



The
British
Psychological
Society

Professional Practice Board

Guidelines and Literature Review for Psychologists Working Therapeutically with Sexual and Gender Minority Clients

February 2012

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A web-only document, published by the British Psychological Society.

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Acknowledgements

While chairing the Faculty of HIV and Sexual Health of the Division of Clinical Psychology (DCP) I had the privilege of being in a position to raise the profile of issues around sex and sexuality within the DCP. I was helped by a hardworking and dedicated committee. This has included: Catherine Butler, Sylvia Kapp, Sarah Zetler, Stuart Gibson, Barbara Hedge, Mime Matthews, Amanda O'Donovan, Claire Mariott, and Claire Stevenson. The work took the form of writing good practice guidelines for training and consolidation of clinical psychology practice in HIV and sexual health, including a curriculum around sexuality awareness training; sexuality awareness CPD workshops; a survey of clinical psychology training courses provision in the area of sex and sexuality; a conference; and the editing of a teaching manual for self-reflection around issues of sexuality (Butler et al., 2009). These guidelines were also part of the vision to facilitate thoughtful, best practice in the controversial area of minority sexuality and gender.

Following discussion with Richard Toogood of the Professional Governance Panel of the DCP, the Faculty was asked to work with the Psychology of Sexualities Section in reviewing the status of the seminal APA 2000 *Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients*. A meeting was held with representatives from the Faculty and Section. From this meeting it was recommended that the guidance would be timely; that the US guidance could be updated for the UK, filling in gaps, broadening the scope to other aspects of sexuality and gender; and that in order to make the guidance useful to all psychologists in clinical practice a Working Party with representatives from relevant Sections and Divisions would need to be formed.

A proposal for the Working Party was put to Nigel Atter from the Professional Practice Board of the British Psychological Society. He has guided and encouraged the process ever since. On its acceptance in April 2007 the core Working Party was formed with further representation invited from the Division of Counselling Psychology, Psychologists Specialising in Psychotherapy, Psychologists working in the Charing Cross Gender Reassignment Clinic, Educational Psychologists and Forensic Psychologists. I thank these individuals for their drive, lively discussion and belief in the guidance: Meg Barker, Darren Langdrige, Catherine Butler, Stuart Gibson, Penny Lenihan, Roshan das Nair, and Christina Richards. Other contributors to the writing have included Peter Hegarty, Allan Tyler, Damian McCann, LihMai Laoi, Sarah Davidson, Polly Carmichael, Jeremy Monsen, and Neil Rees.

In order to develop a structure and contents of the document experts outside the profession were consulted, as well as consulting Sections and Divisions at different stages. Their comments and direction were greatly valued. Special thanks around this to: Dominic Davies, Jan Burns; Martin Milton; Alex Iantaffi; Matthew Waite; Jim McManus; Clinton Anderson; Kathleen Ritter; Ron Fox; Jinthana Haritaworn; Bobbie Petford; James Gray; Damien Riggs; Adam Bourne; Christine Burns; Melanie Steffens; Jan Schippers; Jane Stavert; Doug Ritchie-O'Dell; and Steven Whittle. Thanks are also given to all the Sections and Divisions that helped with their encouragement and with the consultation process.

For their assistance in supporting the process of developing the guidelines I thank the Chairs of the relevant Sections and Faculties including: Lindsey Moon, Peter Martin, Jenny Taylor, Peter Kinderman and John Hannah.

Finally many thanks to the BPS Ethics Committee, Martin Crawshaw for his work editing in the final phases of the document, the Professional Practice Board and the Preparation for Print (P4P) team who work tirelessly behind the scenes and who made it possible to produce the document on the web and publicise it.

Liz Shaw (Chair of the Working Party)

Introduction

Purpose and status of the document

These guidelines have been developed in recognition of the importance of guiding and supporting applied psychologists around their work with sexual and gender minority clients in order to enable their inclusion in clinical practice at a high standard. They also aspire to engender better understanding of clients who may have suffered social exclusion and stigmatisation in order to reduce the possibility of this in the clinical arena.

The guidelines reflect where psychologists and society in the UK have reached in terms of legislation and advances in insight into the clinical issues faced by sexual and gender minority clients. This includes: new core training standards for sexual orientation training developed by the Department of Health (DOH, 2006) for the NHS making it an essential part of diversity training for staff as a part of the knowledge and skills framework; the Public Health White Paper 'Choosing Health' (DOH, 2004) and the Sexual Health Strategy recommendations (DOH, 2001) identify training and workforce capacity issues as integral to the sexual health agenda; guidance for GPs, other clinicians and health professionals on the care of gender variant people (DOH, 2008) and guidance on clear sexual boundaries between health care professionals and patients: responsibilities of health care professionals in order to safeguard patients (CHRE, 2008). The Government at the time of writing has also taken steps to ensure greater equality for Lesbian, Gay, Bisexual and Transgender People in terms of legislation (Government Equalities Office, 2010)

Acknowledgement is also given to the ground-breaking American Psychological Association (APA) Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients published in 1991, which provided the foundation upon which these guidelines are built. The APA document was written following the American Psychiatric Association's 1973 decision to remove homosexuality from its list of mental disorders and later evidence that suggested the implications of the resolution had not been fully implemented in practice. This document extends the APA guidance to include current fringes of common understanding in the area of gender and minority sexuality, which may be challenging to practitioners, in order to provide Psychologists information, knowledge and skills which are affirmative and growth oriented for both clients and practitioners. The APA has recently issued further guidance on: 'Appropriate Therapeutic Responses to Sexual Orientation' (APA, 2009) and the Australian Psychological Society has issued 'Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients' (APS, 2010) which can complement aspects of the guidance.

How to use the document

The document is set out as a series of guidelines statements that are linked to a more detailed evidence-based document with references for personal instruction and reflection by practitioners who wish to use it. They complement the Division of Clinical Psychology's Professional Practice Guidelines (BPS, 1995). The statements have overarching themes so they are not bound to any one model of therapy and represent general affirmative good practice. Detailed guidance on how to undertake therapy is referenced. Central to this is a critical constructivist approach that assumes that beliefs around sexuality and gender

evolve over time and that practitioners need to reflect on their own beliefs and assumptions on these issues in order to work ethically and effectively in this field. The document is comprehensive but not exhaustive. It also does not state positions on medical aspects of treatments but highlights issues that may be encountered related to these.

The authors are psychologists from different sections of the Society working with clients who have sexual and gender minority issues, led mainly by the Faculty of Sexual Health and HIV and The Psychology of Sexualities Section (previously known as the Lesbian and Gay Psychology Section). The inclusion of certain topics and the contents, although broad but not definitive, has been widely consulted upon by experts within the Society and outside the organisation (including relevant international organisations), and mirrors knowledge and frontiers of awareness at the time of writing. This document consists of four parts:

Part I describes the ethical requirements of the Health Professions Council on the need for appropriate sexual boundaries between health care professionals and their patients,

Part II consists of the guideline statements;

Part III, an extended text (which covers some of the latest literature and thinking in the field); and

Part IV, References and Appendix. The areas covered include: psychology and sexual and gender minority clients; the socio-political context and attitudes towards sexual and gender minorities; key issues in sexual and gender minority work (sexual and gender identities and practices; relationships and families and diversity); children, young people, schools and families; and education/training and professional development.

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- DOH (2008). *Guidance for GPs, other clinicians and health professionals on the care of gender variant people*.
- CHRE (2008). *Clear sexual boundaries between health care professionals and patients: Responsibilities of health care professionals*.
- Government Equalities Office (2010). *Factsheet: Lesbian, Gay, Bisexual and Transgender Equality*.

Part I: Ethical Standards and Responsibilities for Practitioner Psychologists

The British Psychological Society advises that these guidelines are set within a context of the requirements of the Health Professions Council's Standards of Conduct, Performance and Ethics (HPC, 2008).

These responsibilities are described in more detail in a report prepared for the regulators of health care professionals by the Council for Healthcare Regulatory Excellence entitled, 'Clear sexual boundaries between health care professionals and patients: Responsibilities of health care professionals' (CHRE, 2008).

It contains information about:

- The importance of clear sexual boundaries between health care professionals and their patients;
- The establishment and maintenance of clear sexual boundaries with patients;
- The action that health care professionals must take if they are informed about of, or have concerns about, a breach of sexual boundaries.

A summary of the advice notes that, health care professionals must not display sexualised behaviour towards patients or their carers, because doing so can cause significant and enduring harm. The health care professional/patient relationship depends on confidence and trust. A health care professional who displays sexualised behaviour towards a patient breaches that trust, acts unprofessionally, and may, additionally, be committing a criminal act.

The report also provides a definition of sexualised behaviour, which is described as, 'acts, words or behaviour designed or intended to arouse or gratify sexual impulses or desires'. An illustrative list of unacceptable 'sexualised behaviours' are listed in Appendix B of the report. Breaches of sexual boundaries include criminal acts such as rape and assault but cover a spectrum of behaviours including requesting details of sexual orientation, history or preferences that are not necessary or relevant and telling patients about the clinicians 'own sexual problems, preferences or fantasies or disclosing other intimate personal details'.

Practitioners are required to meet these standards.

References

- CHRE (2008). *Clear sexual boundaries between health care professionals and patients: Responsibilities of health care professionals*. London: Council for Healthcare Regulatory Excellence.
- HPC (2008). *Standards of Conduct, Performance and Ethics*. London: Health Professions Council.

Part II: Guideline Statements

1 Psychology and sexual and gender minority clients

1.1 Psychologists are encouraged to remember that sexual and gender minority identities and practices are not in themselves indicative of a mental disorder.

Since 1973, when the American Psychiatric Association removed homosexuality from its list of mental disorders, it has been recognised that same-sex attraction is a normal variant of human sexuality. Similarly there are diverse forms of gender identity none of which is specifically related to psychopathology. Consistently found, however, is that stigmatising, stressful experiences for sexual and gender minority individuals, resulting from prejudice, can lead to increased risk of emotional problems, suicide attempts, and substance abuse.

2 The socio-political context and attitudes towards sexual and gender minorities

2.1 Psychologists are encouraged to recognise that attitudes towards sexuality and gender are located in a changing socio-political context, and to reflect on their own understanding of these concepts.

Social attitudes and therapeutic approaches to sexual and gender minorities have evolved over time in the UK to become more accepting and affirmative rather than pathologising. To be able to undertake practice with such clients, psychologists are encouraged to reflect on how the process and history of social stigmatisation may affect both their clients and themselves. For some individuals, societal negative attitudes may be internalised, such that they experience loathing and shame of their sexual or gender minority identities. Psychologists are also encouraged to recognise how their own attitudes, assumptions and knowledge may be relevant to assessment and treatment of these minority clients.

2.2 Psychologists are encouraged to reflect on the limits to their practice when working with sexual and gender minority clients and to consider appropriate referral and training when indicated.

A psychologist unfamiliar with, or having insufficient training in, working with sexual and gender minorities can use their continuous professional development to overcome and/or recognise the limitations they may have in helping their clients and to refer on to more appropriate practitioners or agencies. Personal opinion may not be founded on psychological literature and good practice; this can be acknowledged and explored in supervision.

2.3 Psychologists are encouraged to understand the ways in which social stigmatisation (e.g. prejudice, discrimination and violence) pose risks to gender and sexual minority clients.

Psychologists are encouraged to integrate an affirmative stance to their models of practice when working with sexual and gender minority clients. Central to this transtheoretical stance is an understanding of the adverse effects of social stigmatisation on clients' identities and the distress caused to individuals who are seen as different. Interventions may need to

acknowledge this explicitly. Psychologists are advised also to pay attention to their own language which could inadvertently be prejudiced, heterosexist or gender-biased.

2.4 Psychologists are encouraged to consider engagement with the wider socio-political context regarding sexual and gender minorities in order to reduce social stigma.

Psychologists may consider working on an institutional level, such as by informing policy, supporting community groups, and in social action. Psychologists can be proactive in effecting change, which ultimately will lead to improvement of quality of life and the psychological well being of these minorities. Psychologists should be aware of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) support systems within their workplace or locally, as they may be a valuable source of information.

3 Key issues in sexual and gender minority work

Sexual and Gender Identities and Practices

3.1 Psychologists are encouraged to be knowledgeable of the diversity of sexual and gender minority identities and practices.

There are many sources of information on sexual and gender minorities and psychologists can strive to be aware of those beyond the standard academic/medical literature as it can still be pathologising.

They are advised to provide the space for clients to explore possible identities rather than assuming a particular endpoint. They are advised to be aware that ‘bisexual’ and ‘queer’ are possible identities for some that have same-sex attraction, as these are often less visible and more discriminated against. Some sexual identities and practices do not refer to the gender that people are attracted to, for example asexuality, celibacy, and BDSM (bondage and discipline, dominance and submission, and sadomasochism), and people may adopt more than one identity or practice.

Gender identities intersect with sexual identities in that a transgender person may be lesbian, heterosexual, bisexual, gay, queer, etc. Psychologists should be aware of the diversity of gender identities under the umbrella of ‘transgender’, not all of which involve any kind of medical intervention.

3.2 Psychologists are encouraged to use the preferred language of sexual and gender minority individuals.

Clients may use many different terms to refer to their sexual identities and practices and psychologists are advised to use those that are used by clients themselves. Some people do not use the standard LGBTQ labels but may be comfortable with, say, MSM (men who have sex with men), WSW (women who have sex with women), culturally specific terms, or ‘reclaimed’ terms like ‘dyke’ or ‘slut’.

A client’s preferred name and pronoun should be used in person and, where possible, in documentation. These may be gendered (he/she) or gender-neutral (they). Similarly psychologists are encouraged to use the client’s preferred term for their relationship and to understand how they define it.

3.3 Psychologists are encouraged to understand the unique and particular circumstances and challenges facing clients with diverse gender and sexual identities and practices.

When working with clients with specific sexual or gender identities, it is helpful for Psychologists to be informed about key issues relevant to that group, for example, assumptions of promiscuity amongst gay men, double discrimination experienced by many bisexuals (from both heterosexual and lesbian and gay communities), or transgender people feeling pressure to pass as a member of their preferred gender. Psychologists are advised to be careful not to perpetuate such assumptions or pressures.

Relationships and Families

3.4 Psychologists are encouraged to understand the diversity of forms of relationships and families in gender and sexual minority clients.

Like heterosexuals, many LGBTQ people are in long term-monogamous, or serially monogamous, relationships, but significant numbers are involved in openly non-monogamous relationships. These may take the form of casual relationships, open coupled relationships, or polyamorous (multiple partner) relationships. Some formalise their relationships with civil partnerships or other forms of ceremony. Although 'marriage' is not legal in the UK between same-sex partners, some regard, and refer to, their partnership as a marriage. Psychologists should check with clients what terms they prefer to be used.

Like any client, a sexual and gender minority client may or may not have children, or be planning to have children in the future. They might be, or consider being, a single parent, or be in a 'nuclear' family, or an extended family where more than two adults are involved such as co-parents or step-parents, or people brought in to enable a pregnancy to occur in same-sex relationships, adoptive children, etc. Psychologists are encouraged to be aware of different ways of having children, such as people having children in opposite-sex relationships prior to forming same-sex relationships, sperm donation, gay male couples parenting with a female friend, or adoption.

People in these minorities may refer to their networks of friends, partners and/or ex partners as family as well as, or instead of, their family of origin.

3.5 Psychologists are encouraged to be aware of the potential challenges facing sexual and gender minority clients in their relationships and families.

It is helpful to be aware of the diversity of relationships which may be important for sexual and gender minority clients. They could include sexual relationships that are not ongoing or intimate, or intimate but not sexual, as well as friendships (sexual or non-sexual) and family relationships.

Relationship problems, including domestic violence and abuse, may be an issue for these minority clients as much as for any other client. However, issues can sometimes be hidden, for example in a same-sex couple if there is an assumption that power imbalances and violence only occur in opposite-sex couples, or where a transgender client feels unable to complain about a partner who has been accepting of their transition.

Whilst many relationship and family issues will be very similar to those of other kinds of client, there may be particular issues where one member has a change in sexual identity or goes through a gender transition, or where there is a disparity, for example, where only one partner is asexual, non-monogamous or BDSM.

Diversity

3.6 Psychologists are encouraged to be mindful of the intersections between sexual and gender minority and sociocultural/economic status.

Sexual and gender minority clients may be adversely affected by the additive, negative effects of having other minority status(es). Being from an ethnic minority, and/or being a migrant or refugee or asylum seeker may contribute to the challenges of being from a sexual/gender minority. Some ethnic, cultural and religious communities may not be accepting of an individual's sexual preferences or gender identity, and mainstream LGBTQ spaces may not always be welcoming, leading to alienation. Such instances have the potential to stigmatise, and minority individuals may be eroticised or shunned.

Similarly, the socio-economic status of individuals may limit access to LGBTQ spaces and services. Psychologists should also consider the impact of age on individuals' experiences. Issues related to coming out, parenting, and old age are particularly difficult, given the constraints in negotiating these life stages.

3.7 Psychologists are encouraged to recognise the particular challenges experienced by gender and sexual minorities with physical and/or mental health difficulties.

Sexual and gender minority clients who have a physical and/or mental health problem, or those living with limitations (disabilities) may experience multiple forms of oppression. Some sexual and gender minority communities emphasise the importance of physical appearance, and they (and the spaces they occupy) may be experienced as exclusive. High rates of mental health concerns, particularly depression, anxiety, substance misuse, and eating disorders have been reported in lesbian, gay, and particularly bisexual and transgender populations. The rates of deliberate self-harm and attempted and completed suicide are also higher in these populations. The high rates of these problems are related to negative attitudes in society, and sometimes from prejudice and discrimination in health care and social services.

STIs (including HIV) are prevalent in some, but not all, sexual minority communities. Lesbian, trans and bisexual women's health tend to be sidelined. Practitioners are encouraged to be aware of the sensitivities inherent in discussing conventionally gendered body parts and differing body morphologies of transgender people. These health concerns and associated problems of access to non-prejudicial, affirmative health care may prove to be particularly stressful for sexual and gender minority individuals.

4 Children, young people, schools and families

4.1 Psychologists are encouraged to recognise the diversity of developmental pathways for sexual and gender minority children and adults.

Young LGBQ people often describe feeling ‘different’ from a very early age but may be unable to identify and label it immediately. There are many developmental pathways for sexual minorities. For example, people may embrace an LGBQ identity and engage in same-sex sexual behaviour from an early age. Others may not explore the possibility of same-sex attraction until their 20s or later, some after having explored opposite-sex relationships. It is also possible for people to live with two identities; one of which is public and heterosexual and the other is private and includes same-sex activity. For many, sexual identity formation creates a phase of confusion with possible isolation and distress followed by exploration to the point of integration and acceptance with healthy functioning and life satisfaction. Psychologists should be particularly careful not to assume that bisexuality is ‘just a phase’ as, for many, it is a stable and lasting identity. Others may prefer to avoid identity labels entirely and/or see their sexuality as fluid or on a continuum.

In common with sexual identity, transgender identity development may occur at different times in life, with some being aware from an early age but for others, later. For transgender people and those with diverse sex development, adolescence, with the body changes that occur during this period, may be a key time. Transgender clients may experience a ‘second adolescence’ around transition, and the labels used for sexual identity may change.

4.2 Psychologists are encouraged to recognise the needs and issues of young people from gender and sexual minorities, and their particular vulnerabilities and risks.

The developmental process of ‘coming out’ is not a single event but something that is repeated throughout life as LGBTQ people encounter new situations and circumstances. The first few experiences of coming out (particularly to family) can be amongst the most stressful life events for LGBTQ people, however, for many it becomes easier as they get more experienced, and can even become a non-issue.

Despite positive trends, LGBTQ youth continues to fear rejection, intolerance and even abuse when coming out. This can have a serious and lasting impact on their mental health, leaving them vulnerable to substance misuse, unsafe sex and other risky behaviours. Bullying, teasing and physical violence continue to occur in many UK schools and streets. In the end, LGBTQ youth can be vulnerable to depression, deliberate self-harm, suicide, substance misuse, homelessness, dropping out of school and failing to reach their potential. Psychologists involved with diagnosis should be aware of this since such problems may disappear when the underlying issues associated with being in a minority have been addressed. Transgender youth in particular may be vulnerable to being ostracised due to the social stigma attached to transgressing gender norms. However, we must not forget the number of LGBTQ youth who are strong and resilient, living out their lives with as much happiness and angst as anyone else.

4.3 Psychologists are encouraged to support the self-determination of their clients in the development of their identities and practices.

Young people can develop a vast array of sexual and gender identities and practices. This is something that psychologists should acknowledge and support if they want to help young people to reach their potential. However this may sometimes require psychologists to work with people who are very different from themselves. Sometimes these differences may be difficult for psychologists to understand or even appreciate. Therefore it is their responsibility to inform themselves about these differences so that they can become more comfortable and familiar with them. However some psychologists may not value these differences for various reasons. If this is the case, then they should refer people to other more appropriate practitioners/services, rather than simply discharging them.

5 Education/training and professional development

5.1 Psychologists are encouraged to seek training in sexual and gender minority issues, how to work in an affirmative manner, and be encouraged to reflect on their own beliefs around these issues. Continuous Professional Development is an opportunity for this.

Psychologists are advised to be trained to work affirmatively and self-reflectively with sexual and gender minority clients irrespective of their main therapeutic approaches. Training courses are advised to mainstream issues of gender and sexuality within their regular teaching, in order to avoid mere tokenistic inclusion of gender and sexuality issues.

Psychologists can use CPD to develop self-reflection, skills and knowledge about issues of sexuality and gender, especially if this was not encountered in pre-qualification training. All psychologists can use CPD in this way because there are no areas of psychology where such clients will not be accessing services.

5.2 Psychologists are encouraged to avoid attempting to change gender or sexual minorities on the basis that they can be ‘cured’ or because of stigmatising theory, personal, religious, and/or sociocultural beliefs.

Attempting to change a client’s gender or sexual identities as the goal of treatment because of the therapist’s religious, personal, or political beliefs contravenes international professional guidelines and can be damaging to the client. In the opinion of the authors any Psychologist taking this approach would be adopting unethical and discriminatory professional practice unsupported by the body of professional opinion in the field of sexuality and gender.

Clients may wish to examine aspects of their sexuality and gender identities and explore possible tensions between these and other aspects of their lives. This exploration has a different goal from imposing a cure solely on the basis of their sexual desires, practices, and minority status(es).

Part III: The Literature

1. The sociopolitical context

1.1 The overall context

Psychology, psychiatry, and other helping professions have a long history of pathologising sexual and gender identities that do not conform to traditional heterosexual standards and fixed and binary views of sexuality. However, over the last 50 years there have been significant socio-political shifts towards greater affirmation and acceptance of people with diverse sexualities that is mirrored in legislation and changes in psychotherapy practice. The concepts associated with what makes activities and experiences sexual can be seen as historically, culturally and regionally determined, and are, therefore, parts of a changing discourse involving social and moral judgements (Foucault, 1979).

Sexuality is a bio-psycho-social construct. This means that in order to understand sexuality, we need to consider the biological and psychological makeup of an individual, and their social background. Societal views on sexual and gender minority issues are constantly changing. Affirmative therapists should be aware of the socio-political histories of clients, the society they come from and the society in which they live (see Appendix for a timeline of some of the major events in modern British history that have affected sexual and gender minorities).

The socio-political context has the power to affect both sexual and gender minorities, and the people and institutions they have to deal with in daily life. It can affect the individual's understanding, expressions and acceptance of sexual desires; and access to sexual partners, socialising venues, and goods and services (including health services). The availability of these goods and services are in turn linked to societal permissiveness, civil liberties, and legislation. Lack of support from social systems can have adverse effects on the physical and psychological health of sexual and gender minorities (see Butler, 2004; King et al., 2003). Pathologising or criminalising people solely for being non-heterosexual may force sexual minorities to go underground. This is problematic at many levels, as the needs of such groups are not identified or met, and it has personal and public health implications. Personal health problems can include both poor psychological and physical health, which go undetected due to lack of targeted interventions and/or appropriate affirmative services. Public health concerns may similarly ensue, which may not be curtailed within the sexual minorities' groups, particularly if people are forced to have double lives. Conversely, a social and political climate that affirms minority sexualities provides opportunities to assess needs and provide appropriate services.

Affirmative societal positions on sexual minorities serve as a buffer for such individuals to deal with stress, related or unrelated to sexuality. Socio-political environments that are affirmative also provide agency to individuals, to recognise their rights, assert them, and seek redress when their rights are curtailed or violated. Such an environment can inform legislative and judicial changes that target prejudice and protect individuals; for instance, in provision of goods and services, equal opportunities, etc. This may also promote visibility of sexual minorities in society – creating role models for others. Overall, an affirmative environment provides sexual minorities with formal and informal support systems and networks that they can safely access.

Sexual rights are human rights, and have been enshrined in the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Rights of the Child. These declarations guarantee rights to personal freedom and choice, health, freedom from discrimination, equal access and opportunity, and protection from violence. These also incorporate sexual identities and behaviours. The United Nations High Commissioner for Refugees (UNHCR) recognises that the persecution some sexual minorities experience may make them eligible for refugee status for their ‘membership in a particular social group’ (UNHCR, 2002). The denial of sexual health and rights are at the root of many health-related problems (Butler, 2004).

HIV has played a major role in shaping policy related to sexual health and sexual orientation at a national and international level. Such policies have been essential in providing appropriate services and support for sexual minorities. However, some commentators have also warned that for further development in this area, we must ensure that sexuality is not limited to an HIV ‘policy ghetto’ (Keogh, Dodds & Henderson, 2004). Despite this, health inequities related to minority status(es) (and metamorality statuses) exist in the UK. Such groups also have a predisposition to poor psychological health, inadequate pathways to health care, and negative experiences from accessing such services due to their sexuality (King et al., 2003).

Affirmative psychologists will, therefore, strive to understand the client’s, the society’s, and his/her own understanding of, and attitudes to, sexual minority sexualities. If there is a clash of ideas regarding sexuality on the basis of the psychologist’s own personal, cultural and/or religious sentiments which hampers the therapist from providing a sexuality-minority affirmative environment for the client, he/she should consider other sources of support for the client, including referring to another psychologist (e.g. Davies & Neal, 2000). This approach provides support, and avenues to improve knowledge and skills regarding sexuality, and enhances confidence in working with sexual minority clients (see sections on affirmative therapy, education and models of therapy for overlaps).

Case Study: Jo is a 20-year-old white woman who comes from a rural area. She and her family (who she lives with) are practising Catholics. Jo is torn between her love for her girlfriend and her religious beliefs, which she believes are incongruent. The first person she disclosed this to was the parish priest, who advised her to pray to overcome this problem and referred her to the local counsellor. The counsellor, also from the same parish, was understanding and listened to her but Jo wondered whether she really understood her problem. The focus of therapy seemed to explore why Jo had these feelings, but Jo wanted to know how to deal with them, and how others dealt with similar feelings. The counsellor admitted that she did not know anyone who had same-sex desires.

Comment: Jo's case illustrates the difficulties clients can face when attempting to assimilate two seemingly discrepant aspects of one's life. Her social environment could be alienating if there are no visible support systems or local role-models. Despite the counsellor's best intentions, she would not be able to help Jo in her quest to know how to deal with her feelings if she herself has no contact with, or knowledge of, support systems for sexual minority clients. She would also need to examine her own feelings and attitudes towards same-sex desire if she is to work affirmatively with Jo.

1.2 Phobias, stereotypes, prejudices and 'isms'

1.2.1 Definitions

Social psychologists define prejudice as unwarranted antipathy towards a social group (Allport, 1954; Fiske, 1998) and prejudice against lesbians and gay men and bisexual women and men has been defined as 'homophobia' (Weinberg, 1972), 'heterosexism' (Herek, 1984) and 'sexual prejudice' (Herek, 1999). (The last of these terms will be used here). Social constructionists insist that 'prejudice' is a flexible concept that takes on different meanings in different contexts. Strong versions of this argument insist that social psychological research on prejudice is typically counter to minority groups' interests (e.g. Billig, 1991; Kitzinger, 1987). Weak versions of the argument point out that people construct the meaning of 'prejudice' in local conversational contexts (e.g. Speer & Potter, 2000), and that people who espouse views that might be recognised as 'prejudice' by others often explicitly describe themselves as non-prejudiced (e.g. Gough, 2002). A small number of researchers have been inspired by queer theory (e.g. Minton, 1997; Sedgwick, 1991 [(but c.f., Shidlo, 1994); Warner, 1993) to think of sexual ideologies as 'heteronormative', because these ideologies proscribe heterosexuality as the identity for all (e.g. Hegarty, Pratto & Lemieux, 2004; Kitzinger, 2004). 'Prejudice' can vary widely between majority group definitions and minority group experiences; strategies that heterosexual people adopt to appear 'non-prejudiced' in interactions with Lesbian, Gay and Bisexual (LGB) people do not always work (Conley, Calhoun, Evett & Devine, 2001). Currently, less than 10 per cent of the heterosexual British public think that they are prejudiced against lesbians and gay men (MORI, 2003).

1.2.2 History

Research on sexual prejudice was scant prior to the depathologising of homosexuality in the early 1970s (although see Smith, 1971). The term 'homophobia' became popular beyond sexual minority communities through the work of George Weinberg (1972).

Like other theorists of this period, Weinberg understood 'homophobia' as related to sexual repression, such that both heterosexuals' unwillingness to accept openly lesbian and gay people, and their unwillingness to accept their own same-sex *desires* were included in the definition of 'homophobia' (Hegarty & Massey, 2006). Models of 'heterosexism' that developed in the 1980s re-conceptualised sexual prejudice as a prejudice against a distinct *minority group* defined by sexual object choice, often drawing analogies to ethnic and religious prejudices (e.g. Herek, 1984). For different reasons, both questionnaire researchers (Herek, 1984), and critics of questionnaire research (Kitzinger, 1987) argued for the term 'heterosexism' over 'homophobia.' Both rejected the association of sexual prejudice with pathological fear and mental illness (understood to reside in the suffix – phobia), and both called for more societal level analyses of prejudice against sexual minorities. Lesbians and gay men were understood to be the targets of 'heterosexism' and psychologists' theorising around prejudice against bisexuals developed only later (e.g. Spalding & Peplau, 1997). In the 1980s, researchers also examined the obvious stigma attached to HIV/AIDS that was largely associated with gay men, lesbians, and bisexuals in popular media (e.g. Herek & Glunt, 1988). While the literature on sexual prejudice has grown with each decade since the 1970s, this literature remains, like most of the literature on LGB psychology, focused on men more than on women, and on homosexuals more than bisexuals (see Lee & Crawford, 2007). Research on prejudice against transpeople is rare and recent, but that research suggests that 'transphobia' is rampant (Hill & Willoughby, 2005; Tee & Hegarty, 2006).

1.2.3 Heterosexist attitudes

Questionnaire research has painted a consistent picture of people with higher levels of sexual prejudice as male, uneducated, religious, older, sexually conservative people who don't know any LGB people personally, and who think that sexual orientation is freely chosen rather than determined by biology (Herek, 1994, 1984; Herek & Glunt, 1996; Kite & Whitley, 1998; Whitley, 1990). Heterosexism is learned early, particularly among boys who use gay slurs to insult each other in middle childhood prior to the emergence of adolescent sexualities (Horn, 2006, Preston & Stanley, 1987). Although much attitudinal research assumes that sexual minorities are distinct bounded groups, and such research often draws analogies between sexual prejudice and racism, several findings trouble these analogies. First, unlike racism, sexual prejudice appears to be a form of within-group prejudice, motivated by concern with moral authority and the policing of deviance, rather than an inter-group prejudice like racism (Whitley, 1999). Second, African-American sexual minority individuals report that racism is a more pervasive prejudice than sexual prejudice (Battle et al., 2002). Third, sexual orientation is also understood to be concealable, such that heterosexual people might be misperceived as lesbian or gay while White people rarely express concern about being mistaken for members of ethnic minorities. In straight men in particular the prospect of being misrecognised as gay engenders particular discomfort (Bosson, Prewitt-Freilino & Taylor, 2005).

1.2.4 Modern prejudice

In the UK, under New Labour, Lesbian, Gay, Bisexual and Transgender (LGBT) people have benefited from a wide platform of new civil rights in family, employment, immigration, and educational contexts, leading some to describe Britain as 'the world we have won' (Weeks, 2007). Patterns of sexual prejudice have also changed in Western

democracies in the last 25 years. Support for the civil rights and human rights of sexual minority individuals has increased. Heterosexual people report that they personally know more LGB people than they did in the 1980s. In contrast, emotional responses to lesbians and gay men have shown less progress and attitudes toward the behavioural expression of homosexuality remain negative (Herek, 2006; Yang, 1999). The new norm of equality has led some researchers to conceptualise sexual prejudice as a ‘modern’ prejudice (c.f. McConahay & Hough, 1976) that does not target sexual *identity per se* but particular forms of expression in behaviour (e.g. Hegarty, 2006; Morrison & Morrison, 2002). Support for sexual orientation equality in the abstract – while now common – often evaporates in the contexts where it is most relevant. Many heterosexual people who support lesbian and gay civil rights often reject concrete measures to bring those rights about (Ellis, Kitzinger & Wilkinson, 2002). Heterosexuals will continue to treat gay people negatively if given a chance to do so that is about something other than identity (Moreno & Bodenhausen, 2001; Morrison & Morrison, 2002), even in situations where they are concerned with fairness (Hegarty et al., 2004). In an era of equality, heterosexual people may harbour more prejudice than they are willing to admit (Ratcliff, Lassiter, Markman & Snyder, 2006), and prejudice is subtly communicated through non-verbal channels (Hebl et al., 2002).

1.2.5 Maintaining and reducing sexual prejudice

This section discusses three processes related to prejudice reduction and maintenance. First, intergroup contact, under certain conditions, has long been argued to reduce many forms of prejudice (Allport, 1954). Indeed, intergroup contact breaks down sexual prejudice more than most other form of prejudice (Pettigrew & Tropp, 2006). However, there can be psychological costs associated with such contact. Interactions between gay and straight people are scripted (Hegarty et al., 2004) and play out (Miller & Malloy, 2003) with asymmetric rights and responsibilities for the management of discomfort. Sexual minority people select whom they come out to quite strategically (Conley et al., 2002). Straight people can also experience ‘courtesy stigma’ or guilt by association as a result of known friendships with gay people (Snyder & Omoto, 2002; Sigelman et al., 1991; see also Goffman, 1963)

A second strategy that has been much publicised is the changing of attitudes by changing beliefs in the *origins* of human sexual orientation. Particularly in the US, heterosexual people who consider sexual orientation to be biologically determined tend to evince more tolerant attitudes (e.g. Haslam & Levy, 2006; Hegarty & Pratto, 2001a; Whitley, 1990). Members of sexual minorities sometimes report describing their sexual orientations as inborn to garner better reactions from others (Whisman, 1996). Several authors have interpreted these findings as meaning that biological beliefs *cause* differences in attitudes (e.g. Altemeyer, 2001; Jayaratne et al., 2006; Whitley, 1990). However, studies designed to test this specific claim have suggested that biological beliefs might just as easily rationalise pre-existing attitudes (Hegarty, 2002; Hegarty & Golden, 2008), have evidenced both effects of attitudes on beliefs *and* the reverse (Haslam & Levy, 2006), or have demonstrated the co-occurrence of both ‘nature’ and ‘nurture’ theories in the same heterosexual individuals (Sheldon et al., 2007). The correlation is not controversial; the cause of the correlation remains so.

A third factor which merits attention as something that might maintain sexual prejudice is *disparagement humour* which targets discriminated groups and which allows the expression of blatant prejudice to appear normal (Ford & Ferguson, 2004). British heterosexuals report that they get their information about sexual minorities largely from television (MORI, 2003). This medium contains negative and unrealistic content about LGB people, including derogatory humour focused particularly on gay men's sexuality and expressions of gender (Cowan & Valentine, 2006). This topic merits further research, specifically in a British context.

1.2.6 Stereotypes

Social psychologists understand stereotypes to be beliefs about the attributes of social groups (Fiske, 1998). These beliefs are distinct from negative *attitudes*, which are more clearly evaluative. But stereotypes are thought to play an important role in the maintenance of inequality, by justifying the status quo. Common stereotypes tend to centre on beliefs about gender-inversion for lesbians and gay men (Deaux & Lewis, 1984; Kite & Deaux, 1987), unfaithfulness for bisexual women and men (Spalding & Peplau, 1997), promiscuity for gay men (Simon, 1998), and unattractiveness for lesbian women (Dew, 1985).

People think that they can infer more about a person when they know they are lesbian or gay, than when they know that they are straight (Haslam, Rotschild & Ernst, 2000). Stereotypes do not always colour a perceiver's judgments of individuals, but are more likely to do so when the perceiver's self-esteem is threatened (Fein & Spencer, 1996), and when the perceiver can construct reasonable grounds to justify the stereotype (Kunda & Oleson, 1995). Several findings suggest that stereotypes lead to strategies of information processing that maintain the illusion that they are useful guides about others. For example, heterosexual people call to mind knowledge about lesbian stereotypes only when they learn that a woman has come out (Snyder & Uranowitz, 1978), selectively believe research findings about lesbians and gay men to be valid when they are stereotype consistent (Hegarty & Pratto, 2001b, 2004), and think that lesbian and gay people are more prototypical when they conform to gender-related stereotypes (Fingerhut & Peplau, 2006).

1.2.7 Hate crimes

The most extreme form that sexual prejudice can take is the perpetration of hate crimes. Community surveys report that violent crimes are common experiences among lesbian, gay, bisexual and transgender (LGB and T) populations (Berrill, 1992; Lombardi et al., 2001; Oxfordfordshire HALT, 2005) with physical abuse and violent crimes being experienced by significant minorities, and verbal abuse being experienced by a majority of those surveyed. Studies that have used random-digit-dialing to access more representative samples in the US have found that hate crimes are disproportionately targeted at gay men rather than lesbian women, or bisexual women and men (Herek, 2009). Perpetrators of hate crimes are typically young males acting in concert, often men who understand their attitudes to be 'liberal' (Franklin, 1998). Consistent with the view that homophobia is motivated by conformity to authoritarian norms, this has led some researchers to conceptualise anti-gay prejudice as a ritual enactment of masculinity (Franklin, 2004).

1.2.8 Consequences of sexual prejudice

One of the key assumptions of the ‘stigma model’ of LGB psychology is the idea that mental and physical ill-health issues that are particular to sexual minorities follow from experiences of prejudice rather than from any inherent pathology. Research suggests that LGB people face vexing double-binds about how to enact their identities, and that different strategies lead to different kinds of negative outcomes. For example, those who are closeted are more likely to become physically ill (Cole, Kemeny & Taylor, 1997; Cole et al., 1996), while those who are ‘out’ are more likely to face stigmatisation and hate crimes (Herek, Gillis & Cogan, 1999; Waldo, 1999). Effects of perceived and enacted stigmatisation on mental health have been found in several large national studies (e.g. Bos et al., 2008; Sandfort et al., 2001; Warner, 2004; see Meyer, 2003; Ryan & Rivers, 2003 for reviews). These effects may work through separating LGB people from social contacts – both sexual minority and heterosexual – that sustain mental health (Fingerhut, Peplau & Ghavami, 2005), as well as through the more controversial construct of ‘internalised homophobia’ (c.f., Shidlo, 1994).

1.3 Psychological and psychiatric perspectives

For the most part, the mental health professions have had some difficulties in understanding, accepting and responding to the vast range of sexual identities and expressions. After first being considered as a moral sin and later as a punishable crime for centuries, same-sex attraction and sexual activity became medicalised as a mental illness in the late nineteenth century (Bayer, 1981; Drescher, 2002; King & Bartlett, 1999; Taylor, 2002). Starting with Krafft-Ebing’s *Psychopathia Sexualis* (1886), homosexuality was first categorised as a pathological degeneracy along with criminality and other ‘perversions’ such as paedophilia. Indeed, this movement towards medicalising many forms of deviancy and difference affected many groups of society, often in the most negative and persecutory ways (Foucault, 1979). However, same-sex attraction later became conceptualised as a form of developmental arrest by Freud (1905) who proposed that male homosexuality was the result of an unresolved Oedipal Complex.

Freud believed that a child’s psychosexual development started with an innate and immature ‘bisexual’ state that developed naturally into a mature and healthy heterosexual orientation. Therefore, homosexuality was a possibility for anyone since it was an arrested, immature form of sexuality. As a result, Freud believed it to be problematic and difficult but not evil or degenerate. In fact, his famous letter to an American mother has been suggested as a reflection of his relatively benign acceptance of homosexuality, as a condition that could be tolerated and adjusted to. In the end, Freud’s ideas of homosexuality being a form of psychological immaturity proved unacceptable and/or misguided by subsequent psychoanalysts. Psychoanalysts such as Rado (1940) and Beiber, Dain and Dince (1962) contended that homosexuality was an irrational phobic reaction to heterosexuality whereas others such as Socarides (1965) claimed it was an unconscious reaction to the trauma and pain of maternal separation. Regardless of the specifics, these psychoanalytic views afforded the possibility and promise of reparation and growth towards a heterosexual orientation as the one and only healthy norm of adult sexuality. These theories had significant impact during the mid-20th century and provided the rationale for including homosexuality in the second edition of the *Diagnostic and Statistical Manual* (American Psychiatric Association, 1968). As a result, scores of individuals received

treatment, sometimes with coercion, to cure their homosexuality with questionable results (Drescher, 2002; Smith, Bartlett & King, 2004).

This approach to homosexuality dominated the mental health professions for decades yet the evidence for the effectiveness of such ‘conversion therapies’ has never been able to withstand the scrutiny of science. This in conjunction with gay activism and the growing body of scientific evidence that failed to link homosexuality to mental illness or emotional instability compelled the American Psychiatric Association to remove it from their official list of mental disorders in 1973 (Bayer, 1981; Drescher, 2002; Garnets, 2007). This bold move signalled a change to view same-sex attraction and sexual activity as a normal variant of human sexuality. The significance of this turnaround and de-classification of homosexuality as a mental disorder has been immense. For example, it paved the way for a new legitimate and truly diverse field of theory and research: the experience of being something other than heterosexual or straight (Garnets, 2007; Kitzinger & Coyle, 2002). It also provided the opportunity for mental health professionals to start developing sensitive, appropriate and affirmative psychotherapy guidelines (American Psychological Association, 1991; Davies & Neal, 1996; Milton, Coyle & Legg, 2002).

However, reparative or conversion therapies based on psychoanalytic or behavioural principles have become embedded within fundamentalist religious doctrine and continue to operate today despite being condemned by many professional organisations such as the American Psychiatric Association, American Psychological Association, and Australian Psychological Society. Examples of biased, inappropriate or ineffective psychological practice continue to be observed (Bartlett, King & Phillips, 2001; Bartlett, Smith & King, 2009; Garnets et al., 1991; Milton, 1998; Milton, Coyle & Legg, 2005). While this may be disheartening and concerning for many, it cannot be that surprising given that contemporary society continues to promote heterosexuality as the standard of normality and affords it with prestige and privilege (Group for the Advancement of Psychiatry, 2000; Matthews, 2007; Taylor, 2002, see Section 4 for more on conversion therapies).

2. Key issues in sexual and gender minorities work

2.1 Sexual identities/Ways of being

Surveys and medical forms often ask for people’s sexual ‘orientation’ but, like the word ‘homosexual’, this term is rarely used by people in Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) communities themselves (Perez, DeBord & Bieschke, 2000). The shift from ‘orientation’ to ‘identity’ is a move from a technical/medical language to one which reflects general Western understanding about the individual in society and links to the idea of identity projects where people are working on their self-identities throughout their lives (Giddens, 1992). It is also important to remember that language of identities (including the very notion of identity itself) is historically and socially contingent (Weeks, 2003; Faderman, 1984; Sophie, 1986). It may be advisable instead to focus on the way that a client describes him or herself and avoid the imposition of medical/technical language.

For many people the concept of identity is important in terms of how they understand themselves and how they communicate to others. There may be a sense of security and safety in identifying with a fixed identity (Langdridge, 2007). There can be less work to do in communicating identity to others and less need for justification and explanation in identifying with an established identity. This is perhaps less so for bisexual and trans

identities which remain less recognised in society than gay and lesbian identities (Barker & Langdridge, 2008). An important part of the therapeutic process may, therefore, be enabling clients to feel secure in their self-descriptions.

In the past, and still today, people who work with sexual minorities recognise that there are people who do not subscribe to an identity even if their practices would suggest that they do. This is about self-identity rather than giving someone a label. Terms such as ‘men who have sex with men’ have been used in the sexual health arena as a way of including men who do not identify as gay or bisexual even though their practices may be such that others may apply this label. Labels must be a self-ascription and some may not want to embrace labels for a variety of reasons including a deliberate choice not to live with fixed labels (see below) or due to cultural factors such as race and class, or because they may be engaging in practices in secret.

There are increasing numbers of people challenging the notion of fixed identities. People may see sexualities as what they ‘do’ rather than what they ‘are’, or feel differently about different identities (for example seeing Bondage and Discipline, Dominance and Submission, and Sadomasochism [BDSM] as their identity but the gender of partner they are with as something they practice, see below). ‘Queer’ for a growing minority is a way of questioning fixed and stable sexual identities (Jagose, 1996; Moon, 2008). Some clients may experience shifting identities through their lifetime and/or may be reluctant to embrace identity labels at all.

For most people, identities are plural. Whilst some might be more important aspects than others, the intersection of multiple identities (such as sexual, gendered, classed and racial identities) may well be crucial in terms of how a person identifies and understands themselves within a particular social context (Anthias & Yuval-Davis, 1983). Furthermore, other identifications, such as class or race, may be considerably more significant than a person’s sexual identity and/or may be complexly related to it. It is important to work with clients such that they can be encouraged to elaborate their sexual identity in relation to other possible identities (see section on socio-cultural diversity).

In this section we are dealing with the most common sexual identities in current UK society. However, some will see other sexual or relationship practices as key aspects of their identity (e.g. SM, non-monogamy, transvestism, drag) and increasingly people are defining asexuality as an alternative identity (www.asexuality.org).

2.1.1 Gay

There may well be an assumption that gay men coming for therapy will be presenting because they have issues with their sexuality, for instance developmental or coming-out issues. Whilst this may be the case for some gay men, it is likely that a significant number will be presenting to deal with everyday concerns with living and generic mental health issues unrelated to their sexual identity (Davies & Neal, 1996). However, even in these contexts a client’s sexual identity is likely to influence their experience and potential, although this will not necessarily raise specific issues that the psychologist needs to address with the client.

There are a number of significant issues that psychologists should be aware of when working with gay men. Many of these revolve around gay men’s understanding of what it means to be a man, especially notions of masculinity and femininity. Wider social

understanding of gay men still tends to position them as feminine and passive (Gough, 2002). This can be experienced as problematic, particularly for those who do not experience their identity in this way. Living up to an ideal of what it means 'to be a man' can be a key issue for many gay men (Connell, 1987). There is not just one masculinity but multiple masculinities and ways of being a man, and these are changing and dynamic processes rather than being fixed within people (Connell, 1995).

Gay men may take part in a variety of sexual practices and many of these practices may be considered abnormal outside the gay community but are actually considered normative practices within it. Examples would include cruising/cottaging and non-monogamous relationships, all of which are commonplace activities for gay men (see below, Heaphy, Donovan & Weeks, 2004).

Gay men, like heterosexual men, will adopt a variety of different political and life positions. Not all want to be like heterosexuals and equally not all necessarily want to be different from them (Coyle & Kitzinger, 2002). In recent years gay rights activists have fought for equality in terms of relationship recognition (civil partnerships), adoption rights and so on (Langdridge & Barker, 2006). It is important to recognise, however, that whilst numbers of gay men will embrace these developments wholeheartedly, others may well express a desire to remain outside such heteronormative institutions (see above).

Case Study: A gay male client was being referred to another psychologist and was asked if he particularly wanted to see a gay psychologist. He responded by saying: 'No, just someone who isn't freaked out by me having sex in graveyards.'

Comment: The important issue here was to recognise that this gay man, like many others, was referring to cruising activity that often takes place in secluded areas such as graveyards and constituted a normal and unproblematic aspect of his sex life. His expressed concern represented his fear at being judged by psychologists projecting their own standards of normal sexual contact onto him.

2.1.2 Lesbian

Traditionally, both historically and in contemporary UK, lesbian identities are far less visible than gay male identities (Markowe, 2002). Partly this is due to being in a situation of double oppression in society (being a woman and being non-heterosexual) (Kitzinger, 1987). This is likely to have an impact on the experience of living as a lesbian and to show itself in the ways in which lesbians may present in the consulting room. It may well affect the ease with which some women are able to own a lesbian identity and as a consequence some may talk more of friendships between women, whilst others may project their identity strongly due to the general silencing of lesbian sexuality.

Part of the invisibility of lesbian experience is the common assumption that sex is not important, or even a priority, for lesbians and that they are more focused on emotional aspects of relationships (Markowe, 2002). Whilst of course this may be the case for some, this can be a pernicious stereotype and many lesbians engage fully in a variety of sexual practices. It is often assumed that lesbian sexual practices are entirely focused on oral and/or manual sex. However, there are many other common practices including the use of

strap-on dildos and vibrators, fisting, anal sex and BDSM practices. (see sections on sexual practices and relationships). Similarly not all lesbians are in monogamous relationships and some may be in multiple relationships or enjoy casual sexual encounters (Newman, 2004).

Another common stereotype of lesbian sexual identities is that either all lesbians are masculine in outlook and appearance, or that lesbian relationships will pair along butch/femme lines embracing gender stereotypes of hard, active masculinity and soft, passive femininity. Whilst some lesbians embrace and/or play with such heteronormative dynamics, others actively reject gender stereotypes.

Menopause and such specifically women's health issues (e.g. breast cancer, hysterectomy and infertility) may differentially impact lesbians. For example, infertility may combine with the difficulties already facing lesbians who want to have children. Many lesbians' identities are bound up in their gender, sexual practices, and/or reproductive capacity because their identities were formed in an inherently political way. For example, some women may have particular issues around their femininity which are significantly challenged through the menopause and/or medical interventions such as hysterectomy and mastectomy which alter the body (Wilkinson, 2002).

2.1.3 Bisexual

Bisexuality can often be completely overlooked as a potential sexual identity because Western culture is still prone to see gender and sexuality as 'dichotomous' (you are either a man or a woman, you are either attracted to a man or a woman, see also section on gender minorities below) (Barker, 2007). Therefore, many people feel pushed towards a gay/lesbian or straight identity rather than feeling that bisexuality is a legitimate sexual identity in itself. Bisexuality is less established as a potential identity in wider society than lesbian and gay identities and often perceived as a transitory stage in a person's sexual development (Barker & Langdrige, 2008). It is, of course, important to recognise that some gay men and lesbians do identify as bisexual as part of their coming out process. However, many people may maintain a bisexual identity, and some may identify as gay or lesbian on their way to embracing a bisexual identity.

There can be a tendency to refer to all sexual minority clients as 'lesbian or gay' and, therefore, subsume bisexuals, once again, within a lesbian or gay identity (Fox, 2006). For instance, if a client expresses same-sex preferences, it may be assumed that this means that they have a lesbian or gay identity without bisexuality being offered as a possibility alongside lesbian and gay identities.

Bisexuals often suffer 'double discrimination', being perceived as outsiders by both straight and gay/lesbian communities, sometimes to the extent of being banned from gay clubs and not accepted on Pride marches (Ochs, 1996). This may be particularly pertinent to bisexual people with different sex partners who may feel ostracised by lesbian/gay communities because they are seen as possessing a degree of privilege not available to them and as being able to 'pass' in straight society. Additionally there can be the common media representation of bisexual people as being greedy, sexual predators and amoral, hedonistic spreaders of disease and disrupters of families (Barker et al., 2008). It is possible that bi people will be on the receiving end of both homophobia and biphobia, and research suggests that this may be why bisexual people suffer from higher rates of mental health problems than lesbians and gay men; who in turn have higher rates than the general population (e.g. Jorm et al., 2002).

Gender issues may also be involved in identifying as bisexual. People understand their bisexuality in different ways. Some see it as being attracted to both men and women at the same time, some recognise that attraction on the basis of gender may shift and change over the life course whilst not diminishing the sense of being bisexual. Others regard bisexuality as being attracted to people regardless of gender (Petford, 2003). Gender identity and sexual identity can cut across each other for bisexual people in various ways. For example, bisexual women may be very aware of the ways in which they are eroticised in the media whilst bisexual men may feel the need to prove their bisexuality because of the popular notion that bisexual men do not exist (Barker, et al., 2008).

It may well be difficult for bisexual people to access a community, particularly those who live outside large urban areas. Whilst there are established gay, and to some extent lesbian, communities across the country, bisexuality has no commercial scene and therefore communities are more grass-roots in nature. There are, however, several useful internet resources, magazines such as *Bisexual Community News*, and events such as local BiFests and the annual UK BiCon.

2.1.4 Queer

LGBT people and communities are not unitary phenomena, rather there are many overlapping LGBT communities and identities. The 1990s witnessed the rise of people and communities who termed themselves 'queer' rather than LGBT. Queer as a concept arose within grass root politics with growing numbers of people dissatisfied with the notion of fixed identities (Jagose, 1996). This was particularly prevalent amongst HIV/AIDS activists and black feminist activists dissatisfied with the normativity of particularly lesbian and gay identities and communities. Some embraced a queer label to encompass these differences and (crucially) to emphasise the dissident nature of their sexualities. Queer may function for many as representing the bitchy, fractious, difficult, uncompromising, unapologetic aspects of the movement – the dissident or transgressive gay citizen. This is in contrast to lesbian and gay which is seen to represent the good gay citizen (Bell & Binnie, 2000).

The label 'queer' also relates to the academic theoretical approach of queer theory (Seidman, 1996). This offers a radically different understanding of sex, gender and sexuality, refusing to accept simple dichotomies (like that between men and women or lesbian/gay and heterosexual) and instead poses a challenge to the dominant heterosexual foundations of sexuality. It is a conceptualisation of sexuality which sees sexual power embodied in different levels of social life (enforced through boundaries and binary divides). Queer theory involves the problematisation of sexual and gender categories (and identities more generally), a rejection of civil-rights strategies in favour of carnival, transgression and parody, and a willingness to interrogate areas not usually seen as the terrain of sexuality and engage in queer readings of such texts. At its strongest it entails transgression of all conventional categorisations and the breaking of boundaries. More commonly (though much more narrowly) it entails the reclamation of the word queer from the oppressors by the (previously) oppressed (Seidman, 1996).

People who engage with queer identifications, queer activism and/or queer theory may refuse to take up a fixed position with regard to sexuality, gender, race and so on. It is a strategy that may be politically motivated and/or one which simply represents a person's understanding of how they wish to live (Moon, 2008). Therefore, they may not want to

work towards establishing fixed identities or even fixed relationships as these may not be desirable (Langdridge, 2008). For some, such a temporary and contingent identification may result in difficulties in terms of their own understanding of self, how they communicate with the outside world, and in terms of finding appropriate communities where they feel at home. Others may find alliances with bi and trans communities and with specifically queer groups. Some may identify as bisexual, lesbian, gay or heterosexual and as queer, recognising both the problems and potentials of identity labels.

2.2 Gender Minorities

Gender minorities are often described as trans (Lev, 2004), people who are in some way transgendered or who 'transgress' gender boundaries. Trans is generally perceived as pertaining to gender identity rather than sexual identity, but common experience (of being similarly marginalised and discriminated against) has meant that trans agendas have become aligned with those of LGB communities in recent years. This has not been without some resistance on both sides (Serano, 2007; Wilchins, 1997). In the past trans women have been excluded from women-only spaces and some still may find it difficult to be accepted if it is known that they have chosen not to have genital reassignment surgery (Richards & Barker, 2012; Lev, 2004). Although the exact presentation of different trans people is partially culturally determined, trans people have been found in all cultures and all times (Herdt, 1996).

2.2.1 General Issues

It is important for psychologists to be aware that, as with LGB people, many trans people coming to therapy will want to discuss issues unrelated to their trans identities. It can often be difficult for trans people to access non specialist services as it is assumed that their needs are a 'specialist area' just because they are trans, even though their issues may relate to bereavement, family, relationships, work, or children, areas within the scope of competent psychologists who are not specialists in working with gender minorities. An accepting attitude is important and an avoidance of the assumption that being trans is the problem.

Trans men is a term often used to describe men who are living in a male gender role who were natively assigned as women and trans women to describe women living the female gender role who were natively assigned as men. People may describe themselves as trans men and trans women though still in their natively assigned gender role as essentially they are still the same person in whatever gender role they adopt and their gender identity may have always been of a different gender to their socially assigned natal gender. Transgender (now also, increasingly, just 'trans') is a broad term encompassing a variety of gendered identities including transsexual, genderqueer, third sex, androgynous, drag king/queen, transvestite (see practices below) and/or people who are undergoing, or have undergone, hormone treatment and/or surgery in order that their body form fits with their gendered identity.

Psychologically androgynous trans people can find they do not comfortably fit into dichotomous gender labels and experience themselves as neither male nor female nor both (Carroll, Gilroy & Ryan, 2002; Eyler, 2007). They may find it difficult to describe or communicate their experience within common discourses that assume only two genders. They may start seeking gender reassignment because, having found it difficult to live in one

gender role, they consider that maybe they 'should' be in the other. This is often reinforced by reactions from others who find it uncomfortable not to be able to label the person as male or female. As with common therapeutic encounters it is therapeutically beneficial to listen to the person's actual experience (Cooper, 2008). In the face of continued social emphasis on two genders some people do move down the path of gender reassignment finding it difficult to live in a non-specified social gender. Others find a more androgynous path or a more comfortable compromise once able to explore their experience in a therapeutic space without being judged. When in therapeutic conversation with trans people some researchers have suggested it is useful in creating rapport for psychologists to be open to using the gender labels, names and pronouns used by the client themselves (Goethals & Schwiebert, 2005).

Gender Dysphoria is a commonly used professional term used to describe experienced dissonance between gender identity and phenotype (the external characteristics of the body) (Barrett, 2007). Clients may present stating they have 'gender dysphoria'. It is important to explore what exactly that means for them and the implications it has for their lives. For some gender dysphoria may mean to them an extreme state of confusion, others may have a clear gender identity which is simply incongruent with the body that is socially perceived as fitting that gender identity. The former may want psychological input and counselling specifically around experienced gender dysphoria, the latter counselling around their options and the implications of those options for family, relationships, children, work, friends, etc. Gender dysphoria is usually more appropriate to describe stages of life when distress and/or confusion is experienced in relation to gender identity and social gender role and phenotype. For example a trans woman with a strong female gender identity may have reassigned gender role, be taking feminising hormone treatment, have no gender related stress or dissonance, but have not chosen to have gender reassignment surgery. To describe such an individual as 'gender dysphoric' would be unnecessarily pathologising.

Gender dysphoria can fluctuate over years, not infrequently increasing or decreasing in mid life and it is not unusual for people to present for therapeutic discussion and support later in life (Blanchard, 1990; Barrett, 2007; Richards & Barker, 2012). Social stigma and family issues can also delay people expressing their gender identity. Counselling and psychotherapy to 'cure' transsexuality has generally been unsuccessful and runs counter to current professional knowledge and practice in the field. Indeed some research suggests that analytic psychotherapy prior to physical interventions to aid trans people may be unnecessary (Meyer et al., 2001; Seikowski, 2007) or even harmful (Lawrence, 2003; Loewenberg & Krege, 2007). If clients are referred by external agencies because they have presented with gender related concerns it is useful to identify – with the client – whether they are seeking counselling or psychotherapy or whether referral to a Gender Identity Clinic (GIC) is being requested. The weight of current scientific evidence regarding transsexualism suggests a biologically-based, psychosocial multifactorial aetiology (Cohen-Kettenis & Pfafflin, 2003). The question 'Why am I the way I am?' is a frequent and maybe important question. Focusing excessively on 'causal factors', however, can be pathologising, damaging to self-esteem and position the person not only other to the norm, but in some way defective relative to the norm. Counselling and psychotherapy can be useful in this area.

Some clients may have mild gender dysphoria and may eventually experience it as part of who they are, or develop a positive trans identity. Unfortunately some well-meaning people, trans and non-trans, can be quick to inform people presenting with gender related distress that they ‘must be transsexual’ and should reassign gender and have gender reassignment medical interventions such as hormone therapy and surgery. This does not take into account the broad range of people who experience gender confusion, for many of whom this is not the appropriate path, and who can be left with extreme regrets and irreversible physical changes. Sometimes people experience mild or transitory gender dysphoria. It should not always be assumed that this indicates the person is definitely trans. In some cases the reported desire to change sex may be symptomatic of a psychiatric condition for example psychosis, schizophrenia or a transient obsession such as may occur with Asperger’s syndrome (Barrett, 2007). Trans clients who have these diagnoses do go through gender reassignment, but careful assessment and discussion with the person and significant others will have established with them that the gender dysphoria is not symptomatic of these things. The internet has enabled trans people to communicate more effectively and to support each other, this is a useful resource for a group of people who have historically been marginalised; a list of resources can be found at the end of this chapter. The downside is that the lack of face-to-face information means that they do not always have the full picture on who they are communicating with and may ‘coach’ people on what to say to obtain hormone treatment and genital surgery without any awareness of the real potential consequences for the individual involved (cf Dewey, 2008).

2.2.2 Coping strategies

Due to the chronic stress associated with living with hidden gender dysphoria, substance abuse may be a coping strategy for trans people prior to coming out or receiving treatment. There are not infrequently early histories of alcohol and drug abuse (Israel & Tarver, 1997). Alcohol and drugs may have been used to suppress the feelings of gender dysphoria and occasionally self-harming may be present. These behaviours often stop once the person starts addressing the gender issues but may need additional intervention if there is long-term dependency. Self-harming can continue to occur if there is a contributory psychiatric condition present in which case additional professional support to engage with the self-harming may be necessary on a longer-term basis.

2.2.3 Diagnosis

The Department of Health has explicitly stated that being trans is ‘not a mental illness’ (Department of Health, 2007). However, some psychiatric nosologies do include diagnoses that would fall under the broad rubric of Trans. Transsexualism is defined in the ICD 10 as a strong and on-going cross-gender identification, i.e. a desire to live and be accepted as a member of the opposite sex. There is a persistent discomfort with anatomical sex and a sense of inappropriateness in the gender role of that sex. There is a wish to have hormonal treatment and surgery to make one’s body as congruent as possible with one’s psychological sex (WHO, 2000, p.215) (ICD 10. F64.0). Many trans people who fit this description do describe themselves as transsexual, however not all are comfortable with this label. Psychologists need to be careful in using popular terms to describe trans people which might be reclaimed and used by a community about themselves, but considered highly offensive if used by others (cf Kennedy 2003). Thus a person who may fulfil the requirements of the ICD 10 coding for Transsexualism, and who may be referred to as a

‘Trans woman’ when it is particularly pertinent, may generally be referred to as a woman. Generally it is considered respectful for trans people to be addressed using their preferred terms.

‘Homosexuality’ was removed from the APA *Diagnostic and Statistical Manual* (DSM) in 1973 and the WHO *International Classification of Diseases* (ICD) in 1992 but trans identities remain under both manuals as Gender Identity Disorder (DSM IV-TR) and Transsexualism (ICD-10). ‘Gender Identity Disorder (GID)’ is defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR, American Psychiatric Association, 2000) as ‘strong and persistent cross-gender identification and a persistent discomfort with the sex and a sense of the inappropriateness of gender role’. Individuals experience their ‘gender identity’ (psychological sense of self as male or female) as being incongruent with their phenotype. This categorisation as a mental disorder is viewed as pathologising by many trans people and professionals (trans and non-trans) involved in trans health care and research. The ‘Childhood’ categories of these ‘disorders’ are considered by many to continue to pathologise young trans people as well as some LGB people and others who do not express stereotypical gendered behaviour in childhood (Piontek, 2006).

Many lay trans people, along with many professionals (trans and non-trans) working in the field strongly challenge the psychiatric categorisations of transsexuality and transvestism. Removing Transsexualism and Gender Identity Disorder and Transsexualism from DSM-IV and ICD-10 raises more complicated issues than was the case with ‘homosexuality’. These issues, for example, include access to trans specific medical interventions, funding issues and access to resources. Further information on the debate in this area can be found in (Karasic & Drescher 2005; Richards 2007). It is recommended that psychologists seeing trans people presenting with stories fitting these diagnostic categories do not assume them to have a mental disorder and need to be proactively careful not to pathologise trans identities.

Many people who have reassigned gender do not have a trans identity seeing themselves as just men and women whose natal socially assigned gender role was incongruent with their gender identity. They identify as men or women who have always been their socially reassigned gender. They may be clients with an atypical gender history but will not welcome imposed or assumed labels or political identities. Others may have trans identities that are complex (e.g. Richards, 2009) and informed by a knowledge and interest in LGBT politics.

Gender Reassignment refers to changing social gender role and often taking feminising or masculinising hormone treatment and having surgery to alter the body to be more congruent with the gender identity. Not all trans people who change gender role will elect for hormonal treatment or genital reassignment surgery (Eyler, 2007). Those who do, seek the services of health professionals who specialise in the area. Once it has become apparent that the issue is specifically a trans issue and that the client would like to consider a physical intervention, the client should be referred on to a Gender Identity Clinic. In line with the World Professional Association for Transgender Health standards of care (WPATH, 2011) it is not always required for a client to have had a course of counselling or psychotherapy before physical interventions are undertaken; rather the client must meet certain criteria (see below and Barrett, 2007) and be assessed and counselled by two specialist clinicians, with time between assessments, commonly at least three months.

It is useful for psychologists to appreciate the potentially difficult relationship between some trans people and health professionals who may act as 'gatekeepers' to treatment (for example, for trans people who reject pathologising diagnostic labels and psychiatric/psychological discourse, but are seeking NHS care including hormonal medication and/or gender reassignment surgery) (Hale, 2007). Historically some trans individuals have been thought to embellish or limit personal history information in order to obtain desired treatments by fitting the history to standard clinical histories to elicit a quick diagnosis (Rosario, 2004). This dates back to when treatment paths were more restrictive, the separation of gender identity and sexual orientation less clearly understood and trans people were in a more disempowered social position, some using their knowledge of the medical literature to provide clinical histories most likely to elicit access to hormonal and surgical treatments. Trans clients are often well-informed, with many fitting the profile of 'expert' patients, and now tend to be more challenging and proactive in their own treatment decisions and the relationship is rightly becoming more collaborative between clinician and client. (Lenihan & Hegarty, 2007). The power imbalance, inherent in the way in which dominant discourses frame and limit the discussion and the subsequent decision-making, may be best avoided by building a collaborative relationship with the trans client. Stressing that the gatekeeping role is one which very few professionals are involved in, unless of course that is explicitly the psychologist's role, the purpose of the therapy is not a gatekeeping one.

As with LGB identities, it would be useful for psychologists seeing trans clients to educate themselves about trans experiences and terminology (Goethals & Schwiebert, 2005). Some basic information is included here but psychologists ideally should seek further training. Whilst it can be necessary at times to identify natal assigned sex alongside gender this can be done in a sensitive way. Referring to a trans person generally as 'male to female' or 'female to male' or as 'a female to male transsexual' or 'a male to female transsexual' can be considered offensive. Trans people are occasionally referred to in clinical reports as female to male (FTM) or male to female (MTF). In formal medical and psychological reports and documentation it sometimes causes confusion if someone is only referred to as a trans woman or trans man, so (FTM) or (MTF) may be added afterwards. This should not be necessary where this abbreviation is not relevant. The terms trans man and trans woman alone are becoming increasingly used as these recognise the continued gender identity throughout life.

Psychologists are advised always to question whether it is necessary to identify someone's gender history in their communication with others unless specifically requested by the client or it is essential to their health care. Under the UK Gender Recognition Act (2004) people who have received a gender recognition certificate have the legal status of their preferred sex (e.g. the right to marry) whether or not they have undergone surgery. If someone holds this certificate, the information that they are trans is protected and passing on this information or allowing it to be made available to others without consent is a criminal offence. This offence is an 'absolute offence' meaning that no excuse is acceptable. For example, explaining that the records system requires specific information will still result in a criminal conviction. The authors would suggest familiarisation with the Gender Recognition Act 2004 and Section 5 of The Gender Recognition (Disclosure of Information) (England, Wales and Northern Ireland) Order 2005, or at the very least

taking legal advice prior to communicating this information. The psychologist should also assume that a trans person holds a Gender Recognition Certificate (and consequently is protected under the Act), rather than asking them to provide it (cf Barrett 2007).

2.2.4 Gender Identity Clinics

People with gender dysphoria can present at any stage of their lives seeking the services of specialist health professionals and can have a diversity of presentation. They may or may not want hormone treatment or gender reassignment surgery, or not all the surgical options available. Charing Cross Gender Identity Clinic (CHX GIC) is the National UK Gender Identity Clinic where the majority of trans people seeking NHS health care services for specifically trans issues that cannot be dealt with in a general setting, such as specialist surgery, will be referred. On arrival at CHX GIC each referred client will be offered two initial assessment appointments with two different GIC Consultants (Psychiatrist/Psychologist). There are then follow-up consultations with their primary Consultant. The Consultant Endocrinologist oversees all hormone treatment and sees clients in clinic as necessary. Referral can also be made to a Specialist Senior Speech Therapist on the team. For some clients these consultations will not involve a Real Life Experience. For those clients seeking gender reassignment they include support and endorsement for medical interventions prior to, through and after a two year Real Life Experience. Therapeutic group sessions and individual counselling psychology are also available.

The Real Life Experience (RLE) is the formal transition of gender role for a specified period of time, usually a minimum of one to two years, before assessment for gender reassignment surgery. Clients will also have consultations around feminising or masculinising hormone therapy. If they start hormone therapy after discussion of the risks, effects and ongoing monitoring, their hormone therapy will be regularly reviewed throughout their care. Reproductive issues should always be discussed prior to starting hormone therapy and storage of ova or sperm offered. Referrals for speech therapy will be made for those clients who desire this service. Funding for facial hair removal is requested for trans women, but is currently subject to local Primary Care Trust decision, as is genital area hair removal if recommended prior to genital reassignment surgery for trans women. Facial hair removal for trans women is usually by electrolysis, laser treatment or Intense Pulsed Light (IPL).

2.2.5 Surgery

Gender reassignment surgeries can include for a trans man:

- bilateral mastectomy with male chest reconstruction
- phalloplasty (creation of phallus)
- metoidioplasty (creation of micropenis)
- urethroplasty (creation of urethra)
- scrotoplasty (creation of scrotum) and placement of testicular prosthesis
- implantation of penile prosthesis
- vaginectomy (removal of vagina)
- salpingo-oophrectomy (removal of ovaries and fallopian tubes) and
- hysterectomy.

Trans women may have:

- a penectomy (removal of penis)
- orchidectomy (removal of testes)
- vaginoplasty (construction of neovagina)
- labioplasty (construction of labia) and
- clitoroplasty (creation of clitoris).

Some trans women who elect for genital surgery have the penectomy, labioplasty and clitoroplasty but do not want the neovagina or are unable to have a vaginoplasty on health grounds. Some trans women may also want chondroplasty ('Adam's Apple' reduced), or after completing speech therapy with unsatisfactory results seek cricothyroid approximation (vocal cord surgery).

2.2.6 Trans Sexualities

Trans people can identify as gay, heterosexual, lesbian, bisexual, asexual, or queer, etc., and may have multiple sexual identities. Sexual identity is usually associated with the gender identity, and it is recommended that the client is given the space to define their sexual identity prior to any assumptions being made. For example, a natively assigned male with a female gender identity may present in a male gender role and describe themselves as being attracted exclusively to women. Sexual identity may be lesbian.

The sex of any partner of the patient bears no predictable relation to outcomes of gender reassignment and should not be considered to be a measure for its effectiveness (Green et al., 1996). Some trans clients may experience confusion around sexual orientation and identity at some stage in their lives and seek counselling or psychotherapy. A change in gender role can change how society views their partnership or sexual orientation. Partners may have to re-negotiate their relationship and the non-trans partner can feel uncomfortable if previously they believed themselves to be in a heterosexual relationship and now they are in a partnership with someone of the same sex. They may not want to be socially perceived as gay or bisexual. This can affect the couple's friendships, extended family relationships and the future of the relationship.

Sexuality may also be something that a client would wish to explore in therapy. As bodies change sexuality and sexual expression can change also. People may become aware of being attracted to a different gender to pre-transition, or their preference towards one gender increasing (Lawrence, 2005; Daskalos 1998). They may become more relaxed in their changing bodies and more confident that prospective sexual partners perceive them as the gender congruent with their gender identity. Trans people may also be unsure as to how to gain pleasure from their own bodies and to interact with others in a sexual way with a social identity and body that differs from the one they have been socialised with.

It should be remembered that trans people often do not have the socialisation that cisgendered (non-trans) people have in their preferred gender, and consequently are expected to spring fully formed into an adult gender role in their preferred identity. Some trans people may encounter challenges and difficulties in gender performance for a short while after transition. Some organisations and websites offer advice and support. This support should only be offered if the trans person expresses a wish for it. Many trans people settle into a comfortable role quite quickly after having tried out various options.

2.2.7 'Cross Dressing'

Cross Dressing is a term used to describe someone who dresses in clothes commonly worn by another sex. For example, someone who identifies as female may wear clothes more usually worn by people who identify as male. Clearly what is and is not ascribed as belonging to one sex is culturally determined and will vary over time along with fashion. In common with many of the items in this guide cross dressing has long been considered to be psychopathological in its own right and is no longer considered to be. However, diagnoses do remain in the DSM and ICD. These diagnoses should not be used to pathologise. Any distress caused by these behaviours should be attended to, assessing with the client where the problem really lies, as often it can be concerns around friends, family, or social judgements, etc.

Within the psychiatric nosologies 'Fetishistic Transvestism' is defined in ICD 10 as 'the wearing of clothes of the opposite sex principally to obtain sexual excitement and to create the appearance of the person of the opposite sex' defined as differing from 'transsexual transvestism' 'by its clear association with sexual arousal and the strong desire to remove the clothing once orgasm occurs and sexual arousal declines'. It is described as sometimes occurring as an earlier stage of Transsexualism. 'Dual role transvestism' is described as 'the wearing of clothes of the opposite sex for part of the individual's existence in order to enjoy the temporary experience of membership of the opposite sex, but without any desire for a more permanent sex change or associated surgical reassignment, and without sexual excitement accompanying the cross-dressing' (ICD 10).

The authors consider that these diagnostic categories are clearly pathologising in defining cross-dressing (wearing the traditional clothes of the opposite gender) as a 'Gender Identity Disorder' (cf Lev, 2005; Richards & Barker, 2012). Some trans people do lead a dual role lifestyle, and of these some move into a transsexual pathway, and of these a significant proportion may have always sought hormonal and surgical gender reassignment and/or identified as Transsexual.

'Fetishistic transvestism' is often thought to describe a natally assigned man who always requires to be cross-dressed for sexual arousal, but the majority of people who cross-dress do not fall into this category. Cross-dressing may vary in frequency from daily, a few times a week to a few times a year depending on opportunity and inclination.

Cross-dressing often starts in childhood and as a result of social stigma, and the awareness that others will incorrectly see them as having a mental health problem, it may be hidden for years. The child can feel isolated, 'abnormal' and inauthentic, affecting relationships with friends and family (Lev, 2005; Richards & Barker, 2012; Hill, Rozanski, Carfagnini & Willoughby, 2005). In adulthood people can purchase their own clothing but still may keep it secret and disclose to partners and spouses only after the relationship has started, although people often gain confidence over time in discussing their cross-dressing with new partners. A supportive new partner not infrequently is the catalyst which enables them to increase their time cross-dressed and go out in public in their chosen persona. Hiding cross-dressing from friends and family, and coming out to them about cross-dressing can be accompanied by shame, guilt and fear of rejection. For those clients who do enjoy wearing eroticised clothing frequently in sexual activity and seek professional help, again it is useful to explore with them where the problem lies and for whom it is a problem. In the past

there have also been legitimate concerns around being incarcerated in a psychiatric hospital or being seen as mad (e.g. Marks & Gelder, 1967). The media have often reinforced this simply incorrect stereotyping by portraying trans people as sad, mad or bad, or not uncommonly all three.

In the 21st century the term 'cross-dressing' is itself starting to seem outdated. Trans men often wear androgynous, unisex or masculine clothing from childhood, or for years prior to a social gender role transition, without encountering excessive social comment. Trans women are more likely to appear to be wearing female clothes if the overall presentation effect is female, but again can wear androgynous, unisex and odd feminine-appearing items of clothing, jewellery and make-up without this being the case, which many are aware of if they are still being perceived socially as male and want to partially express their female side without changing gender role. General social dress is often not gender specific. Some trans people would argue logically that for them it has been wearing the stereotypical clothes of the natively assigned gender role which has been the real cross-dressing.

2.2.8 Trans parents

Trans parents may have concerns around the effects of their being trans or of a gender role transition on their children and/or partners. Parenting issues may need addressing over a significant period of time. Although trans is not in itself a sufficient or necessary requirement to involve support agencies, there may nevertheless be a need for such involvement, which as always should wherever possible be with the full support of the client. The psychologist making provision at times to see other family members with the client is often appreciated, as family support resources can be very limited in many areas. The reaction of children to a parent disclosing they are trans and/or transitioning gender role can vary widely and be influenced by age. Younger children seem to find it easier to accept than teenagers, but that would also be true of many parental decisions and changes. There is no doubt that the disclosure can be very distressing for some children but the degree and quality of adult support can go a long way towards relieving this distress over time. The attitude of the non-trans parent is extremely important here. Pre-adolescent children whose parents change gender role and divorce have been found to fare less well than those who stay together. They are not found however to fare less well than children whose parents divorce for other reasons. Divorce and separation seem to be the risk factors here, not the changing of gender role (Barrett, 2007).

2.2.9 Trans youth and their families

There is a great deal of contention in the professional literature about the correct treatment of young people who show atypical gender behaviours (WPATH, 2011; Royal College of Psychiatrists, 2006; Gooren & van de Waal, 2007). Like all the other groups in this document, young people with gender atypical behaviours may well present for counselling for issues unrelated with their gender. The many issues attendant to growing up will be present with this client group.

With specific regard to engaging with gender atypical behaviours there are some people who take the view that all gender presentations should be encouraged, as the gender dichotomy is not inherently 'right' and indeed has caused a great deal of harm to many people. Some more radical versions of this stance insist that gender freedom of expression should be the case irrespective of the cost to the young person in terms of personal distress

due to bullying and social disapprobation, etc., as the benefit to society as a whole outweighs this personal cost in terms of the deconstitution of the gender binary.

The alternative view supports the gender binary, believing that interventions should be aimed at facilitating young people in adhering to the sex roles that accord with their assigned sex. In this way it is argued distress will be lessened as the young person will be able to blend in with others of the same anatomical configuration.

A middle ground can be for young people expressing more severe gender dysphoria to be offered a series of staged treatments, much as in the case of adult clients, in order of increasing irreversibility. With young people there is also the option of stopping puberty using Gonadotropin-Releasing Hormone Analogue (GnRHa) in order that the young person has a chance to mature, and they have a chance to consider if gender reassignment is really something they wish to pursue. A sequence of treatment might look something like this:

1. Exploratory counselling and psychological input.
2. Change of living arrangements to reflect the young person's preferred gender.
3. Administration of GnRHa.
4. Administration of Cross Sex Hormones.
5. Gender Reassignment Surgeries.

Throughout stages 2 to 5, and afterwards if necessary, there will be ongoing supportive counselling and psychological input. There is also the option for any stage to last as long as is deemed necessary by the patient, family and clinical team. All the stages other than GnRHa may also be the final stage, again if this is deemed necessary by the patient, family and clinical team. Some patients may be unable to undertake certain treatments due to physical reasons, for example if someone has a cardiac problem they may not be a viable candidate for surgery.

Different clinics and clinicians have different ideas about when each of these stages should begin. For example, in the Netherlands' national clinic (University Hospital, Utrecht) for the treatment of trans related issues GnRHa may begin quite early in puberty at Tanner Stage 2 (cf. Richards 2007, 2008). This is also the stage recommended by the World Association for Transgender Health, formerly HBGDA (HBGDA, 2000, p.10). Whereas in the Portman Clinic – the usual place for English referrals – GnRHa has been prescribed much later in puberty at Tanner Stage 5 (See below). GnRHa cannot be used indefinitely as the delay of puberty decreases bone mineral density, which can lead to brittle bones.

The issue at contention, then, is how early one can tell if a person will continue to request gender related interventions, or to be gender dysphoric, in adulthood. It is suggested by some that the majority of gender atypical young people will go on to be gay or lesbian, rather than trans people who are desirous of medical interventions. For this group it is imperative that no irreversible decisions are made, by them or others, that they will later go on to regret. Balanced against that is the desire to curtail puberty early in those that will continue with their trans identity in order that they can be provided with cross sex hormones and surgery early and so inhabit a body that best accords with their gender identity.

It is suggested that clinicians working psychologically with children are aware of the broad spread of non-problematic behaviours shown by young people that may have, in the past, been deemed to be gender atypical. It is now quite usual for girls to play football, whereas this was not the case as little as twenty years ago. It may also be the case that a behaviour is deemed to be a gender atypical behaviour, but is actually related to an entirely different issue. For example, a young boy's father may be concerned that his son is 'sissy' or effeminate because he is not keen on rough and tumble sports, but this is not properly a gender issue, rather it is a sporting one.

It follows then that it is incumbent on the clinician to determine, if the behaviour is indeed atypical, if the behaviour is actually a problem, and if so for whom?

There is no reason that gender atypical behaviour that is not causing distress be discouraged, or pathologised. If the behaviour is causing mild distress the clinician should be reassuring to the young person and their carers and ideally have familiarisation with the diversity of gender present in culture (Herdt, 1996) and nature (Roughgarden, 2004). Interventions should not be aimed at this stage at changing the behaviour of the young person to be conforming to a cultural norm, but rather should be of a supportive nature to the young person and the network of support that surrounds them, such as their family and school. If the distress is marked then referral should be sought to a specialist in a childhood gender dysphoria clinic, where more intensive interventions can be given, possibly with a view to medical interventions. Specialist clinics and practitioners can vary on protocol, the UK protocol has been somewhat more cautious in this regard than the Netherlands.

2.2.10 UK Treatment of Gender Dysphoria in children and adolescents

'Gender Dysphoria' in children and adolescents is a clinical term that is used to describe someone who is so distressed about the incongruity of their sex and gender identity that they seek physical treatments to remedy this. For most children, gender dysphoric and otherwise, gender awareness develops early, commonly as children become socialised around the age of three (La Freniere, Strayer & Gauthier, 1984). At this point children who feel differently from others of the same sex and who prefer playing with children of the opposite sex may become negatively labelled. As their preference for games and playmates of the opposite sex continues into later school years, family and school staff may become concerned that they are different and the child can become stigmatised or bullied.

Supporting a child's gender development is important since gender identity is connected with all aspects of identity development, including a child's sense of self and confidence. A sense of being different and of not conforming to stereotypical gender roles may emerge at any point in development. As secondary sexual characteristics emerge at the time of puberty, distress is frequently encountered. Young people whose gender identity is not in line with their biological sex find their changing body a cause of considerable distress and confusion. Supporting the young person as they encounter such physical changes and responses is imperative to their wellbeing.

These young people unhappy with their gender can feel trapped in the wrong body with the only solution being to change their body. Related aspects of identity, such as sexuality and changes in relationships associated with physical development, may be usefully considered and explored; particularly since clinical experience and research has found

that the majority of pre-pubertal young people who are referred to services for gender do not go on to change their bodies through surgery. In one long-term follow-up study in a gender service many of the children referred later identified as gay or bisexual, but not trans (Green, 1987).

Helping young people and their families to consider a broader range of outcomes than changing their bodies is one of the therapeutic aims of psychotherapeutic assessment and intervention (De Ceglie & Freedman, 1998). However, this approach does not preclude eventual physical interventions if these are indicated. This approach is also recommended by national and international guidance on working with young people who are unhappy in their gender (Royal College of Psychiatrists, 1998; Harry Benjamin International Gender Dysphoria Association, 2001).

Engaging family members, particularly parents and carers is important to promote understanding and open communication about feelings and difficulties and avoid secrecy and shame (De Ceglie & Freedman, 1998). Since bullying and stigma is a significant risk in young people, also important is liaising with the systems and organisations surrounding the young person and their family, such as schools and other health or social care professionals. A range of toolkits and leaflets have been developed to increase awareness of gender issues in schools (e.g. Press for Change, and Gender Identity Research and Education Society [GIRES]). Additionally, network meetings which aim to find solutions to particular challenges, such as which toilet to use and which PE kit to wear can be useful (De Ceglie & Freedman, 1998) to facilitate acceptance and support.

Psychological interventions also aim to evaluate, in a collaborative way between professionals and young people and their families, the persistence of the diagnostic category of Gender Identity Disorder (APA, 2000a)

Young people who have significant and enduring gender identity difficulties and who meet the diagnostic criteria for Gender Identity Disorder (APA, 2000a) may require pharmacological intervention such as GnRHa to provide a period without the influence of their biological sex hormone. Although, young people and families can find a psychiatric diagnosis difficult; currently this is necessary in order to secure funding for specialist resources, although it should be unnecessary to refer to it in any great depth during the ordinary course of counselling, psychotherapy or general psychological input. The decision to pursue pharmacological intervention should be made with the young person, parents/carers and multi-disciplinary teams as per professional guidance (Royal College of Psychiatrists, 1998; WPATH, 2011). A stage approach is recommended in terms of physical intervention. The stages progress through reversible interventions, moving on, if appropriate, to partially reversible and finally to irreversible interventions in adulthood (after the age of 18 years). Whilst there are differences between guidelines and standards of care in relation to the timing of intervention, they all support the combination of psychological, social and physical interventions, when appropriate, as the best therapeutic approach for a carefully assessed and selected number of young people.

It is important to note that the treatment of Gender Identity Disorder (APA, 2000a) in young people is largely experimental. In Europe there are only two countries (Britain and The Netherlands) that provide a specialised service for young people. Research evidence for the treatments adopted is still limited, although currently being developed.

As the objective of changing the body to adapt it to an enduring and stable cross gender identity is a long term process with a number of stages, it inevitably carries with it a certain degree of frustration. Therapeutic help is also aimed at helping trans-gendered young people to bear this frustration without becoming involved in behaviours which are self-destructive, and to have adequate time to think through and assimilate the interventions to date.

2.2.11 Diversity of sex development

The majority of people, regardless of age, race and sexuality, take entirely for granted that there are only two types of bodies – male or female. In reality, many people are born with body parts that are male-typical, female-typical, both or neither. Here are just a few examples.

Some women are born without a womb, cervix and vagina but with healthy ovaries and therefore do not require exogenous hormones to maintain health. Some boys have their urethral opening at the base of the shaft of the penis rather than the tip. Some men have a single testis, and some have testes that are ‘vanishing’. Some babies present ambiguous genitalia at birth, rendering it difficult for doctors and parents to assign sex; and some of these babies require lifetime steroidal management for survival. Some girls look typically female from birth then do not menstruate in their teens, only to find that they have abdominal testes instead of ovaries, womb and vagina as expected, with a chromosomal make-up typical for males. Some men look male-typical then upon fertility investigations find that they have a uterus and ovarian tissue and are potentially capable of menstruation. Some babies are born with their urogenital sinus outside the abdomen and, amidst other features, present two incomplete sets of genitalia; once associated with 100 per cent mortality, multiple operations and treatment regimes nowadays enable the majority to reach adulthood.

Advances in bio-technology have contributed to the identification of an increasing number of genetic causes for non-standard sex characteristics. Some of these conditions used to be called ‘hermaphroditism’ (see Dreger et al., 2005), however, this term is unhelpful to most individuals and does not provide a useful taxonomy for scientific research and medical treatment. The term ‘intersex’ (Hughes, 2002) has been coined, as well as more recently ‘disorder of sex development’ (DSD) both commonly used in clinical settings and the literature. These are umbrella terms that include a much broader range of diagnoses that include all ‘congenital conditions in which development of chromosomal, gonadal or anatomical sex is atypical’ (Hughes et al., 2006). It should be understood that all terms are potentially pejorative and taxonomy could change. Within this document we have used the terms *diversity of sex development*, as well as *non-normative sex development*, and *atypical sex characteristics*.

There are other more common situations associated with atypical sex characteristics that fall outside the above definitions. These conditions may be congenital or acquired. For example, it is not uncommon for men with otherwise male-typical bodies to grow breasts. And, many women with otherwise female-typical bodies are capable of growing more prominent facial hair. Furthermore, problems of pituitary function may inhibit spontaneous pubertal development in some boys and girls. And, for reasons not currently well understood, some boys and girls show signs of puberty in early childhood.

All skilled and reflexive psychological practitioners can contribute to the health and well being of this broad client group. Whatever the specific medical diagnosis or biological basis, psychosocially, people and close others thus affected share similar challenges. The key is to have a firm grasp of the major themes and develop a robust psychological response (see Liao & Boyle (2004) for an overview of key psychological perspectives), not to get lost in the complex if interesting biology.

Diverse sex development may present in childhood or adulthood, sometimes alongside other body differences or health problems. In case of childhood presentation, most individuals would have come under medical management. The paediatric specialists most likely to assume clinical responsibilities are paediatric endocrinologists and urologists. Where genital differences are detected, virtually all children with a known female karyotype are assigned female and feminising genital surgery usually ensues; children with a known male karyotype whose penis is absent or very small are also likely to be assigned female. (For an overview, please refer to Creighton & Liao, 2004.)

Until relatively recently, patients discharged from paediatric services were lost to follow up, and little was known about how they fared in the adult world in terms of benefits and harms of corrective genital surgery, psychological well being, quality of life, relationships and parenthood outcomes. Although there are now a small number of designated adult clinics in the UK, people living with atypical sex characteristics may present to any psychological service.

2.2.12 Practice models and methods

Dominant stories of 'normality' and 'abnormality' in the social world shape people's experiences of living with body differences. This also applies to living with diverse sex development conditions. Therapy models able to take account of the social context can be useful for work in this field. However, although a robust personal identity may to some extent need to grow from alternative narratives of diverse sex development, the fundamental difficulties in creating entirely separate ideas and stories from the dominant ones should be acknowledged in therapy.

An important task, early on, is to engage with the client's reality; shared attempts to deconstruct normalcy are only possible when founded on a strong therapeutic alliance. Any premature attempt at deconstruction, however well intentioned and skilfully carried out, could make clients feel further diminished. People presenting diverse sex development conditions are not necessarily committed to sexual politics, and many do not feel they have the personal resources to be catalysts in social change.

Within a formulation that contextualises distress, a broader range of methods can be usefully applied, including techniques drawn on narrative, cognitive and behavioural approaches. Within this framework of technical eclecticism, the basis for selection is actuarial rather than theoretical, i.e. what works best from experience and available literature for similar types of problems of living (Norcross & Arkowitz, 1992).

Individual face-to-face work tends to be the norm in psychological practice and this will be true for people with diverse sex development. However, consultations may also be carried out with couples and families. Groups are a useful forum for making apparent to their participants diverse identities and positions, thereby deconstructing notions of normalcy. They can be an effective intervention for reducing distress (Weijenborg & Ter Kuile, 2000),

though frequent attendance could be difficult due to the large geographical spread of some services.

2.2.13 Engaging with patient needs

An important aspect of psychological work is to facilitate processing of the diagnostic and treatment information in ways that are helpful to the individual or family. However, many people have never met a psychologist, thus the first questions may be concerned with thoughts and feelings about the consultation. In order for patients and parents to have greater control of their health care, they need to become more expert about all aspects of the condition in question. But any of the following information, delivered in a clinical language, can be shocking: ambiguous genitalia, absent vagina, absent menstruation, infertility, chromosomes, heredity, lifelong medication, hirsutism, obesity, and short stature. An important first task then, is to develop a shared language with clients.

Questions such as the following may be helpful for starting a discussion:

- What words would you use?
- Were these words given to you, by whom?
- Can you think of a different way of describing the situation?
- How should I say that?
- What's the most challenging aspect of your situation to put into words?
- Can I check with you if I've got this right?

Relating to the diagnosis

An important task even at the early stage is to help clients develop richer vocabularies and drawing from alternative discourses aimed not only to increase medical knowledge but also to address the social, emotional and sexual aspects. Questions such as the following may be helpful for exploring the client's understanding of the condition and, should they be necessary, treatment options:

- Can you tell me the name of the diagnosis?
- What kind of information have you been given about this?
- What other information would you like?

The following questions may be helpful for extending the dialogue:

- These are some very clinical words, what do they mean to you?
- What effects do these words have on you?
- How would you describe the way you're feeling right now?
- Who is able to support you, and whose support would you like to seek?
- How do you see this affect how you feel about yourself (/child), or not?
- Is there another way of viewing the situation?
- In what way will your relationships change, in what way will they remain the same?
- How would you like other people to understand this?

2.2.14 Psychological intervention

At any stage of the care episode, or independently from medical settings, people may seek support from a psychologist. When people do, there is sometimes a specific agenda, such as managing self-disclosure, or decision-making regarding (more) complex treatment, or counselling or psychotherapy for sexual difficulties. At other times, however, the conversations are more exploratory. The client may be the adult presenting with diverse sex development, the couple affected by diverse sex development, or one or both parents

of a child presenting with diverse sex development. Individuals may face very complex decisions upon learning that they have a diverse sex development diagnosis concerning what to do about the information and how to decide about investigations and treatments.

A most common concern relates to self-disclosure about non-normative sex development conditions in social and sexual contexts (Liao, 2003). Many feel challenged by 'ethical dilemmas' about withholding information from significant others (e.g. sexual partners), and about the timing of information. Communicating to people about non-normative sex developments may feel unsafe (e.g. 'people would flip'), whilst withholding information may threaten personal integrity (e.g. 'what kind of person does that make me?'). Information relating to infertility is often thought of as less risky to disclose than information relating to a gender-incongruent karyotype (e.g. a self-identified female with a karyotype typical for males). Whereas a person can choose not to disclose in many situations, given the physical signs, choosing not to disclose to sexual partners can be difficult for some individuals, some of whom may withdraw from intimate relations in order to avoid potential discussion.

Early on, it may be important to enable clients to explore the difference between privacy, which all individuals are equally entitled to, and secrecy. People with diverse sex developmental diagnoses should not feel obliged to share medical information indiscriminately, any more than people with cancer, diabetes or sexual health problems. Some of these questions can help patients explore their feelings about disclosure:

- What kind of ideas do you have about sharing information with people?
- If you were to share something with one person, what and who would that be?
- How have you come to decide that?
- What other resources can you draw on?
- What are your hopes and fears?
- What could you say to let people know how you would like them to respond?

For parents, information management is their responsibility. Provision of well timed information appropriate for different stages of development has been recommended (Carmichael & Ransley, 2002) but, without support, for many parents this is easier said than done. For the currently small proportion of parents who decide to defer corrective surgery until their child can give consent, intensive professional and community support may be needed. These parents may need skills to educate not just the affected child but also siblings and the extended family or wider community, to develop a more constructive, systemic approach for education about non-normative sex development.

2.2.15 Medical/Surgical investigations and treatments

Where a gender boundary is blurred by characteristics deemed to belong to the 'opposite' sex, individuals can become extremely preoccupied with fixing the problem. Many women with diverse sex development diagnoses speak of feeling like outsiders and feeling unentitled to relationships until they have had surgery to remove the obstacles for 'normal sex' (Boyle, Smith & Liao, 2005). When patients seek medical treatment, they may also be seeking 'normality' in identity, relationships and sexual practices. Health professionals feel under a great deal of pressure to ensure that diagnostic information simultaneously comes with offers of some form of a 'corrective' solution. But, whilst this may help to contain doctor and patient anxiety, such action inadvertently comes with the subtext that body differences are unacceptable, indeed inconceivable. It is this subtext that is ultimately unhelpful.

Decision to undergo surgery is sometimes influenced by a perceived need for concealment. In these situations surgery can be an avoidant strategy, that is, avoidance of emotional challenges posed by body differences is accomplished via elimination of difference. It is possible to further the client's understanding of the benefits and limitations of any treatment, for example, by asking:

- Can you repeat to me what the doctor has told you about the treatment?
- What do you understand to be the potential benefits? And risks?
- Which aspects of your life are dependent on the operation? Which aspects are more up to you?
- Who and what else can help you decide?
- What do you think the operation may not address?
- What else might be needed?
- Who and what else can help?

The potential for some psychological approaches to enable patients to avoid certain forms of surgery has been clearly demonstrated (see Liao et al., 2006; Ismail-Pratt et al., 2007). However, these approaches would need to be endorsed by the multi-disciplinary team and clients' engagement may need to be gently negotiated.

With technical advances and the privileging of genetic research in Western sciences, the race to discover genes that cause non-normative sex development is on. The impact of genetic testing on family relationships is seldom attended to, and quality psychosocial support is seldom planned for. It is strongly recommended that psychologists providing care for people with diverse sex development conditions also liaise closely with medical researchers. A well informed psychological opinion can be invaluable and this can be made available even if the psychologist is working outside the specialist context, for example, in a service based in the community.

Health professionals' behaviours can be expected to be highly influential on their patient's sense making of the situation. Preoccupation with the non-standard sex characteristic, with an eagerness to correct what is portrayed as an aberration, could inadvertently set off a negative chain reaction in the individual and close others. Avoidance may become the most common end point, when preparation to confront bodily differences might have been a more adaptive strategy (Simmonds, 2004). It is important to explore both the positive and the less positive aspects of health care transactions, and to identify the impact this might have on current adjustment.

Non-normative bodies fascinate clinicians and researchers – including psychologists. Intimate examination, medical photography or indeed psychological research may not have been optimally managed from the client's perspective. If there have been adverse experiences, the impact would require sensitive exploration. In her detailed study with clinical experts involved in medical management of children with non-normative sex development, Kessler (1998) concluded that whilst most doctors claimed that parents were equal partners in decision making regarding sex assignment and corrective surgery, she could not elicit from them clear examples of parental participation. Furthermore, inadequate psychological support at these times is likely to compromise parents' capacity to take into account and prioritise the child's potential future issues.

2.2.16 Experiences and impact of family transactions

Adults with diverse sex development conditions suggest that parents need to ‘come to terms’ with the diagnoses themselves in order to help their children. Indeed the importance of open communication between parents, children and doctors in adaptation has been emphasised across medical contexts. When presented with a child with non-normative sex development parents can be expected to feel extremely confused and emotionally vulnerable. ‘Coming to terms’ may require sustained support, for coping with losses and fears and for examining our taken-for-granted beliefs about ‘normal sexuality’ and ‘normal life’.

Many parents choose cosmetic surgery to ‘correct’ genital differences in infants and children with non-normative sex development. But whilst the alleviation of parental distress is often cited as a major reason for medically non-essential childhood surgery, it is not clear to what extent such surgery mitigates distress or doubt over the sex of the child (Wilson & Reiner, 1998).

For the children, multiple visits to hospitals, absences from school, treatment regimens, parental anxiety, invasion of personal privacy, pain and discomfort, and evasive responses to questions can impact upon socialisation. There can be other repercussions for the family as a whole. Financial hardship may result as one parent gives up work. Siblings who have to be repeatedly ‘farmed out’ to other caretakers may be emotionally distressed. The psychological well-being of all family members and their relationships with each other may be negatively strained, with potentially long lasting consequences. Psychologists can have a major role in prevention.

2.2.17 Sexuality

People with non-normative sex development may identify as bisexual, lesbian, gay, heterosexual or any other sexuality. Research suggests that lesbian relationships are more common in some diagnostic groups compared to the general population. Regardless of partner preference, sexual difficulties are more common (Minto et al., 2003) compared to general population norms. Difficulties identified include: reduced sexual interest (Zucker et al., 1996), sexual anxiety (May, Boyle & Crouch, 1996), impaired genital sensitivity (Crouch et al., 2008) and poor genital appearance outcome of often multiple operations that have begun in early childhood (Creighton, Minto & Steele, 2001).

Within therapy a move in focus away from ‘normal sex’ and an increased emphasis in sensuality and pleasure rather than gendered performance, can offer some clients greater scope for pleasure as they explore what works best for them and to become more open to opportunities for good-enough sexual enjoyment and relating (Liao, 2007). Thus therapeutic exploration might focus on the developmental trajectories of the following (not in any particular order):

1. gender positioning of self;
2. gender(s) of preferred partners;
3. body perceptions;
4. sexual concerns and experiences – actual and fantasised;
5. sexual and relationship aspirations; and
6. knowledge and attitude relating to a range of sexual activities.

Therapy may also work towards one or more of the following goals:

1. expanding a shared understanding of past and present influences on the identified problem(s);
2. increasing awareness of variations in male and female sexualities and de-centralising heteronormative sex;
3. increasing control over social and sexual situations;
4. self-permission to explore a range of sexual activities – alone or partnered – with or without erotic material or mechanical aids;
5. self-permission not to pursue sexual activities where there is no identifiable barrier other than an absence of desire or even a wish to desire.

Through shifts in emphasis, it may be possible for some individuals to begin to validate a range of consensual sexual activities (or inactivity) that has otherwise been constructed as inadequate or abnormal.

The presence of non-normative physical sex characteristics de-stabilises gender, and gender insecurity can profoundly shape choices in contexts across the lifespan. The importance of psychological support for people with non-normative sex development is frequently alluded to, even more so by doctors and patients than by psychologists. However, its delivery – remit, scope, theories, methods, accountability – is seldom coherently articulated or adequately resourced, perhaps, at least partly, because it is not obvious how such work may fit with the centrality of corrective treatment and concealment.

With new resources being developed to tackle the issues at grass root (e.g. [Error! Hyperlink reference not valid.](#)) and more psychologists making a firmer commitment to people with diverse sex development conditions beyond theoretical research, future generations of psychologists can expect to contribute more usefully to the lives of people affected by non-normative sex development.

Example intervention

Dan was a 26-year-old man presenting a pre-pubertal hypogonadism syndrome. This means that he had not gone into puberty spontaneously. He struggled to talk about his difficulties; he felt very ashamed about his body, in particular his breast development, sparse body hair and smaller than average-sized penis. He had been teased and bullied at school, which he left at the earliest opportunity. He had never dated, although there had been opportunities.

During therapy, self re-storying was pursued where Dan's exclusive focus on 'deficits' was transformed into partial owning of some abilities. Also, hopes and fears about communicating with potential partners about any perceived physical differences were explored, and alternative ways of thinking about the situation were identified and rehearsed during sessions.

Five months and six meetings on, Dan returned to say that his mood had lifted, though he still did not consider himself 'confident'. He had met a woman and fixed their third date. He had not told her about his condition and was apprehensive about it, though he was excited about the dating and determined to continue with it.

2.3 Other sexual practices and identities

As mentioned above some regard the sexual practices they take part in as (key) aspects of their identity, whilst others may see them as behaviours rather than integral parts of who they are. Here we consider some of the main practices which may be important for sexual and gender minority clients.

2.3.1 BDSM

BDSM is considered to be a criminal activity in the UK if it causes the infliction of bodily harm. Aspects of this situation continue to be controversial, as does the fact that sadism and masochism are listed in DSM-IV and ICD-10 despite evidence (Richters et al., 2008) that people in BDSM communities have no greater level of psychological problems than the general population. Many therapists hold negative assumptions about this sexual practice (Bridoux, 2000) including, for instance, the ideas that it is based in early sexual trauma and that it is abusive or psychologically harmful to the people who engage in it. Whilst, of course, any of these things may be true for particular individuals, the vast majority of people who engage in these practices do so for the pleasure it affords and do not suffer any harm as a consequence (Moser & Levitt, 1995). There are, however, particular issues which may arise because this practice has been both criminalised and pathologised. For example, clients may present with concerns and confusion over their sexual behaviour primarily due to stigma and stereotyping which exists around this issue. It is also worth noting that for others there may be no problem whatsoever and it may simply be part of the broad sexual repertoire that they engage in. It is important not to ascribe meaning beyond that provided by people with oppressed and stigmatised identities and practices such as these (Barker, Iantaffi & Gupta, 2008).

Understanding of BDSM is broad and includes all sexual identities and practices involving pain play, bondage, dominance and submission, and erotic power exchange. BDSM stands for bondage and discipline, domination and submission, and sadomasochism, although some shorten this just to SM or prefer the word 'kinky'. Various words are used for the different participants or positions in BDSM. Generally 'sadist', 'dominant', 'dom/domme', and 'top' are used for the person in the position of power or the one giving out the stimulation and 'masochist', 'submissive', 'sub', and 'bottom' are used for the person with less power or the one on the receiving end. A 'switch' is someone who takes both kinds of roles. Often the words 'dominant' and 'submissive' are used for more psychological BDSM (e.g. that involving humiliation or servitude) and 'top' and 'bottom' for more physical (e.g. that involving pain or other sensations), although there is also often overlap between the two. BDSM activity may be referred to as 'play' or a 'scene' and non-BDSM sex may be termed 'vanilla' (Langdridge & Barker, 2007).

Many 'BDSMers' use the phrases Safe, Sane, Consensual and/or Risk Aware Consensual Kink to emphasise the importance of informed consent within their practices.

Psychologists may encounter clients who are not happy with particular activities or feel things have gone too far, and in such circumstances it is useful to help clients to negotiate boundaries and agreements which suit them (Barker et al., 2008).

Case Study: A client presented having been seen by two previous therapists diagnosing sexual addiction because of his frequent visits to professional dominatrices. The client presented having been dissatisfied with his previous therapeutic experiences as he did not feel he had an addiction but instead had problems with his current BDSM relationship. For him, his presenting concern was clearly his current relationship difficulties and whilst he had frequented professional dominatrices for many years he thought this was his only option given his age, history and lack of knowledge about any alternative ways of gaining the sexual satisfaction he desired.

Comment: Putting aside the appropriateness of diagnosing clients, the other therapists failed to recognise the broader context involved in this client's life. With little knowledge of, or access to any BDSM scene, he perceived his visits as the only possible outlet for his particular sexual desires. Part of the therapeutic process involved the psychologist and client working together to enable him to access virtual and real BDSM communities whilst also recognising that he may still wish to visit professional dominatrices and that this may not be a problem for him and how he understands his sexuality.

2.3.2 Asexuality and celibacy

According to Asexual Visibility and Education Network (AVEN), 'an asexual is someone who does not experience sexual attraction'. Many asexuals distinguish this from celibacy, which is seen as a choice rather than an inherent part of one's sexuality. Some may engage in solo sex whilst others may have no sexual experiences at all. Bogaert (2004), in a national probability study, found one percent of people to endorse the phrase 'I have never felt sexual attraction to anyone.' Particularly within the psychosexual therapeutic community there may be an assumption that sexual attraction and desire are a universal part of human being, therefore, it is important to recognise that some may not experience themselves as such. The website www.asexuality.org provides useful information on this topic.

Asexuality may be distinguished from the ways in which some people may experience themselves as non-sexual during the process of coming out or transitioning. There are many times in life when it is common to feel non-sexual, also many people decide not to be sexual for political or religious reasons. Lack of sexual desire or arousal can be experienced as a problem but may not necessarily be.

Celibacy is an active choice to abstain from sexual practices which is particularly associated with membership of some religions. In a clinical context it is important to work with clients to understand and respect their motivations for being celibate rather than view this as indicative of psychosexual problems. Whilst there are undoubtedly occasions when people choose celibacy as a result of problems in relating or due to earlier sexual trauma this is not necessarily the case as people may actively choose this option for a variety of reasons unrelated to sexual or relationship difficulties and indeed even if people have suffered sexual or relationship difficulties, celibacy may still be a positive choice which need not be the focus of psychological intervention.

2.3.3 Solo sex, pornography, and erotica

Masturbation is still often pathologised and seen as less worthy than other forms of sex. In psychosexual therapy and sexual self-help books it is generally seen as part of a process towards 'proper' sex: which is generally defined, heteronormatively, as penile-vaginal intercourse (Tiefer, 2004). However, masturbation (whether mutual or solo) constitutes a major part of the sexual practices of many people (LGBTQ and heterosexual).

Masturbation might be considered problematic or sinful by some cultural/religious groups. This links with the idea of sex for pleasure (in this case self-pleasure) being selfish or wrong. This view could make it difficult for clinicians working with clients using a sex therapy programme that would recommend masturbation as a step in self-learning and control of one's sexual responses. Clinicians could either forfeit this step, or some clients may be willing to use masturbation as part of the 'treatment' if it is put within a medical frame – for example called 'hand practice' rather than 'masturbation'. For example, this could be permissible in the same way that someone with diabetes regulated by food can eat during Ramadan.

Solo sex may also involve the use of pornography/erotica. Whilst legitimate concerns have been expressed around the objectification of women in much pornography/erotica, LGBTQ people frequently access pornography/erotica, much of which is produced specifically for these communities. There is often widespread acceptance within LGBTQ communities about the use of these materials and it may frequently form an integral part of people's sexual practices.

Pornography/erotica may be accessed, or produced, particularly in order to enable people to explore (often in creative ways) new and/or alternative sexual desires and possibilities. For example, there is an increasing amount of 'slash' fiction on the internet where authors and readers write about same sex relationships between fictional characters from popular culture and may also use this to experiment with BDSM and other sexual practices at a fantasy level (Barker, 2002). Use of online pornography, internet sex chat, and other types of solo sex are, recently, being frequently pathologised under the label of 'sex addiction' (Irvine, 2005). This may function as a continued stigmatisation and marginalisation of LGBTQ groups, particularly a number of gay men, for whom this constitutes a major part of their sexual practice (Davies, Barker & Langdrige, in press).

2.3.4 Sex work

There are a number of misconceptions about sex work. It is not illegal in the UK to sell sex, although national legislation and local by-laws impose many restrictions on it (Brooks-Gordon, 2006; Sanders, 2005). The profile of a person who sells sex may not comply with stereotypes of the vulnerable person who works in the street and is addicted to drugs. Much more paid sex takes place 'indoors', in private flats, saunas, or brothels, with more and more people using the internet to advertise (Bernstein, 2007a; Bimbi, 2007; Sanders, 2006). The needs of the client who presents as a sex worker will be dependent on a number of factors influenced by their gender, sexual identities, gender identities, economic situation, age, race, nationality, migration status, relationship status, proximity to drug and alcohol use. Feelings of self-esteem, empowerment, and stigma will be key mediating factors to the client's response between these variables and their needs from therapeutic intervention. The best advice to a psychologist who is seeing a client who has

presented as a sex worker is never make assumptions about the person's background (Christina, 2004). The client who has presented as a sex worker will be more open to questions than assumptions about their personal situation (Bernstein, 2007b).

Whilst sex workers report being able to distinguish between sex-as-work from sexual-expression-of-intimacy, in the context of counselling, some may confuse professional care for a more personal relationship if they are unused to emotional care without physical demands (Mai, 2008). Some may be more comfortable talking about sex than about their personal lives, whilst others may be sexually aggressive to redress a perceived imbalance of power.

2.3.5 Men who sell sex

Most men who sell sex are hired by other men, since the female client base is small by comparison. Whilst most men who sell sex to men identify as gay, some have a straight or bisexual identity in their personal lives, and are 'gay for pay' (Dorais, 2005). This may change through their period of involvement in paid sex work, and some men may 'come out' as bisexual or gay, whilst others will continue only to have sex for men for economic purpose (Dorais, 2005). Some men do use sex work as a way of exploring their own homosexuality, justifying it through the financial benefits. Some young men may realise financial opportunities when they themselves are exploring the gay scene or public sex environments such as cruising grounds or public toilets (Mai, 2008).

Clients may experience dissonance between their identity and their occupation, that is, between what they *do* and who they *are*. This may be true both for their sexual identities, and their identification as sex workers (Mai, 2008).

Some men sell sex occasionally or part-time. Many have other employment in mainstream jobs, or even professional careers. Most men sell sex because they have been faced with some sort of financial crisis. Some men work in other areas of the 'sex industry' including photographic modelling, pornographic films, or stripping (Dorais, 2005).

Issues of stigma tend to be common across all types of sex work and all profiles of sex workers. Men who sell sex may either experience more stigma because of the double taboos of homosexuality (real or perceived) and selling sex; conversely, they may experience less stigma from gay men who may define 'authentic intimacy' differently (Morrison & Whitehead, 2007; Bernstein, 2007b).

Some male sex workers will experience a level of esteem because of their physical attributes, particularly their physique, penis, and face. Some young men who have not yet sold sex may aspire to become male escorts because they see the lifestyle as glamorous (Gaffney & Beverely, 2001). Men who have capitalised on their youthful looks and stamina may struggle with ageing (Dorais, 2005).

Some sex workers may need help with an exit strategy from sex work, whilst others may need assistance with finding empowerment within their current situation (Gaffney & Beverely, 2001). Some sex workers may have experience of violence with clients (from or towards). Issues of assertiveness may be paramount, particularly when the client is negotiating boundaries of safer sex. Often, safer sex practices (condom use) will be foregone for financial compensation or whilst under the influence of drugs (Dorais, 2005; Jackson et al., 2005).

Sex workers who use condoms regularly in their professional lives may not do so in their personal lives. This is one of a number of issues for sex workers who must negotiate paid sex as well as, or in secret from, their personal, intimate relationships (Jackson et al., 2005). Many male sex workers have personal romantic relationships with other men who sell sex. People who sell sex who have relationships with others who do not often have difficulty gaining understanding of the contexts and meaning of sex within their personal and professional lives (Gaffney & Beverely, 2001). People who do not sell sex may have different expectations from a relationship than a person who sells sex professionally (Gaffney & Beverely, 2001). People who sell sex in secret may not have disclosed the true nature of their professional activities to their partner, their families, or their friends (Morrison & Whitehead, 2007). For many sex workers, a primary concern is their fear of being found out. Many sex workers use a pseudonym for their working relationships.

Some sex workers will have multiple needs (eg drugs, homophobia, abuse). These needs are multiplied again if the person is foreign, as they may present issues of racism and xenophobia, alongside concerns about migration status (eg illegal migrants, migrants on holiday visas who are not permitted to work). Migrant sex workers may also feel the impact of assimilation into another culture. Cultural norms and attitudes may be quite different in the client's parent country, particularly if they are from religious or rural backgrounds (Mai, 2008).

2.3.6 Lesbians and Bisexual Women who sell sex

The number of women selling sex to other women is relatively low. It is more likely that a woman who identifies as a lesbian in her personal life will be selling sex to men, as 'straight for pay' (Shrage, 1999). Some women may have tentative or new feelings of same-sex attraction, which may or may not be related to their work (Gochros & Bidwell, 1996). This invisibility may be seen as negative, as in wider considerations of lesbian invisibility, or as a positive method of managing stigma. Like other sex workers, these women may lead a double life, to avoid the stigma of being labelled a 'prostitute' or a 'whore' (James, 1996). Some women may have identified as straight prior to taking up sex work, but develop relationships with other women as a way of separating their professional intimacies from their personal relationships. Avoiding pregnancy will be a concern for women, as well as sexually transmitted infections (STIs), including HIV (Jackson et al., 2005). Some women have children (Sanders, 2005). Issues of trafficking and coercion into sex work are reported to be much more common for women than for men (Agustin, 2007).

2.3.7 Trans people who sell sex

Trans men working as sex workers are comparatively rare. Trans women are much more common, particularly in some areas. Many trans women do sex work because discrimination has forced them to find alternative income, particularly during the initial stages of their transition if they are trans-sexual, or if they have difficulty 'passing' if they are transvestites. Some people may have been forced out of home or housing. Many trans women do sex work to pay for gender reassignment operations and related cosmetic surgeries. Some will have issues with 'passing' as their new gender identity. People may have issues with body dysmorphia as well as gender dysmorphia. Others may not identify with either a male or a female identity, and may wish to occupy an 'other' space that is neither male nor female. Additionally, they may feel pressure to conform to a single sexual identity and 'complete' their transition through surgery, whilst paradoxically realising a

higher market demand exists for 'chicks with dicks'. Trans women sex workers have both male and female clients, although most are men.

2.3.8 Drag

Drag (not to be confused with transvestism or transgender) encompasses drag queens and drag kings. Drag queens are usually men who dress in a stereotypically female gender role, often exaggerating characteristics for dramatic effect. Drag kings conversely are usually women who dress and may perform in a traditionally male gender role. 'Faux' or 'Bio' queens are women who dress in the drag queen style and 'faux' kings are men who dress in the drag king style.

Drag is not necessarily for the purpose of performing. Drag events, such as drag balls and more modern 'drag races', have long been a regular part of some social calendars. For many years, such masquerade balls were the only opportunity for men to dress and behave a particular way in public (Cole, 2000). Drag queens have been a central part of the commercial Western gay scene since its inception, although this may vary in different areas and eras. The drag king phenomenon is more recent and reasonably common in some major cities today. However, there are numbers of people who engage in drag in other contexts, for instance for the pleasure it affords them personally or socially. Some drag queens also identify as transvestites whilst, for most 'transvestism' and 'drag' are separate pursuits with quite separate identities (Bornstein, 1994). Drag king identities and practices may have some overlap with butch identities and be more focused on performativity rather than performance (Schacht & Underwood, 2005; Halberstam, 1998).

2.4 Relationships

2.4.1 Spaces for meeting (including internet spaces)

Cottaging is a gay slang term referring to anonymous sex between men in a public lavatory. Cruising is a more general term for looking for potential partners, for example, in a well known area for meeting or a nightclub. Cottaging/cruising is engaged in for a variety of reasons, not least of which is the pleasure it affords. It is commonly assumed that gay men engage in such practices because this is the only sexual outlet they can find. This may be the case for some men, particularly those in isolated rural communities. However, it is important not to assume that this is the case for all. Many out gay men with access to a commercial gay scene will still cottage/cruise and not see this as a problematic aspect of their sexual behaviour.

It is important to recognise that LGBTQ people are increasingly using the internet as their primary place for meeting and forging relationships, and, for many outside urban centres, for accessing communities. For example, the website 'gaydar' is an extremely popular place for LGBTQ people to have a profile, to cruise and to meet other LGBTQ people. There are similar online sites for people who identify as bisexual BDSM and polyamorous. These smaller groups who are often without a commercial scene are particularly likely to use the internet to form and develop communities (Ritchie & Barker, 2006).

2.4.2 Relationship forms

Whilst, like heterosexuals, many LGBT people are involved in long term monogamous, or serially monogamous relationships, significant numbers of those in gay, bisexual, trans and to some extent, lesbian communities, are involved in openly non-monogamous relationships (e.g. Adam, 2006; Klesse, 2005; Munsen & Stelboun, 1999). For example,

non-monogamy in the form of 'fuck buddies' and open relationships are well-established stories amongst gay men in the UK, with 56 per cent of UK gay men in openly non-monogamous relationships (Hickson et al., 1994). LGBTQ people are more likely to have 'open' relationships rather than 'secret infidelities' (Nichols, 1990). Some have argued that open non-monogamy is more common in LGBTQ relationships because people are questioning 'the rules' already around identity and this makes it more likely to question other 'rules' around relating (Heaphy, Donovan & Weeks, 2004).

The terms people use for relationships are different in different contexts. For example, gay men may be more likely to use the term 'open relationships' (Adam, 2004) whilst heterosexuals may be more familiar with 'swinging' (generally a relatively similar relationship style involving sexual relationships outside a main couple and/or other people being brought into the couple for sex; DeVisser & McDonald, 2007). In bisexual, trans and lesbian communities the concept of 'polyamory' is more common, although this may be becoming more widespread (Klesse, 2007). Polyamory refers to 'a relationship orientation that assumes that it is possible [and acceptable] to love many people and to maintain multiple intimate and sexual relationships' (*Sexualities*, 2003, p.126). There has been a proliferation of polyamorous communities and identities with the increase in internet use from the 1990s. Generally there is an emphasis on openness, communication and relationship skills within such communities. Common models of relating include: somebody having one main or 'primary' partner and other 'secondary' ones, somebody having multiple partners who they may or may not live within a triad, quad, tribe or family, and someone having multiple non-primary partners (Labriola, 2003). Polyamorous groups may be 'polyfidelitous' (with sexual contact only within the group) or open. Some feel that polyamory is an inherent part of their sexual identity; others claim it as a politically chosen way of relating in reaction against the norm of monogamy (Barker, 2004). Different languages are emerging to describe the relationships, structures and emotions involved in non-monogamous relationships, so it is worth becoming familiar with these when working with openly non-monogamous clients (Ritchie & Barker, 2006).

Therapeutic issues with openly non-monogamous people may include: the societal lack of respect and recognition of a diversity of possibility relationship structures, demands on the time and communicative competence of those involved, difficulties arising from different desires and wants amongst partners, commitment issues, maintaining balance in triadic/quad/family relationships, explaining relationships to others (colleagues, family, friends), and jealousy and trust issues.

People forging relationships which are different from traditional ways of relating may present with particular difficulties concerning their struggle to find satisfactory ways of living. Whilst this may offer considerable creativity and freedom for some, others may find themselves engaged in complex living arrangements which do not necessarily meet their needs. Care must be taken to work with the client and their own desires in a constructive way rather than assume that the unorthodox relationship/s is in itself problematic. Furthermore, it is important not to assume that relationship problems (such as those mentioned above) will necessarily be any greater in non-monogamous and/or non-traditional relationships than amongst traditional monogamous relationships.

2.4.3 Marriages and civil partnerships

The Civil Partnership Act (CPA) came into force in the UK on the 5 December 2005 and has potentially affected thousands of people who are in same-sex relationships (Langdridge & Barker, 2006). The CPA gives formal recognition to same-sex couples and is the second piece of legislation in Britain (following the Adoption and Children Act, 2002) that begins to redress the legal inequalities between opposite-sex and same-sex couples.

In British culture (as in many cultures) opposite-sex interpersonal relationships are highly valued and are afforded an even higher financial, legal and social status once they are formally recognised through marriage (Herek, 2006). Same-sex couples on the other hand, have not enjoyed the same level of social acceptance due to the socially stigmatised identity of LGB people and heterosexism in society. The legal recognition of same-sex relationships has long been a sensitive and complex social and political issue, where opposing views, ranging from extremist anti-gay religious groups to LGB human rights groups, have all been highly vocal. Some are still campaigning for full equality in terms of marriage whilst others are equally arguing that LGBTQ people should resist embracing institutions which may be deemed sexist, heterosexist and mono-normative.

Exploring the decision to enter into a civil partnership, or not, can provide the psychologist with an understanding of the meanings relevant to the client and the couple. This is in terms of the meanings of relationships, LGB rights, social recognition and status, the notion of 'family' and how concepts of religion and commitment might or might not fit. There are many potential therapeutic issues for people considering partnerships including the involvement of families, the complexity of people living in non-monogamous relationships, possible financial benefits, intersections with age and culture, child-rearing and the guaranteeing of security of partners.

2.4.4 Partner abuse

Understanding violence and abuse within the couple relationships of lesbians, gay men, bi and trans individuals requires an appreciation of the way in which prejudice and discrimination (i.e. homophobia, bi-phobia, trans-phobia and heterosexism) operate to create a context for isolation, rejection and disbelief, the very ingredients which increase the risk of violence and abuse within these relationships (Ristock, 2002).

Domestic violence and abuse within the relationships of sexual minorities is characterised by conscious manipulation and control of one person by another through the use of threats, coercion, humiliation and/or force (Hart, 1986; Island & Letellier, 1991; Hester, Pearson & Harwin, 2000). Most definitions incorporate physical, emotional and sexual abuse and it is worth noting that in a recent UK study (Donovan et al., 2006) levels of sexual abuse within same-sex abusive relationships were comparable to those of physical abuse, particularly so for gay men in abusive relationships. Although, to some extent, violence and abusive behaviours within the relationships of sexual minorities mirror those seen in heterosexual relationships, some abusive behaviours are specific to LGBT relationships. For instance, threats to:

- reveal the sexual or gender identity of a victim to family, friends or work colleagues;
- jeopardise the custody of one's children or immigration status on grounds of sexual orientation;
- reveal a partner's HIV status, telling the victim that no-one will believe him/her given the level of prejudice within the agencies that exist to offer support.

To date, the largest body of research on abuse and violence within same-sex relationships is that relating to the prevalence of such abuse. However, given the level of shame and self-blame and the hidden nature of the phenomenon, Donovan et al., (2006) suggest that this is a population who keep the abuse to themselves and as a result of this and differing thresholds and definitions of violence and abuse within the studies, findings vary enormously. For instance, Island and Letellier (1991) in their survey of violence and abuse within gay male relationships place the rate of abuse at 15 to 20 per cent, whereas Waldner-Haugrud, Gratch and Magruder (1997) believe the figure to be as high as 29 per cent and in a comparison study conducted by Gardner (1989) rates of abuse for lesbian couples was as high as 48 per cent and for gay male couples the figure was 38 per cent. Sigma, a British survey of gay men and lesbians (Henderson, 2003) found that one-in-four individuals in same-sex relationships experience domestic abuse, a ratio that is close to the figure for heterosexual domestic abuse against women. For trans and inter-sex people, Courvant and Cook-Daniels (2000) found that 50 per cent of the respondents in their study had been raped or assaulted by an intimate partner. There is currently a paucity of data relating to bisexual intimate partner abuse since bisexuals tend to be subsumed under lesbian and gay couple relationships.

As with all abusive relationships, one of the main challenges facing those in the helping professions is that of intervening in a safe and effective manner. Unlike heterosexual relationships, where a gender exclusive framework has been invaluable in supporting female victims at the hands of male abusers, in same-sex relationships power dynamics, such as financial advantage, physical size, status defined by employment and gender, play out differently since gender is a constant. Ristock and Timbang (2005) suggest that the power dynamics may seem confusing, because same gendered partners might be the same size and strength, and therefore physical appearance cannot be used to determine who in the partnership, is actually the abuser. Furthermore, victims report using physical violence in self defence and/or even retaliating (Ristock, 2002; Marujo & Kreger, 1996) and this can add a further layer of confusion. For that reason, the level of risk needs to be carefully assessed to ensure that victims get the protection they need and that perpetrators in turn are encouraged to take responsibility for their actions and referred to appropriate perpetrator programmes, assuming they do want help.

When it comes to seeking help, only 22 per cent of the subjects of the British study on same-sex partner abuse (Donovan et al., 2006) sought help from anyone and of those who did, the majority used informal networks of friends or private means, rather than turning to voluntary or statutory agencies. It seems that victims of abuse within same-sex relationships are more likely to turn to individual counsellors, which, by its very nature, can unwittingly play into the dynamic of pathologising the victim, especially if the victim believes him or herself to be the cause of the abuse. Practitioners must, therefore, carefully position themselves and be mindful of the fact that many victims will be reluctant to name the abuse and it may be the case that counsellors are primarily working with the symptoms and impact of the abuse, i.e. depression, low self-esteem, and fear, rather than the abuse itself. A central challenge facing professionals is that of reaching perpetrators and helping them face up to the consequences of their actions, with a view to offering some effective input. Couple work is only indicated once the nature and extent of the abuse is clear, the victim is safe and the perpetrator has taken responsibility for his or her actions and is

motivated to change, otherwise the couple sessions may place the victim in further danger of abuse and violence.

As with all intimate partner abuse, a co-ordinated approach is recommended. To that end the LGBT Domestic Violence Forum has been established to pool information and to co-ordinate initiatives on behalf of a population who, historically, have not been well served by helping agencies that were established to tackle abuse of women by men. Russo (2001) suggests that the ethical challenges of developing appropriate responses to LGBT relationship violence is to think through a framework of intersectionality (one that considers the connection of relationship violence to all systems of oppression) and to keep this work rooted in larger anti-oppressive and social justice efforts.

2.5 Sociocultural diversity

The United Nations Education, Scientific and Cultural Organization (UNESCO) describes culture as being the ‘set of distinctive spiritual, material, intellectual and emotional features of society or a social group’, and encompasses ‘art and literature, lifestyles, ways of living together, value systems, traditions and beliefs’ (UNESCO, 2002). Within society there are majority and minority groups, with the majority groups setting the (dominant) ‘norms’, which minority groups deviate from. Metaminorities are minorities within minorities, who with ‘dual-minority’ or ‘multiple-minority’ statuses, separately or synergistically, are restricted access into dominant groups and their discourse. For example, Black and Minority Ethnic (BME) people who are also sexual minorities are metaminorities of ethnicity and sexuality. As an applied psychologist you will be different and similar to your client on a number of different dimensions (as discussed below). You need to be aware of these similarities and differences and how they may influence your work. For instance, if you are a monogamous heterosexual, you should not make assumptions about monogamy, or about the labels people use to describe their sexuality, sexual practices, or sexual partners.

There are some overarching issues about being a minority within a minority that cut across the separate socio-cultural differences listed below. These include feelings of isolation, feeling ‘aberrant’, experiencing low mood, cognitive dissonance, and anxiety. These issues are discussed in more detail below and in the rest of this document. In addition, a number of these socio-cultural variables described may apply to the same individual (e.g. an Asian lesbian with a disability), and these differences sometimes have interactive effects. It is, therefore, important for the clinician to keep these various dimensions in mind and let the client privilege one above the others depending on their opinion as to which is more relevant at any one time.

2.5.1 Gender and sexuality

An individual’s gender will influence the meeting places they frequent, their socio-cultural norms and their sexual practices. In general, lesbians have traditionally had less visibility than gay men, both in mainstream (predominately heterosexual) media and the generic gay press. Because of this, ‘lesbian visibility’ has been important for sexual minority women to make public their sexuality, with practices such as cutting hair short and not wearing make-up (Clarke & Turner, 2007). These images of more ‘butch’ lesbians have become less important since the early 1990s, when ‘lesbian chic’ or ‘lipstick lesbians’ brought the image of lesbians into the public eye in a more mainstream feminine way. Today the appearance

(or ‘performance’) of lesbians varies enormously from the butch/femme dichotomies of the 1950s.

While many meeting places are for both men and women from sexual minorities, there are a significant amount of same-gender functions, events, and venues. These serve an important function in social and sexual networking, and developing and campaigning for common causes. Such events range from the lesbian separatism meetings of the 1980s (where women denounced all relationships with men) to the predominance of men-only sex clubs and saunas in large British cities today.

When trans people change their gender this can also change their sexuality label, and that of their sexual or relationship partner or partners, which may or may not be acceptable to the partner(s). This is discussed in more detail in the section on Trans issues.

2.5.2 Ethnicity/race

Homosexual practices are found in many cultures/geographical regions historically and contemporaneously (e.g. ‘motsoalle’ relationships between women in Lesotho, ‘two-spirit’ individuals in Native North America, ‘kathoey’ of Thailand, ‘kōçeks’ and ‘bacchás’ of Central Asia, etc.). A distinction should be made between sexual acts and sexual identities. Individuals may not always ascribe a particular sexual identity to their sexual practices or acts, therefore terms such as gay, bisexual, lesbian, etc. must be used with caution. There are varieties of sexual identities and sexual identity labels based on language, ethnicity, race, religion, culture, and socio-economic status (e.g. panthi, kothi, Down-Low/DL, gay-for-pay, etc.).

‘Coming out’ as belonging to an identity-affirming sexual minority may not always be an option, or even desirable, for some BME people; and does not always lead to positive experiences in this group (Chan, 1987; Nair, 2006; Nair, in press). Therefore, while it is important for the psychologist to explore the client’s beliefs and expectations of ‘coming out’, it should not be considered as a vital milestone in the development of the client’s sexuality.

There may be issues of visibility and invisibility for some BME sexual minority people. They may fear being exposed or ‘out-ed’ if they access mainstream LGBTQ venues. Others may experience alienation due to a lack of visibility of non-White people represented in mainstream LGBTQ press and other media and/or LGBTQ venues, as well as overt racism in these contexts. Such exclusion could lead to confusion and distress, no sense of belonging, and poor social support/networks with other sexual minority people, who could be a potential support against homophobia. An attempt to integrate with dominant LGBTQ communities may lead to internalised racism in BME sexual minorities (Chuang, 1999). This internalised racism may further alienate the client from his/her own ethnic communities, which would normally provide solidarity and protection from wider societal racism. People from sexual and ethnic minorities, therefore, face the potential for double discrimination on the basis of racism and homophobia from the societies they are affiliated with.

External and internalised homophobia among BME sexual minorities, and the wider effects of racism, may lead to stronger ties with their own ethnic groups, which mainly promote reproductive heteronormativity and condemn other aspects of sexuality. Heterosexual marriage and reproduction are rites of passage in some such cultures, and hold high socio-cultural significance, placing sexual minorities under immense pressure to

conform to these standards. There may also be stringent gender-roles and mores, and these are linked to promoting compulsory heterosexuality and discouraging/chastising all other sexualities. People may find themselves agreeing to traditional marriages and living a secret ('closeted') life to express their preferred or alternative sexual identities.

Both ethnic and sexual minorities report having negative experiences accessing mental health services (King et al., 2003). Therefore, particular care must be taken to ensure that their (negative) expectations of psychologists are not confirmed. Understanding clients' previous experiences accessing mental health and/or psychological services is important when establishing rapport at the start of working together.

Some BME groups may be eroticised by the dominant culture, reflecting colonial forms of racism that were prevalent in the slave trade and can still be evidenced today (e.g. the colonial and postcolonial stereotyping of black men having a voracious (animalistic) sexual appetite and prowess, and black women as being licentious).

Case Study: Andrew, a British-Asian man, married a woman his parents 'chose' for him, which permitted him to come to England. He has always been attracted to men and enjoys sexual contact with them. He identifies as being heterosexual, and rejects any notion of being 'gay'. He repeatedly experienced erectile dysfunction while attempting to have sex with his wife, which led her to ask for a separation. He wants to get married again and to have children. He also attests that he wants to continue having sex with other men, but doesn't feel the need to disclose this information to anybody else (from Nair, in press).

Comment: Andrew's refusal to accept the notion of being 'gay' is important, and highlights how culturally loaded such a term is. Here, the therapist would benefit from understanding what 'gay' means to Andrew, and how he can negotiate his sexual choices without identifying as a sexual minority.

2.5.3 Migrants, refugees and asylum seekers

In countries around the world, people from sexual minorities are criminalised, tortured or ill-treated because of their sexuality (see Amnesty International Campaigns at www.amnesty.org.uk/). Migrants, refugees, and asylum seekers may experience difficulties in being a visible sexual minority for fear of rejection (from members of their own diasporic communities), and fear of persecution from the State because of their sexuality, based on previous negative experiences from their home countries. However, being invisible reduces the possibility of meeting other sexual minority people, and being seen with visible sexual minorities may jeopardise their own invisibility. This conflict between being visible and invisible can be problematic. It requires the clinician to spend time developing rapport and trust, being culturally sensitive to the meaning of the client's sexuality in their sociocultural context and developing a language to discuss these issues in a meaningful way in therapy.

Migrants, refugees, and asylum seeker clients who are also in sexual minorities may find adjusting to local sexual scripts, codes and practices difficult, and may find mainstream sexual identity labels imposed on them. Alternatively, they may feel pressured to assimilate

with dominant sexual minority groups to gain acceptance, the values of which may be at odds with those of the client (e.g. Muslim sexual minorities having issues accessing 'the scene' where alcohol is served). Further complications and misunderstanding can occur as a result of language barriers and difficulties.

Limited financial resources may preclude some migrants, refugees, and asylum seekers from being able to access certain LGBTQ spaces and events, preventing them from integrating with other sexual minorities. Poor availability of the internet which can be accessed in private, because of lack of funds, may further hamper possibilities of meeting other 'out' or invisible ('straight acting' or 'discreet') sexual minorities. The internet is well used by sexual minority communities to find sexual and romantic partners, as well as to forge links with others.

Refugees and asylum seekers may also find it difficult to access health services (e.g. Genito-Urinary Medicine clinics, Mental Health services, etc.) due to language barriers, lack of information and knowledge about health conditions and available services, and poor targeting of such groups by health services. This places such individuals at higher risk of mental health problems, and/or contracting and/or infecting others with sexually transmitted infections. Immigrants may lack knowledge or accurate information about health problems, or not perceive themselves to be at risk (e.g. Chinouya, Davidson & Fenton, 2000). Furthermore, this group may not have adequate resources to treat or manage health conditions, or to access psychological help. In addition, new refugees and asylum seekers may have difficulty distinguishing between the Home Office and the NHS, both being government agencies, and so have fears about confidentiality.

Case Study: Musa, a young Muslim asylum seeker, fled from his country after being attacked for having had sex with a statesman there. Living in Britain now, he finds himself unable to connect with gay men. He feels shunned by other black gay men because he doesn't speak English well and cannot afford to dress 'trendy', and feels that only white men who are older than his father are sexually interested in him – this makes him uncomfortable. He is also scared to disclose his sexuality to (heterosexual) people from his homeland, as he fears being cut off from them and the mosque – his only friends and community here.

Comment: Musa's predicament is not uncommon. He faces prejudice based on his multiple-minority statuses. This highlights how an individual's identities can be in the foreground or background, depending on circumstances. The therapist's challenge here is to help the client understand and negotiate his/her various identities, to facilitate coexistence with minimal dissonance.

2.5.4 Urban/rural issues

Living in a small community can make it difficult to 'come out' or transition gender, as anonymity may be impossible and such changes may be met with hostility and lack of acceptance. Similarly, same-sex partners living together or moving into the area may be concerned about 'coming out' and being accepted in the new community. In addition, access to supportive communities or places to socialise and meet friends and partners might be limited in rural settings. Some people may move to urban areas due to the

problems associated with being a sexual minority in a rural area. Rural-urban drift brings with it associated difficulties (e.g. employment issues, housing, financial difficulties, etc.). However, there are also advantages to such moves as most of the services for sexual minorities are based in large cities. Information about these services is usually available from local LGBTQ helplines.

2.5.5 Religion/faith/spiritual communities

Dominant interpretations of most religions admonish same-sex practices, but liberal interpretations generally only reprove coercive sexualities. However, strong feelings of guilt and shame may be experienced by both believers/religion-practising individuals and for others, for example, parents or siblings, for whom religion and culture exist as one entity and are a way of life. Therefore, rejection and acceptance by significant others may be important factors in the client's decision to 'come out'.

People may find it difficult to negotiate sexuality with religious and cultural views, causing cognitive dissonance and distress (de Jong & Jivraj, 2002). Religious views may deter sexual minorities from accessing mainstream LGBTQ social venues, which predominantly tend to be clubs and bars (e.g. venues with a 'backroom' where anonymous sex takes place). This is more of a problem in smaller cities, where alternative meeting places are not always available, such as LGBTQ-friendly cafes.

Fortunately, many LGB faith groups exist as a resource:

- Jewish [www.jglg.org.uk]
- Muslim [www.imann.org.uk]
- Muslim women [www.safraproject.org]
- Christian [www.lgcm.org.uk]
- Catholic [www.questgaycatholic.org.uk]
- Buddhist [www.sgi-uk.org].

2.5.6 Age

There is a premium placed on youth in dominant LGBTQ cultures and social spaces. This makes it more difficult for older lesbian and gay people to meet friends or partners, particularly if they came out later in life (perhaps after having been married and/or having children) and so do not have an LGBTQ social network. Older individuals may face isolation and exclusion, leading to experiences of loneliness, with loss of friends and partner(s), particularly in the absence of familial or other traditional support systems. In addition, some older adults have lived in a time when their sexuality was considered a criminal offence (until 1967 in England, 1980 in Scotland, and 1982 in Northern Ireland) and a mental illness (until 1973). This may have had a detrimental impact on their formation of a sexual identity or have led to homophobic abuse (sometimes at the hands of mental or physical health professionals). This could have an impact on their trust in you as a psychologist and the service you work for. Older sexual minorities living in nursing homes have concerns about their being accepted by staff and other residents. There are organisations that work for better services for older sexual minorities, for example:

- Polari [www.polari.org]
- Age Concern's Opening Doors programme
www.ageconcern.org.uk/AgeConcern/openingdoors.asp
- Alzheimer's Society LGBT Carers [www.alzheimers.org.uk/Gay_carers/index.htm].

'Coming out' (models of which include Cass (1979), D'Augelli (1991), and Rivers (1997)) can happen at any age. It is a process that repeats itself in every new environment or with new people, and might be particularly pertinent in adolescence where there is peer pressure on opposite-sex sexual experiences and relationships. For those living with parents, coming out to them might be problematic, particularly if the young LGBTQ individuals are dependents. There are organisations that work with young sexual minorities, for example, Alfred Kennedy Trust [www.akt.org.uk], gay youth UK [www.gayyouth.org.uk]. It should be remembered that while the age of consent for sex between men has been equal to heterosexuals (16 years in Great Britain, 17 years in Northern Ireland) since 2000 (Sexual Offences (Amendment) Act, 2000 (Office of Public Sector Information, 2000), All adolescents can be offered confidential sexual health services between 13 and 16 years, if assessed to be mature as rated by Fraser Guidelines and Gillick Competence in England and Wales (Department of Health, 2001), and the Age of Legal Capacity (Scotland) Act, 1991 (C50) in Scotland (Office of Public Sector Information, 1991).

Parenting issues in mid-life can be relevant for LGBTQ individuals, trying to find a donor, facing prejudice from family, friends, medical professionals, or even uncovering internalised homophobia within the relationship. Finding a psychologist to work with these issues can also be a challenge, because of the strength of the assumptions of what a 'family' consists of being based on heterosexist models.

2.5.7 Class

Class can affect one's sense of confidence and eloquence to speak about one's sexuality and expect to be accepted. For those from lower class/socio-economic communities, access to mainstream venues might be a problem, for example, Pride events, commercial LGBTQ spaces and venues, private counselling, etc., and they are less likely to engage in communitarian gay activities (Keogh, Dodds & Henderson, 2004). However, for some working-class sexual minorities, financial autonomy may have resulted from having left school/college early to seek employment, which may create inroads to such spaces. Lack of access to mainstream events and lack of opportunities to move to more gay-friendly areas may result in isolation, hostility from heterosexual counterparts, or pressure to conform to dominant forms/expressions of masculinity/femininity (e.g. 'gansta' machismo).

Homophobic bullying is rife in British schools (Rivers & D'Augelli, 2001), and children from working-class backgrounds are often left to deal with the situation themselves without the help of parents or school (Keogh et al., 2004; Henderson, 2004). Even after leaving school, working-class gay men face more discrimination at work and from public and commercial services, compared to gay men from other classes (ibid.).

People may be eroticised for their class identity within sexual minority communities (e.g. 'Chav Boi', 'hoodie lad', 'trackie boy', etc.). Interestingly, in places with few LGBTQ-specific venues, class barriers may not be an issue, as people are brought together by having their sexuality in common.

The association between working-class (lower socio-economic status) and limited access to health care has been repeatedly documented from the time of the Black Report (Department of Health and Social Security, 1980) and continue to be acknowledged in recent times (e.g. Cattell, 2001; Scambler & Higgs, 2001). Finding access to a psychologist may, therefore, be problematic.

2.5.8 (Dis)abilities

LGBTQ communities can be body fascistic in the extreme (with the dominance of one body type that is considered attractive, for example, men in the gay press tend to be very muscular). The importance of appearance associated with physique and style in dominant LGBTQ cultures may make connecting with able-bodied counterparts arduous and problematic for people with physical disabilities. Thus, making friends and partners if an LGBTQ person has a physical or learning disability can pose a challenge.

Sexual minorities with learning disabilities are less likely to have their needs recognised because of social and practice disincentives (Cambridge, 1997). There is also evidence to suggest that this metamajority also faces high HIV-related risks (Cambridge, 1994, 1996). Sexual minorities with learning disabilities may also not take on the labels of lesbian, gay, or bisexual, as these may be associated with discriminated groups. Adopting such labels in addition to the label of learning disabled increases the likelihood of double-discrimination.

As most sexual minority social or commercial meeting spaces (apart from virtual spaces) tend to be clubs and nightclubs, access could be a limitation for people with disabilities. This might have improved with new legislation, such as the Disability Discrimination Act (Office of Public Sector Information, 2005), but it is still a problem, particularly for people with mobility restrictions. This is more of a problem in smaller cities, where alternative meeting places are not always available. There are some LGB disability specialist groups, such as those for people who are deaf, but by and large the LGBT social networks are geared for able-bodied people. Clients may find it beneficial joining organisations which support LGBTQ people with disabilities, such as Regard [www.regard.org.uk].

2.6 Health

2.6.1 Physical Health

Lesbian health can easily be sidelined as most literature (particularly sexual health literature) is aimed at gay men. There are also fewer specialised resources available to lesbians (e.g. lesbian sexual health clinics). However, there are a number of health issues that are highly relevant to lesbian and bisexual women, including high risk of breast, cervical, and ovarian cancer (Carroll, 1999; Bailey et al., 2000), and obesity (Boehmer, Bowen & Bauer, 2007). However, many lesbians do not visit a gynaecologist, viewing them as only relevant in cases of contraception and motherhood (ILGA, 2006). In mainstream health services, lesbians, gay men and bisexuals may face prejudice and discrimination from medical staff. A lack of acceptance and knowledge of sexual minority lives and queer sexual practices in health settings have been well documented (e.g. McFarlane, 1998). Health professionals often assume heterosexuality, as well as overtly or covertly discriminating against sexual minority patients.

High rates of STIs are prevalent in sexual minority communities, particularly in gay male communities; with gonorrhoea having increased by 10 per cent between 2004–2005, syphilis by 66 per cent between 2001–2005, and herpes by eight per cent between 2004–2005 (Health Protection Agency, 2007). However, as with other health conditions, the focus in sexual health has been on gay men and so lesbian sexual health and HIV issues are under-researched and under-resourced.

2.6.2 HIV

There are high rates of newly acquired HIV infection among gay and bisexual men or men who have sex with men (MSM) in general, when compared to heterosexual counterparts (although there have been more heterosexual people diagnosed with HIV in the UK since 1999 (Health Protection Agency, 2007)). Being HIV positive can be an identity, as well as influencing sexual practices and forming new identities, such as 'barebacking'. Knowledge of Highly Active Anti-retroviral Treatment (HAART) and Post-Exposure Prophylactic (PEP) in gay communities can be well developed and expert patients are common. Lipodystrophy, a side-effect of anti-retroviral treatment, which redistributes lipids and changes body shape in characteristic ways, can be a prime concern for HIV positive gay and bisexual men on medication, as it can potentially disclose their HIV status. Outside of sexual minority communities, gay and bisexual men can be blamed for spreading disease, which can be a further cause of distress and/or abuse.

2.6.3 Mental Health

High rates of mental health concerns have been reported in LGBT populations (e.g. King et al., 2003a, 2003b). Some of these problems are related to homophobia and heterosexism from the wider society and from further prejudice and discrimination in the NHS (e.g. McFarlane, 1998). Frequently reported problems include: depression, anxiety, substance misuse, and eating disorders. There are also high rates (when compared to heterosexual counterparts) of deliberate self-harm, suicide attempts and completed suicides, particularly in youth (Rivers, 1997). However, there is some evidence to suggest that there may be over/under-diagnosis of conditions; this has been argued in particular for Borderline Personality Disorder (Hagger-Johnson, 2007). Clinicians should also be wary of considering a diagnosis of 'Sex addiction' in sexual minorities, simply on the basis of any predefined 'norm', as this can vary with individual or group sexual identities and practices.

2.6.4 Substance use

There are higher rates of drug and alcohol use in lesbian, gay, and bisexual communities than in the general population (Hughes & Eliason, 2002), including the use of steroids and recreational drugs. This has been suggested to be linked to comorbid conditions or poor socio-cultural support against heterosexism and homophobia. However, it could also be attributed to the focus of the major socialising avenues open to sexual minorities, which are connected to drinking and recreational drug use (i.e. bars and clubs). The use of anabolic steroids has also been linked to the desire for the ideal mesomorphic body image, and also associated with 'muscle dysmorphia' (Pope, Phillips & d'Olivardia, 2000).

2.7 Children, young people, families and schools

2.7.1 Sexual Development and Sexual Identity Development

Despite the recognition that sexual desires and attractions form an essential part of adolescent sexuality, very little attention is given to their origin or presence during childhood. It has been suggested that cultural norms maintain a silence around this topic (Savin-Williams, 2005). Research on the development of sexual attraction (e.g. Remafedi, Farrow & Deisher, 1992) suggests that young children can recognise attractions, but self-identity labels do not become consolidated until adolescence. However, young LGB people often describe feeling 'different' from an early age but are unable to clearly label this difference (Flowers & Buston, 2001; Bell, Weinberg & Hammersmith, 1981). Maguen et al.,

(2002) found that the mean ages in their survey for first awareness of same-sex attraction was 11 years, with 16 years for first same-sex sexual contact, and 17 years for first disclosure of sexual identity.

Issues of identity and sense of self and self-esteem are relevant for adolescents in the widest sense (Erikson 1959, 1964, 1967) as they explore their relationships to develop a sense of who they are, how they can feel good about that, and the kind of future they would like. Erikson states that the unique developmental task of adolescence is to solidify a personal identity. Sexual behaviour has been described as one of the key ways, in contemporary society at least, for adolescents to 'de-satellise' and begin, emotionally and physically, to leave the parental orbit and move toward independence (Selverstone, 1989). This process is challenging enough especially in a media focussed society which portrays very negative images of youth, and indeed, the future of society. Adding the developing sense of oneself as LGB can add considerably to the stress of this process. All adolescents share the same physical, cognitive, psychological, and social tasks of development, regardless of sexual identity. However, if one of the primary psychological tasks of adolescence is the development and consolidation of identity, then LGB adolescents face many challenges that heterosexual adolescents do not (Fontaine & Hammond, 1996).

2.7.2 Identity and coming out for LGB Youth

An individual's sexual identity as part of their overall identity is clarified and consolidated through several processes; cohort comparisons, societal confirmation, and peer affirmation (Fontaine & Hammond, 1996). The systems around adolescents (families, schools, neighbourhoods, work places etc.) provide the contexts for these processes but for LGB adolescents they often, at best, fail to foster these positive processes. More often, however, the situation is harsher in that they provide negative and stigmatising contexts for sexual identity formation. Therefore, many LGB adolescents develop a sexual minority identity *in spite* of the fact that the systems they live within promote the heterosexual norm.

Of course, for many, the process of developing a LGB identity is completed after adolescence. For others the questioning of sexual identity will never result in a LGB identity, even though some may continue to engage in same-sex behaviour (Savin-Williams, 2005). This brings into question the limitations of common usage sexual identities, as these labels can be too reductionist to capture the full extent of people's sexuality. It is important to remember that although transitory same-sex behaviour can cause some confusion, it is the minority of adolescents who go on to develop LGB identities (Savin-Williams, 2005). It has been suggested that fluidity of identity is more relevant to young women than young men, with the majority of college-aged, same sex-attracted women shifting sexual identities, sometimes multiple times (Diamond, 2003). However, it is safe to say that adolescence is the usual period when sexual identity formation commences. Several models of this process have been offered (Cass, 1979, 1996; Lewis, 1984; Troiden, 1989). All of these models describe stages moving towards an increasing level of acceptance of a LGB identity, with a progression from confusion, through exploration, to integration (Fontaine & Hammond, 1996).

For example, Cass (1979, 1996) describes six stages of identity formation: confusion, comparison, tolerance, acceptance, pride, and synthesis. At the first stage, confusion is great as heterosexual identity is called into question and the adolescent may seek

information on being LGB, which is a difficult task given the dearth of accessible information. In the identity comparison stage, strategies may be developed to reduce the incongruence between same-gender attractions and heterosexual identity. Such strategies may include believing a same-gender attraction to be a one-off, believing same-gender attraction to be a phase, and considering oneself to be bisexual (which provides the potential for heterosexual behaviour). The identity tolerance stage means a move further from a heterosexual identity and towards a LGB one. This can often include seeking out the company of LGB people to alleviate a sense of isolation. Identity acceptance suggests the development of a stronger LGB identity and increasing contact with LGB people. Accessing the company of other LGB youth can be extremely difficult however, especially for those living in more rural areas. The identity pride stage often results in strong identification with LGB culture and a devaluing of heterosexuality. This gives way to less polarising views in the final stage of identity synthesis when a realisation and acceptance of the similarities between LGB culture and heterosexual culture can be accommodated through more inclusive behaviour.

As is usual with psychological stage models, the stage theories of LGB identity formation have attracted considerable criticism. These stages are considered to be clear and obvious, representing a universal, linear process that does not necessarily fit with reality because of the diversity of LGB populations (Savin-Williams, 2005). Troiden's (1989) model, which describes the four stages of sensitisation, identity confusion, identity assumption, and identity commitment, is perhaps more realistic in being more spiral than linear, suggesting that individuals move back and forth between stages and that not all will experience all stages or substages (Savin-Williams, 2005). It is recognised that development is moderated by external factors (such as heterocentrism and prejudice) and internal factors (such as internalised homophobia and personal strengths). Savin-Williams (2005) also stresses that the stage models are ethnocentric, and he suggests that in ethnic minority communities, sexual identity can be strategic and situational, being negotiated and renegotiated. The stage models have also been described as a developmental psychology of the remembered past which fails to recognise that recollection may be affected by subsequent life events. For example, the experience of being different as a child may be an adult interpretation of earlier life experiences. Little is known about how LGB youth experience their lives as they are living them (Moore & Rosenthal, 1993).

2.7.3 The process of coming out

For most, coming out is an ongoing process and not a one-off event. LGB people return to explaining their sexual identity to others throughout their lives as heterosexuality is so often assumed. The early coming out events to family and friends can be the most stressful however, and are among the most stressful LGB related life events described by LGB youth (D'Augelli, 1991; Rotheram-Borus et al., 1995). Survey results (Fox, 1995; Savin-Williams, 1998) are suggesting that the ages of disclosure of sexual identity are becoming younger, indicating that LGB youth are progressing through the process of sexual identity development at a younger age. Reasons proposed for this include increasing numbers of adults identifying as LGB and hence an increase in positive role models, increased media attention, growing cultural acceptance, and growing opportunities for socialising with other LGB youth (Boxer, Cook & Herdt, 1991). Ryan (2001) suggests that, until relatively recently, most LGB youth 'came-out' in their late teens or early 20s when they were either

working or attending college or university, rather than when they were at secondary school (see also Clarke & Broughton, 2005). More young people are 'coming-out' whilst at secondary school, and, with few exceptions (for example, the charities Family and Friends of Lesbian and Gay Men, in the UK, and Parents, Friends and Family of Lesbians and Gays, in North America), school and community support services have not kept pace with this apparent cultural change.

Not all LGB youth do come out of course (some never) and learn to live a life of dual identities; one public and one private. Even for young people, the hiding of sexual identity can cause insecurity, social withdrawal, and demoralisation (Hetrick & Martin, 1987).

2.7.4 Risks of coming out

The disclosure of sexual identity is a stressful event for most LGB youth because of the fear, often justified, of negative reactions from those they disclose to. For many young people, a fear of rejection by parents appears to be well founded. A British survey of LGB youth in London (Trenchard & Warren, 1984) revealed that approximately 40 per cent of parents reacted negatively to a child's disclosure of LGB identity, with the most extreme consequence being that some young people left home (11 per cent). Another common parental response was to send their son or daughter to a doctor (10 per cent) or to a psychiatrist (15 per cent). In Wallace and Monsen's 2004 study, (Personal communications) conducted in London, they found that, in comparison to 1984, more young people were being rejected by family members when they came out (32 per cent) and more were being thrown out of home (27 per cent of those who disclosed to parents/carers were thrown out). Of those young people who reported experiencing violence from family members as a result of their sexual orientation, over half still lived with the violent family member(s). Finally, 23 per cent of the 2004 sample were 'out' to their doctor, five per cent had attended a psychiatric unit and a further 42 per cent reported that they had received a clinical diagnosis from medical staff focused around anxiety disorders and depression. Rejection by parents can have a particularly strong impact because the maintenance of parent-adolescent bonds facilitates the achievement of developmental tasks for adolescents (Savin-Williams, 1989). The importance of coming out to parents in particular, despite the stress experienced, is indicated by the high percentage of LGB youth who succeed in the task. In a North American sample of LGB youth, 81 per cent had disclosed to at least one family member (D'Augelli & Hershberger, 1993).

As well as experiencing rejection from their families, many LGB youth receive direct abuse from prejudiced and intolerant peers (Rivers & Carragher, 2003; Rivers & D'Augelli, 2001; Rivers, 2003; Reid, Monsen & Rivers, 2004). There is particular pressure to conform to certain sex-role stereotypes in adolescence. Gonsiorek (1988) observed that failure to conform could result in cruel behaviour from peers. Savin-Williams (1995b) found that adolescents (particularly boys and young men) are frequently intolerant of difference in others and may actively punish and ostracise peers, particularly if the perceived difference concerns their sexuality (Gough, 2002; Phoenix, Frosh & Pattman, 2003).

In Trenchard and Warren's (1984) survey, 58 per cent of respondents reported verbal abuse and 21 per cent reported some kind of experience of physical assault. In a survey conducted by the LGB political lobbying group Stonewall (Mason & Palmer, 1996), 48 per cent of respondents aged under 18 had experienced violence and 90 per cent name-calling

because of their sexuality. Of the violent attacks reported, 50 per cent involved fellow students and 40 per cent took place within school. In Wallace and Monsen's (2004, Personal communications) study, about 66 per cent of respondents indicated that they had experienced bullying at school because of their sexual orientation. Ellis and High (2004) found similar patterns in their partial replication of Trenchard and Warren's (1984) survey. About 31 per cent of respondents indicated teasing, 37 per cent had been verbally abused and 15 per cent had been physically assaulted. These figures confirm that the fear of violence, intimidation and rejection reported by many LGB youth is indeed justified (Bontempo & D'Augelli, 2002; Garofalo et al., 1998).

2.7.5 Sexual identity and ethnicity, culture and religion

Young people born within ethnic minority families often face the task of synchronising cultural and religious identities from the country of the family's origin with dominant cultural identities relating to the country of residence. For ethnic minority LGB youth this process can be further complicated by having to co-ordinate minority sexual identities that can be in opposition to cultural and religious beliefs. This has been described as facing identity barriers on many fronts simultaneously (Fontaine & Hammond, 1996). Research in this area is sorely lacking, however (Maguen et al., 2002), especially in the UK. In North America, Dubé and Savin-Williams (1999) and Loiacano (1989) suggested that African Americans may be less likely to come out to others for fear of disconnection from networks that support ethnic identity. The importance of social networks that support the development of LGB identities has been highlighted here. The task of finding networks that support numerous minority identities can be a difficult one. On the other hand, some studies have failed to detect ethnic group differences in coming-out processes (e.g. Newman & Muzzonigro, 1993).

2.7.6 Vulnerability of LGB youth

The discrimination, rejection and victimisation that young LGB people frequently face can have a major impact on their mental health. Most of the studies of LGB youth in the UK have been small-scale but a consistent picture emerges from them of LGB youth facing particular risks to their mental, emotional and physical health, safety and well-being (PACE, 2004). LGB youth are vulnerable to low self-esteem, self-harm, suicide, and depression. A review of international research found that LGB youth were two to three times more likely to attempt suicide than other young people and probably account for around 30 per cent of all completed suicides of young people, which is of course disproportionately high (Warwick, Aggleton & Douglas, 2000). Young lesbians in the UK may be especially vulnerable regarding these mental health issues, including alcohol and drug abuse (Bridget & Lucille, 1996). Indeed, higher prevalence rates for alcohol and substance misuse have been described in LGB youth populations (The Metro Centre, 2005), as they have been for adult LGB populations in the UK. Several factors have been associated with this higher prevalence (PACE, 2004). A pressure to use alcohol and drugs remains in youth culture generally of course. Many LGB youth begin to participate in the lesbian and gay 'scene' which often accounts for higher levels of using alcohol and drugs. Many LGB youth use alcohol and drugs as a way of coping with their developing sexual identities and the stressors that come with that.

High rates of engaging in other 'risky' behaviours, such as unsafe sexual contact have been described by LGB youth in London (The Metro Centre, 2005). There may be many

reasons for this. For instance, it has been suggested that LGB youth who find it difficult to access social networks which support their sexual identity may seek out social contact in situations that involve sexual or personal risk. The need for the provision of LGB-sensitive sexual health information has been highlighted accordingly (Blake, Ledsky, Lehman, Goodenow, Sawyer & Hack, 2001).

Homelessness and running away

As described above, LGB youth have increased vulnerability for homelessness. In a recent survey in London (The Metro Centre, 2005), one in five young LGB respondents had been homeless with half of these homeless at age 16 or younger and half have been made homeless solely due to their sexual identity. This does not include those who were thrown out of their parent's home. A quarter of respondents who disclosed their sexuality to parents whilst living at home were forced to leave. Of respondents who reported feeling unsafe at home three quarters still lived with parents (and siblings).

Internalised Homophobia

LGB youth are vulnerable to developing negative attitudes about themselves and other LGB people because of exposure to and internalising homophobia (PACE, 2004). In one research study 10 per cent of young gay men describe realising they were gay as the first negative experience they could remember, and for a number of them their feelings were still very negative about this (Warwick et al., 2001). Positive LGB role models may help to diminish this problem, but although increasing, their numbers remain minimal.

2.7.7 Resilience of LGB youth

Whilst recognising and stressing the vulnerability of LGB youth, recent thinking and research has brought into question the victimised and pathologised positions that are often ascribed to LGB youth (Talbert, Rofes & Rasmussen, 2004; Youdell, 2004). This work has asked whether, and under what conditions, a positive non-heterosexual experience of life might be possible and has actively fought against perpetuating a narrative of LGB youth that frames them as victims in need of tolerance and understanding (D'Emilio, 2002; Youdell, 2004). 'Unencumbered with this knowledge about how they are supposed to feel, act, and believe, millions of teens with same-sex attractions continue to live their daily life with as much happiness and angst as any other teenager' (Savin-Williams, 2005). It is difficult to imagine practitioners (let alone the public) holding an image of LGB youth as vital, empowered, strong and sexual. Such an image is very difficult to accommodate for many schools, parents/carers and support workers. The focus has been on the image of LGB youth as 'victims' of prejudice and bullying, 'at risk' of HIV/AIDS, substance abuse, alcoholism, depression and suicide, homelessness, violence, dropping out of school and failing to reach their potential (D'Augelli & Patterson, 2001; Fikar, 1992; Garofalo et al., 1998; Savin-Williams, 1995a; Savin-Williams & Cohen, 1996). However, it is important to remember that those coming to the attention of psychologists in educational settings and child and adolescent mental health services are usually those who are indeed vulnerable.

2.8 Psychological interventions

2.8.1 Individual interventions

Schneider (1998) provides a useful framework for thinking through the issues associated with managing the needs of LGB youth at an individual level. First, young people may seek assistance to obtain support for issues (such as confusion, isolation and distress) directly

related to their developing sexual identity. These young people require connection with other young people like themselves so they can construct a positive identity. Second, adolescents may present with general issues that are related to and exacerbated by fears and tensions surrounding their developing sexual identity (such as family and relationship problems). Applied psychologists need to facilitate the management of the immediate dilemma, in the broader context of distress associated with possible undisclosed sexual identity. Third, young people may present with issues unrelated to their sexual identity.

LGB Youth may well be referred to child and adolescent mental health services for any of the above reasons. However, adolescents will more likely not ask directly for psychological support or counselling. Any confusion about sexual identity may be reflected indirectly. It is also important to remember that at the time of the referral the young person may not yet have labelled their sexual identity and so the contribution of sexual identity to the presenting problem can be unclear (Coleman & Remafedi, 1989). In the school context, it is unlikely (although not unknown) that a pupil will be referred to the school's link educational psychologist as a result of concerns *directly* related to their sexuality. It is more likely that LGB adolescents will be referred due to concerns regarding their behaviour, emotional well being and/or schoolwork. There is little or no information about the incidence of requests for referrals to educational psychology services for LGB adolescents in the UK, and little in the way of specific recommendations for suitable interventions for this age group (Comely, 1993; King & Bartlett, 1999; Radkowsky & Siegel, 1997; Smith, Bartlett & King, 2004). Psychologists' hypotheses should allow for the possibility that sexual identity *may be* an important aspect to explore with adolescents, even if not explicitly mentioned (Monsen et al., 1998; Monsen, 2001).

The careful exploration of sexual identities and sexual behaviour should form part of all assessments conducted with adolescents, therefore. Many are of the opinion that it is the psychologist's responsibility to bring up this topic (Coleman & Remafedi, 1989). Assumptions of heterosexuality will discourage many adolescents from mentioning same-sex behaviour or feelings. It has been recognised that psychologists tread a thin line between not focusing too closely on sexual identity issues or pushing toward premature resolution of identity development for fear of exacerbating adjustment difficulties, and dismissing the relevance of same-sex attractions, which could be as damaging (Coleman & Remafedi, 1989). It is easy to see therefore why many psychologists avoid exploring sexual identities with adolescents altogether. Other adolescents may disclose their sexual identity to psychologists, in which case the psychologist must be sensitive to issues of confidentiality, especially because the young person might not have (and might have no desire to) come out to their family, school staff or their peers.

When working with LGB young people, as well as using generic psychological practice frameworks (i.e., Problem-Analysis, Monsen et al., 1998; Monsen & Frederickson, 2008; Woolfson et al., 2003), the stage models of sexual identity formation have informed the practice of LGB focused counselling approaches, with the primary task seen to be supporting LGB youth through these stages (Fontaine & Hammond, 1996). Other individual approaches to psychological intervention also have an important role to play when supporting LGB youth. While there is no reason to believe that Cognitive Behaviour Therapy (CBT) would be less effective with LGB youth, very little has been published about how to integrate issues of sexual identity into therapy with younger people. However,

there are unique clinical issues that need to be incorporated into thorough case formulations and interventions when working with LGB youth (Safren & Rodgers., 2001). For example, from a cognitive perspective, exposure to negative attitudes about same-sex attractions can promote the development of negative core beliefs about the self (Safren et al., 2001). Narrative therapies (e.g. Freedman & Combs, 1996) may be particularly helpful in co-ordinating stories of identity with the cultural and religious stories held by the systems that LGB youth inhabit, and these approaches can be of particular relevance to the experiences of LGB youth from ethnic minority communities. Narrative therapies are recognised for offering interventions that are culturally sensitive and acknowledge the role of power and privilege in the construction of stories about what it means to be LGB in particular societies (Saltzburg, 2007).

To sum up, in terms of interventions at an individual level, evidence suggests that working to increase feelings of self-worth is more likely to reduce self-destructive attitudes and behaviour. Much of the work with individuals is focused on creating a safe and supportive environment so that they can feel good about themselves. There is also an emphasis on finding social groups that can enhance self-acceptance and help the young person to understand that the stigma they experience is not intrinsic to them, and on building coping skills and resilient attitudes and behaviours (including assertion and problem solving skills).

There are limitations when working at an individual level – for instance, sexual identity is perceived as being fixed. This kind of intervention prompts (and requires) a coming out story that leads to a declaration of lesbianism, gayness or bisexuality. A story with an end point is seen as more conducive to the development and maintenance of positive mental health than a story that is about ‘becoming’ and never quite getting to ‘out’. Another limitation is that most psychologists outside of child and adolescent mental health services are unlikely to have time to work closely with one pupil (and their family) over an extended period. In educational settings, most tend to work through those adults who have daily contact with the adolescent to develop supportive groups, and provide access to information and services designed for LGB pupils, such as youth groups, mentoring programmes and help-lines (Crowley et al., 2001). The most effective way for educational psychologists to increase self acceptance and resilience in LGB pupils (both those who are ‘out’ and those still in the ‘closet’) is by directly working with school staff to challenge unhelpful practices.

2.8.2 Family Therapy Approaches – nurturing queer youth

The identity formation models have focused on the individual. The family therapy literature is beginning to address family issues in the coming out process (e.g. LaSala, 2000; Sanders & Kroll, 2000), but this remains limited. The issues are not adequately addressed in family therapy practice. It has been suggested that this is because of a tendency to confuse sexual identity with sexual practice. Adults are uncomfortable with talking about sexual practice with young people (Stone Fish & Harvey, 2005). It has been recognised that family meetings can provide parents with the education, modeling and support they need to accept their child’s LGB identity (Saltzburg, 1996). It should be acknowledged that families can experience their own process of coming out as they integrate the child and family’s new identity (Coleman & Remafedi, 1989). Family members often desire a heterosexual outcome for their child. ‘We want our children’s lives

to be easy and those who live on the margins know how difficult it is when the rulebook was not written with you in mind' (Stone Fish & Harvey, 2005, p.27).

Narrative therapy has been used with parents who are coming to terms with their LGB offspring's coming out, providing a framework for reauthoring stories and adjusting identities as they negotiate the challenge of becoming LGB-membered families (Saltzburg, 2007). Stone Fish and Harvey (2005) have detailed an approach to family therapy which they call 'nurturing queer youth'. They describe the therapeutic tasks as creating a refuge that can validate the unique pressures faced by LGB youth, lessen isolation by promoting identification with similar others, and promoting a sense of uniqueness while improving the family context so that it can hold all of its members. Overall, the approach helps to work with families through the transition from a family of heterosexuals to multiple sexual identities in the same household.

2.8.3 Working at the institutional level

Applied psychologists can promote primary prevention activities by involving themselves in or supporting public and institutional policy decisions regarding LGB youth (Coleman & Remafedi, 1989). They can also support community groups for LGB youth which provide important sources of social networks and sometimes a necessary refuge from toxic environments.

Research in the UK suggests that many schools do very little to counter prejudice associated with LGB issues, either directly through mentoring, counselling and equal opportunities policies, or indirectly through the curriculum and the general ethos of the school (Adams, Cox & Dunston, 2004; Douglas et al., 1997). Until Section 28 of the Local Government Act¹ was repealed in 2003, many schools in England and Wales² used this legislation to justify a failure to address issues of homosexuality. Section 28 would not have prevented an objective discussion of homosexuality within the classroom, or the counselling of students concerning their sexuality (Department for Education and Science Circular, 5/94). In practice, Section 28 delivered the message that there were 'legal restrictions on the discussion of sexuality in schools and in reproducing inequality and prejudice more widely in society' (Epstein, 2000, p. 387; see also Ellis & High, 2004). Even though Section 28 has now been repealed, a significant number of schools (and local authorities) still operate as if it is still in place and seem unaware that their activities are not as restricted as they might believe (Adams et al., 2004).

2.8.4 Positioning of Self (as a Psychologist)

The appropriate use of therapist self-disclosure of personal information has the subject of debate for many years. However, most contemporary therapists agree that some degree of self-disclosure can be therapeutically useful under specific conditions. This includes the judicious use of disclosure of the therapist's sexuality. Indeed, many aspects of the therapists identity will, of course, already be apparent, for example, age, gender, skin colour and (unless otherwise explicitly addressed) there may well be an assumption of heterosexuality. In considering disclosure sexual orientation it is important that clinicians

¹ Section 28 of the Local Government Act was a piece of legislation introduced by the Conservative Government (1979–1997) that made it illegal for local authorities to 'promote the teaching in any maintained school of the acceptability of homosexuality as a pretended family relationship'.

² Scotland and Northern Ireland had their own versions of this legislation, both of which have now been repealed.

are fully aware of the requirements of the Health Professions Council Standards of Conduct, Performance and Ethics (HPC, 2008). These responsibilities are fully set out in Clear Sexual Boundaries between Healthcare Professionals and Patients: Responsibilities of Healthcare Professionals (CHRE, 2008) which is described in Part I of this guideline. The report also provides a definition of sexualised behaviour, which is described as, 'acts, words or behaviour designed or intended to arouse or gratify sexual impulses or desires'.

Therefore practitioners who disclose their sexual identity to their clients when motivated by their own need for sexual arousal or gratification are violating professional boundaries.

In view of the potential for misunderstandings, the Society has a duty to its members to highlight the potential risks of self-disclosure of sexuality in relation to the possibility of complaints being made against them.

Practitioners considering disclosing their own sexual orientation to clients are advised to exercise appropriate caution by ensuring that they examine carefully their own motives and also consider the possibility that the client could potentially misconstrue their reasons for making such disclosure.

2.9 Ethical issues and the Law

Specific ethical considerations and legal issues hold particular significance when working with adolescents around their sexuality and sexual behaviour. The age of consent for sexual activity (now 16 for males and females) stands irrelevant to sexual identity.

Psychologists working with LGB youth may find themselves cognizant of sexual activity taking place between adolescents under this age, or more problematically, when one partner is below the age of consent, and the other above it (the latter then legally holds culpability). It is the psychologist's task to make the adolescents involved aware of the legal position, whilst assessing the situation to determine the competency of parties to consent to and enter into this activity. Competence would need to be examined, as well as the identification of any possible coercion or abuse. Local child protection professionals can be consulted to aid this process. However, prejudices and stereotypes about same-sex activity can sometimes cloud the advice and judgements offered. The principles of Gillick competence and the Fraser guidelines (Wheeler, 2006) support the psychologist in determining a client's competence to consent to treatment in the form of psychological therapies, particularly around issues of sexual identity. A young person under 16 may request this work without the knowledge of parents or legal guardians. They may seek to protect the confidentiality of this contact for many reasons. Often for fear of adults' reactions to the disclosure of a sexual identity this work would create or indeed, for fear of adults' reactions to the undertaking of this psychological work *per se*. Some parents may fear that this work encourages the development of a sexual identity that they reject for their offspring. Advocating same-sex exploration for instance can be risky for the professional (Coleman & Remafedi, 1989). Sobocinski (1990) tells the story of a father of a 16-year-old male in therapy who threatened to sue the therapist for negligence, for teaching his son to become a 'social deviant'. Clearly, the assessment of risk around a young LGB person will be no different to any young person, where confidentiality can be compromised if risk to self or others is judged to be present. When working with sexuality and sexual behaviour, this can involve risk relating to unsafe sexual practice, as well as possible coercion or abuse.

3. Education, training and professional development

3.1 Education, training and professional development needs of psychologists

There is increasing consensus amongst trainers that self reflection about a psychologist's own beliefs around sexuality and sex are essential for an applied psychologist to be able to work effectively with clients from sexual minorities irrespective of the setting and theoretical approach (Davies & Neal, 2000, Murphy, Rawlings & Howe, 2002). Within clinical psychology training there is some evidence that sex and sexuality training is provided inconsistently (Shaw, Butler & Marriott, 2008) leaving qualified psychologists with a general lack of knowledge and confidence in discussing pertinent issues that might affect lesbian, gay or bisexual clients (Snowdon-Carr, 2005; Murphy et al., 2002). There have been some attempts to set minimum standards for training courses around sex and sexuality training by the Society's Faculty of HIV and Sexual Health in their good practice guidelines for the training and consolidation of clinical psychology practice in HIV/sexual health settings and provided sexuality CPD workshops (DCP, 2007; Butler & Shaw, 2007). The DH, the biggest employer of clinical psychologists in the UK, has recently issued core-training standards for working with lesbian, gay and bisexual clients in order to prevent discriminatory practice (Department of Health, 2006) that reflects the Equality Act on sexual orientation (HMSO, 2007).

- In this country there have also been some attempts to look at psychologists' practice and attitudes towards sexual minorities in the UK. Milton (1998) replicated a survey undertaken by the American Psychological Association (APA; Garnets et al., 1991), which explored counselling psychologists' views on good and bad practice when working psychotherapeutically with lesbian and gay men.

Unhelpful practice included:

- an overemphasis on the relevance of sexual orientation in evaluating the problems of gay and lesbian clients;
- trying to change a client's sexual orientation;
- applying heterosexual frames of reference;
- clients were assumed to be heterosexual;
- not underestimating the effects of prejudice and discrimination on a client's problems; and
- lack of knowledge about gay and lesbian issues.

More helpful practice included:

- not trying to change the sexual orientation of a client without their request or evidence that it is relevant to the client's problems;
- facilitating the development of the client's gay or lesbian identity;
- making clients feel positive about themselves.

This can be facilitated by a psychologist's openness, comfort with and acceptance of sexual diversity, the non-use of assumptions and stereotypes, an acknowledgement of the effects of societal discrimination and prejudice, and knowledge of the issues faced by lesbian and gay men. Milton also provided a series of recommendations about psychology practice and training, including developing consistency in training, emphasising the need for trainees to look at their attitudes and prejudices and also that the Society establish a committee (like the APA) on lesbian, gay and bisexual concerns to review and monitor practice.

Murphy et al. (2002) surveyed 378 clinical psychologists' on treating lesbian, gay and bisexual clients. The survey asked about psychologists' caseloads, training, mental health concerns and future training needs. It found that LGB clients were a significant part of the average caseload and that training was at best partially addressing these concerns, leaving practitioners seeking further training after qualification. Annesley and Coyle (1995) looked at 69 clinical psychologists' attitudes to lesbians by adapting Herek's attitudes to lesbians and gay men questionnaire (1984) and found that three-quarters of respondents provided answers indicating positive attitudes with 84 per cent reporting feeling comfortable working with a lesbian client. Sixty-three per cent believed that lesbians should not be allowed to adopt children or have artificial insemination. Positive attitudes were linked more to their social experiences and low religiosity, rather than training or clinical experience. They again suggested the need for attitude and intervention-based training of clinical psychologists. Ellis et al. (2002) looked at 226 psychology undergraduate students' attitudes towards lesbian and gay men and their support for lesbian and gay human rights. The study suggested a prevalence of negative attitudes in heterosexual students.

3.2 Models of affirmative practice

Models of therapy have a historical and social context that leaves their principles open to interpretation and development depending on the position that a psychologist may have around sexuality and gender. Some theoretical orientations clearly have a history in which principles and/or assumptions have led to oppressive treatment of people from sexual and gender minorities. However, affirmative practice can be integrated across all theoretical approaches, although more easily with some models than others.

The term, 'gay affirmative therapy' is used inconsistently in the literature (Harrison, 2000). It has come to be associated with therapy with sexual and gender minority clients (though more usually the former) in which a minority sexuality/gender position is valued equally with a dominant sexuality/gender position, with practice informed by appropriate knowledge of minority communities, their diversity and specific needs. Concerns have been expressed about the term and, in particular, the use of 'gay' to denote affirmative work with all sexual minority clients (e.g. lesbian or bisexual) and the clear failure to refer directly to gender minorities in the label. However, this term has gained acceptance and is used widely in the literature for affirmative therapy with both sexual and gender minorities.

Langdridge (2007) distinguished between two forms of gay affirmative therapy: a 'weak' version and a 'strong' version. The former describes the most common approach to affirmative practice where minority identities and practices are valued equally with dominant identities and practices, with due consideration for minority cultures and the issues that such clients may bring to therapy. This entails psychologists engaging in a process of continuing professional development to ensure they are aware of the relevant issues for the clients that they work with. This rarely involves any significant alteration to practice within the context of the theoretical model that they work with. The 'strong' version is much less common, and indeed more contentious, and refers to versions of therapy in which the psychologist not only values minority identities and practices but also uses the weight of their authority to actively affirm minority identities and practices and directly counter the effects of heterosexism. This may also be extended to include some of

the more radical revisions to extant theory and practice, most notably psychodynamic theory in which fundamental theoretical principles have been re-worked using ideas from social constructionism, feminism and queer theory (see, for instance, Isay, 1989; O'Connor & Ryan, 1993).

The series of three *Pink Therapy* books (Davies & Neal, 1996, 2000; Neal & Davies, 2000) represent one of the most significant expressions of affirmative practice in the UK, and, along with the recent addition of the edited collection by Moon (Moon, 2008; Butler, O'Donovan & Shaw, 2010; Richards & Barker, 2012), probably represent the clearest expression of affirmative practice. The books by Perez, DeBord and Bieschken (2000) and Ritter and Terndrup (2002) are similarly important US statements on affirmative therapy. There is limited empirical support for affirmative practice, a notable issue for the 'strong' versions in which substantive changes are made to theory and practice. There have, however, been a small number of qualitative studies which have sought to explore the experience of clients who have had affirmative therapy (Lebolt, 1999; Pixton, 2003). These studies have shown how clients valued affirmative approaches and, whilst more research is clearly needed, provide some support for the value of such developments.

3.3 Therapies focused on attempts to change sexual orientation (reparative or conversion therapies)

Therapy based on the premise that non-heterosexual sexuality is a mental illness, pathological, ethically or religiously wrong, or a client should change their sexual orientation to heterosexual is fundamentally counter to an ethical or human rights approach to therapy (APA, 2000b; Haldeman, 1994). However, it is increasingly becoming recognised that sexuality can be seen on a continuum from heterosexual to homosexual involving some degree of flexibility and change over a lifespan (Kinsey, Pomeroy & Martin, 1948; Kinsey, 1953). Clients may wish to review aspects of their sexuality and this needs to be assessed on a case-by-case basis.

There have been treatments applied to clients focusing on this, including:

1. Reparative therapy (Nicolosi, 1991) that is based on the premise that gay or lesbian adjustment is never a satisfactory resolution of sexual identity. This has also been used interchangeably with the term Conversion therapy used to describe therapy aimed at changing a person's sexual attraction/arousal. Reparative therapy is invariably linked to fundamentalist religious organisations, hence the notion of 'repairing' a 'damaged' sexuality. 'Conversion' therapy is used by opponents of these positions to highlight the fact that it more properly implies an attempt to engage in religious conversion. This is particularly carried out in the USA and the National Association for the Research and Therapy of Homosexuality is the organisation that provides this approach. However there is a growing trend towards reparative therapy in the UK.
2. Early psychoanalytic understanding was based on the notion that same-sex orientation resulted from developmental arrest (Freud 1905/1953). There have been attempts among recent psychoanalytic writers to posit more progressive and positive understanding of different developmental trajectories.
3. Behavioural aversion therapy and systematic desensitisation using emetics and electric shocks based on the notion that social learning results in sexual orientation (e.g. Barlow, 1973).
4. Medical treatments such as sterilisation, lobotomy and clitoridectomy.

These were routinely offered when homosexuality was viewed as a mental illness prior to the *DSM-III-R* revision in 1987 and are now mainly viewed as unethical on theoretical grounds with very little evidence for effectiveness and some for harm.

The American Psychiatric Association (2000b) issued a helpful position statement on therapies focussed on attempts to change sexual orientation suggesting:

1. That homosexuality is not a diagnosable disorder and efforts to re-pathologise homosexuality by claiming clients can be cured are often guided not by rigorous research but religious or political forces opposed to full civil rights of gay men and lesbians.
2. That as a general principle a therapist should not determine the goal of treatment coercively or through subtle influence.
3. That the reparative therapy literature uses theories that make it difficult to ethically research the treatments proposed as it actively stigmatises clients.

3.4 Therapies focused on attempts to change other aspects of sexuality or gender

Therapy aimed at 'normalising' behaviour, reparative therapy, has also been unsuccessfully attempted to address gender issues in trans youth and with trans adults. Other examples of application of reparative therapy to well adjusted individuals have included people who practice consensual BDSM; and people who have a fetish which is integrated into their lives without impairment to daily activities, social relationships or mental well-being.

Motivations for therapy to address transgressive behaviour should be carefully considered, as the psychologist may be taking a moral or religious stance which is inappropriately being brought into the therapeutic space. In contrast some psychologists act, with apparent compassion, to ameliorate the client's distress at their practice or identity, or in the belief that that distress must inevitably follow from an act or identity that is subject to a great deal of opprobrium. Two issues are pertinent here: the psychologist's understanding of the client's act or identity; and any internalised phobia that the client is experiencing. We shall examine them in turn.

The psychologist's assumption that an act or identity is necessarily distressing may be wrong (see, for example, the BDSM section above) and the subsequent therapy for something that is not distressing to the client is of limited utility. The psychologist should not bring assumptions into the therapy space and should instead either refer appropriately to a specialist practitioner, or support the client in accessing useful resources such as internet sites, books and magazines. These resources can explore transgressive identities and practices from a less pathologising perspective, as the information within the general media and even mainstream clinical professional literature can be somewhat limiting, and often does not cover non-pathologising ideas and theories.

Internalised phobia, such as internalised transphobia, may strongly motivate a client towards reparative therapy. However it would be counter therapeutic for the psychologist to add to that internalised phobia through therapeutic practice. Especially in the case of identities, cessation of practice is not the same as cessation of desire and the client will be left with unexpressed feelings that have the potential to be very damaging. Instead, the psychologist should attempt to be non judgemental of the client's practice per se and engage with attendant consequences, whether cognitive, affective or social. Should the client wish to modify their practice that can be facilitated in a manner that does not denigrate it.

It is of particular importance in this area to establish for whom the difficulty is a problem. For some clients, coming to therapy is an attempt to please others or is on the instruction of others, as in the case of parents who bring their gender variant children to therapy to be normalised to gendered social roles. Or a man who has come to therapy to satisfy a female partner who does not like him wearing traditionally female clothing. Sometimes clients who enjoy BDSM present in a clinical setting because their partners are unsupportive and want them to change. In these instances psychologists should remember who the client is and to act in the client's best interest, whilst taking into account their social and family relationships. The client should not be situated *de facto* as having the problem through their coming to therapy (cf. Rosenhan, 1973). Applied Psychologists do need to carry out adequate assessment and identify those clients who may be better referred to a specialist practitioner and service. They should not act beyond their competence if the presenting problem(s) fall outside their areas of expertise. This is clearly distinct from the use of 'reparative therapy', which is more motivated by social norms rather than significant clinical need.

3.5 Continuing Professional Development

Working with people with diverse sexuality and gender issues throws up many contemporary, changing and often challenging concerns for psychologists who also have to navigate a backdrop of many constructs around aspects of diversity that have been entrenched in heterosexism, and which may connect to a broader socio-political climate and cultural issues, such as immigration. For this reason training and consideration of clinical issues should continue post-registration, even for psychologists who may work with clients or settings that present more sexual and gender diversity issues. This could take the form of discussion groups, informal networks of psychologists working with similar issues, reading, supervision, research and training.

Part IV: References and Appendix

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Appendix

Timeline

- 1869 Term 'homosexuality' coined by Karl-Maria Kertbeny
Herzer, M. Kertbeny and the Nameless Love. *Journal of Homosexuality*, 12(1), March 1986 (pp.1–26).
- 1897 Magnus Hirschfeld co-founded the Scientific Humanitarian Committee, which undertook research to defend the rights of homosexuals in Germany.
- 1935 Freud normalises homosexuality in therapy.
- 1948 Alfred Kinsey publishes *Sexual behaviour in the human male* and *Sexual behaviour in the human female*, suggesting a continuum between homosexuality and heterosexuality.
- 1954 The Home Secretary appoints the Wolfenden Committee first recommends that homosexual acts between consenting adults in private should no longer be illegal based on arguments that the law was impractical rather than not immoral and the age of consent set at 21. Supported by the Archbishop of Canterbury, the BMA and National Association of Probation Officers.
- 1966 Martin Seligman uses Aversion Therapy to change sexual orientation.
- 1967 Sexual Offences Act receives Royal Assent, partially decriminalises sex between men aged over 21 in England and Wales.
- 1968 Charles Socarides uses psychoanalytic theory to promote reparative therapy.
- 1969 Stonewall riots start gay rights movement in the USA.
- 1969 Word 'Homophobia' appears in print in American *Time* magazine.
- 1970 First meeting of London Gay Liberation Front.
- 1973 The American Psychiatric Association removes homosexuality from a list of mental disorders.
- 1978 Formation of the International Lesbian and Gay Association (ILGA) in Coventry, UK. ILGA is a world-wide network of national and local groups dedicated to achieving equal rights for LGBT people around the world.
- 1979 Michael Foucault writes about anti-essentialist notions of sexual identity suggesting sexuality identity is socially-constructed.
- 1980 HIV first named.
- 1982 Homosexual orientation decriminalised in Northern Ireland with the passing of a law reform in the House of Commons.
- 1986 DSM (III? Or IV?) and American Psychiatric Association removes all references to homosexuality as a psychiatric disorder.
- 1987 Section 28 of the Local Government Act, preventing the 'promotion of homosexual orientation by local authorities with help of Local Government Minister Michael Howard.

- 1989 Stonewall lobbying group established in response to the introduction of Section 28.
- 1990 Term 'queer theory' first used at a conference in California by Theresa De Laurentis.
- 1990 Term 'Heterosexism' coined by Herek.
- 1992 Nicolosi, Socarides and Kaufman found National Association for Research and Therapy of Homosexuals.
- 1992 WHO ICD drops classification of homosexuality as a mental disorder.
- 1994 Age of consent between two men is reduced from 21 to 18. An amendment to reduce to 16 is defeated in the House of Commons.
- 1996 *Pink Therapy* published, by Davies and Neal.
- 1997 Government immigration policy recognises same-sex couples under certain conditions.
- 1998 Age of consent for sex between two men is reduced to 16 in House of Commons but not House of Lords.
- 1998 Division of Counselling Psychology surveys its members attitudes and practices of working with Lesbian and Gay clients.
- 1998 Formation of the Lesbian and Gay Psychology Section of the Society.
- 1999 The Law Lords rule that same-sex partners are entitled to the same tenancy rights as a heterosexual spouse.
- 2000 The American Psychological Association produces guidelines for psychotherapy with Lesbian, Gay and Bisexual Clients.
- 2000 The Australian Psychological Society produces *Guidelines for Psychological Practice with Lesbian, Gay and Bisexual Clients*.
- 2000 A new code of conduct is introduced by the army following the removal of the ban on lesbian and gay men serving in the armed forces.
- 2000 The Sexual Offences (Amendment) Act 2000 came into force, reducing the minimum age of consent from 18 to 16 in England and Wales, and making male rape a criminal offence.
- 2002 *Handbook of Affirmative Psychotherapy* by Ritter and Terndrup published.
- 2002 Unmarried and gay couples are given the right through Parliament to adopt.
- 2003 Section 28 of The Local Government Act is repealed after 15 years.
- 2003 Employment Equality (Sexual Orientation) Regulations became law making it illegal to discriminate against lesbians, gay men and bisexuals in the workplace.
- 2004 The Civil Partnerships Act receives Royal Assent.
- 2004 The Gender Recognition Act provides transgender people with legal recognition in acquired gender, subject to some specified exceptions.

- 2005 Section 146 of the Criminal Justice Act 2003 is implemented, empowering courts to impose tougher sentences for offences aggravated or motivated by the victim's sexual orientation.
- 2005 The introduction of the Adoption and Children Act gives wide-ranging rights to same-sex couples wishing to adopt a child.
- 2006 The Equality Act makes inclusion of LGB staff and user/patients within health and social care a requirement.
- 2007 BABCP publishes a systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people with training recommendations.
- 2007 The Faculty of HIV/Sexual Health of the DCP write best practice guidance for the training of clinical psychologists in sex and sexuality and surveys the training course provision.
- 2007 The British Psychological Society sets up a working party to develop guidelines for working clinically with sexual minority clients on request of the Faculty of HIV and Sexual Health, of the Division of Clinical Psychology.
- 2008 *Pink Therapy* starts a certificate course in sexual minorities therapy.

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