexuality from gender and his 'Letter to an American Mother' a radical view of same sex love. By 1913, however, in trying to make psychoanalysis acceptable as science, he created Oedipal crises and a goal for sexual development and returned to 'better' and 'right'.

After the second world war, the employment of psychologists and therapists by the military and the state in the US and UK in the era of McCarthy, led practitioners further away from the original radical project as they struggled to survive in a rigid and conservative climate of fearfulness.

Homosexuality was finally declassified as a mental illness by the World Health Organisation as recently as 1993. This means that most experienced therapists -those in practice for more than a decade - have been trained to see same-sex attraction as pathological, or at least as of less value or less healthy than heterosexual love.

This urgently needs to change. At a Royal Society of Medicine conference on Lesbian and Gay Health issues (June, 2005) it was reported that 80% of young people attending one delegate's lesbian and gay youth group were taking Prozac, many having done so for several years.

In 2003, Professor Michael King and colleagues, in a special report for MIND, found that lesbians, gay men and bisexuals were more likely to have consulted mental health services and experienced higher levels of depression and substance misuse than heterosexuals.

'Analysis' has Greek roots, meaning to open up. How do we go about opening up matters of sex and sexualities within psychology and psychotherapy? I have discovered at least **two major hurdles** - both to do with our ways of seeing.

The first hurdle-the context in which we grow

We tend to ignore the significance of the body and of sociocultural contexts

or locations in which the psyche grows. Let us no longer pretend that sex and sexualities are distinguishable from the history of our bodies, our personalities or our psyches, or separate from the sociocultural locations through which we travel. Biology, psychology **and** sociocultural contexts are as important as one another. We need to hold all three, yet usually one, at least, is excluded.

Queerness has flourished in all times and places, it has survived persecution and denial, qualified approval and hatred. What have varied hugely have been the meanings given it by others and by queer people themselves.

This is not a minor facet of social history. Cultural responses to 'queerness' are crucial indicators of wider notions of sex and gender, role, family, power and identity. Sexuality has been subject to cultural mouldings to a greater extent than most other forms of behaviour. Because sexuality is considered a critical basis for identity in modern Western cultures, most people feel a need to adopt a particular sexual identity as soon as possible,. The reason this is given such importance is as a vehicle for enacting socially determined roles. In other words, we are required to **perform** sexualities just as we perform genders.

All identities are fictions, including gender identities. Our belief in them makes us feel real. Whether we feel we are 'male' or 'female' depends on our psychic reality and how it relates to our sociocultural contexts. There is no difference between a gender and a transgender - both are equally real and equally fictitious.Genders and sexualities are, in fact, actions- incessant and repeated becomings.

Psychotherapy has generated lots of stories, mostly attempting to complete (define, control) desire, which is by its very nature incomplete! For example, Developmental psychology's 'stages of development' towards ideal goals (or 'maturities') or Ego psychology's 'fully nurtured ego', the Humanist's notions of self-actualisation or the Psychoanalytic myth of the cure, or 'full analysis." Let us also stop pretending that human development is linear towards a finished state. These repeated psychological completion stories limit and imprison our experience and perception.

Another favourite psychological narrative is the aetiology, or origin, story. One obvious negative way these can impact on therapy are when the therapist's theory of 'causes' distracts them from genuine listening to the client's experience. Another, positive, way is when the client's overt and subliminal theories provide rich material for making sense of cultural forces which have shaped and defined their own identity. It is invaluable for me to ask clients how they talk with themselves about their gender and sexuality and the origins of these, not because I have the slightest interest in causes (or cures) but because it illuminates what underlying scripts the person has been recruited into holding, originating from the contexts in which they have experienced their own body growing and desiring.

I'm really interested in sharing infinity stories: ones which acknowledge limitless possibility; ones which hold ambivalence and difference. I want to think about gender and sexuality as pulsatory, unending, opening processes. I know this is a less comfortable and comforting approach. It requires considerable discipline to open up to, and rest in, contingency and unknowing, incompleteness. Re-examining gender, for example, can be deeply disturbing of the certainties with which we console ourselves - we can feel dizzy on unfamiliar ground.
There is no doubt that we gain confidence from categorisation. On the other hand, there is excitement and challenge to be had in surrendering ourselves to the impact of the other, being prepared to listen to those on another side, in a different place. This, for me, is the best therapeutic position. I believe this is what distinguishes an enabling therapy. When we look at things without judgement we are stunned by the magical complexity and multifacetedness of what is natural, what grows. This should include sexuality.

The second hurdle-who makes meaning

The second hurdle concerns who is in charge of making meanings. In a Western world view there is a 'right' and a 'best' and the one who is right and best gets to define the others. The one who is right and best, for instance, labels the majority of the world 'Third' or 'Developing' and those who perform sex roles incorrectly as 'deviant', 'neurotics' with 'arrested development'. When we accept these definitions, we collude in oppression.

I am especially interested in how we use words. My original training was in psycho-, and socio-, linguistics. We often use them crudely and confuse nouns and adjectives. The words male, female, homosexual, heterosexual are adjectives. They do not name discreet things. We are not things. Like other living organisms we are in a constant state of pulsatory flux, a constant state of growth and change. So are our social groups and the meanings we generate.

Yet our languaging shows how keen we have become on adversarial notions of opposites - able and disabled, feminine and masculine, sane and insane - yet these are not opposites at all. Our true, intrapersonal, experience of living and growing ourselves belies this opposition.

We like to imagine that you cannot be both at once, if we are not one we must be the other. And of course, one is right, the better one to be. You can't be something altogether different and you can't be neither. If you are not male or female, what are you? What should be done about you? What should be done **to** you? Categories lead to hierarchies. Male and female and heterosexual have become, without doubt, the gold standards.

Paradoxes trouble us, yet we experience them all the time. We call this ambivalence or conflict and think therapists can help us sort it out. Difference can be threatening to the whole and, therefore, often split off, dissociated, projected. Women, since Anna Freud, have been unhappy with dominant descriptions of their experiences and the last great overhaul of thinking and practice in psychology and therapy resulted from Feminist critiques of thirty and forty years ago. One group was privileged and put in charge of meanings, however.

So it came to be that 'queerness' resulted from **nurture**: an overprotective, or over demanding parent; a too close binding, or too distant parent; too positive or else too negative an experience of

sex with one gender or another. Or else it originated in **nature**: too little, or too much oestrogen, testosterone, androgen; an extra, or a missing gene; a too large, or a too small, hypothalamus. Oh dear, we are tired of this search for causes whose secret agenda is a search for cures!

In my view, therapists are wordsmiths: we are in the business of meaning making. At its best therapy assists clients in creating their own meanings and developing new vocabularies with which to think and talk about themselves in the world, so as to become meaning makers.

Beyond the hurdles

So what about 21st century psychotherapy?

Are we therapists interested in improving the service we provide to our sexual minority clients - and to **all** clients, as matters of sexuality and gender, identity and meaning affect us all equally?
Andrew Samuels said, at the 2004 Pink Therapy 'Queer Analysis' conference, that therapists not interested in learning more about debates in queer therapy were "crap therapists" as they were missing out on the next wave of radical thinking and practice. Queer therapy stands today where feminist critiques did in the 70s and 80s in relation to these professions. We are challenging existing hierarchical thinking, the role of analytic neutrality, the uses of counter transference and self exposure, issues about the developmental influences of nature and nurture and so on.

Sixty years since Kinsey, forty since Evelyn Hooker, we are still wedded to the idea of types of people: aetiology stories. Few counselling and psychotherapy trainings actually provide much education in sexual minority psychology and therapy issues (or in sex!) beyond helping students explore their attitudes to gay and lesbian people. Bisexual and transgender people rarely get a look in. When 'gay issues' are taught, it is usually by one of the students rather than an experienced therapist – the implication being that personal experience is sufficient qualification.

The treatment of queer people in therapy today parallels the disempowering messages 'therapy-as-usual' previously sent to women. We are often ignored, some therapists believing that avoiding fear and loathing is enough, or that liberal notions of 'acceptance' will suffice. Therapists' failure to take account of the real meanings of fear, discrimination and violence in clients lives contributes to misdiagnosis and further trauma. There is little discussion of queer issues at most conferences and in most trainings. Many practitioners still believe that queerness is less than normal or less preferable and some believe minority sexuality results from family dysfunction.

In 2005 Cordelia Galgut's research into lesbians' experiences of therapy showed that 83% of respondents felt it was important that their therapist disclosed their sexuality. Just over half (54%) of lesbian respondents found their heterosexual therapist helpful, but 96% reported a lack of understanding of lesbian lifestyle and culture.

The first volume of the 'Pink Therapy' trilogy, published a decade ago (1996, McGraw Hill), shows there is plenty to learn about minority sexualities and psychology. Subsequent books in the series began to fill an urgent lack of European theoretical and training materials (Vols 2 & 3, 2000, McGraw Hill). It is lamentable, however, that this work remains accompanied by so little else focussing professionally on these issues in Britain.

Pink Therapy Associates in London, the largest provider of specialist therapy services for sexual minorities and of training and consultancy in the field for professionals, are addressing this continuing need with a programme of workshops and two-year professional training in sexual minority therapy. (See www.pinktherapy.com for full details)

Take up of such trainings by professionals who are not themselves members of minority sexualities has been slow in the past. We are optimistic that this will now improve.

Valuing difference

There has been much advancement in the position of sexual minority people in recent years and further gains are imminent. Spain and Canada have just voted to allow same sex marriages and the UK has introduced a **Civil Partnership Act (2004)** which, in December 2005, will see the first same sex couples being able to register their partnerships and have equal rights with married heterosexuals in matters of finance, property, inheritance, medical care, pensions and so on.

The long overdue recognition of transgender people through amendment of their birth certificates to reflect their acquired gender has been made possible by the **Gender Recognition Act (2004)**, and Gender Recognition Certificates are beginning to be received by transsexuals.

The **Adoption and Children Act (2002)** made provision for same sex couples wishing to adopt to do so. Regulations have been drawn up to support this and later this year we will see more equitable parenting procedures for increasing numbers of sexual minority families.

All therapists need now to be willing to recognise their sexual minority clients as 'different but equal' to their heterosexual peers. To do this effectively they need to have worked on their attitudes to the different groups which comprise the sexual minority rainbow, to increase their understanding of the social contexts and lived experiences of what it means to belong to sexual minorities today and to be open and willing to continually investigate sex and sexuality within themselves. There is now provision for all these opportunities and I hope readers will feel inspired to take some of them up.

CHARLES NEAL is a UKCP accredited Humanistic therapist in private practice in East Sussex and at Spectrum in London. He is a Clinical Associate with Pink Therapy, London and Coast in the South East.
He directs Transform Consultancy and is a supervisor, trainer and consultant. Co-editor of the 'Pink Therapy' trilogy with Dominic Davies, he founded the former Association for Lesbian, Gay & Bisexual Psychologies. Charles runs long term groups for gay men and on creativity, and has been a gay father for 33 years.

Contact: 01424 719123
CharlesNeal@pinktherapy.com