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How gender and sexually diverse friendly is your therapy training?

Dominic Davies and Meg John Barker

We were delighted to see all of the major psychological and therapeutic bodies signing the Memorandum of Understanding on Conversion Therapy which was launched at the Department of Health earlier this year (UKCP, 2015). This little-read document makes it an ethical obligation that therapists are adequately trained to work with requests for change to clients' sexuality (and we hope to see gender added to this soon). To meet that obligation, training organisations will need to develop a curriculum that embeds gender and sexual diversity issues throughout the syllabus as well as ensuring some specialist and specific material that stands separate to it.

Unfortunately this still is very far from the current situation. When we were asked to write this paper we asked colleagues on our Pink Therapy Facebook group about their experiences of training, and the situation has not changed since Davies explored this in a paper in 2007. At best it is a brief workshop delivered by an LGBT student, rather than a tutor, because they are 'the only queer in the classroom'. Such tokenism means many aspects and identities are excluded. This is unprofessional and inadequate. On some courses students are encouraged to vote for a one-off additional afternoon training on a topic of their choice. In such situations GSD has to compete with other vital topics such as race and ethnicity, class, or disability.

Why include Gender and Sexual Diversity¹ (GSD) training?

LGBT people are at higher risk of mental health problems than the general population (Davies & Barker, 2015; King et al., 2008), and the evidence suggests that many of them have poor – and even pathologising - experiences when they do approach therapists and other mental health professionals (King et al., 2007). Therefore it is clear that counsellors and therapists are not currently sufficiently trained in this area. This is dangerous as therapists who have not had the opportunity to question their assumptions often give GSD clients messages that they are less normal, or more pathological, than other clients (Moon, 2008). There is further evidence that trans and bisexual people have the highest levels of distress, and the worst treatment at the hands of therapists, of all those under the LGBT umbrella (Moon, 2009), and these are the GSD identities which are often the least visible on training courses and elsewhere (Baker et al, 2012).

Another important reason for including GSD training is that, currently, LGBT+ people who embark on psychotherapy or counselling training themselves often have a poor experience. Frequently they are extremely isolated and have to constantly decide whether to confront prejudice from their peers – and even staff – or whether to stay quiet about it. The decision is often between allowing poor training to continue (and pass the course), or being the one who

¹ GSD is our preferred acronym which goes beyond the exclusivity and restrictions of LGBT (lesbian, gay, bisexual, trans) to include everyone on the gender spectrum and diverse sexualities and practices including BDSM/Kink, asexualities, consensual non-monogamies etc.

constantly has to be labelled as 'difficult'. This is one of the reasons why Pink Therapy recently set up a mentoring scheme for GSD trainees, so that they could get support from people who have been through this. People who are marginalised on a societal level should not have to be further marginalised on training courses, or to feel unsafe, but sadly this is a story that we hear again and again.

Even those whose experience is more positive than this feel that they have to constantly point out, for example, when case material assumes heterosexuality, or when theories being covered are explicitly heteronormative or homophobic, biphobic or transphobic. It is deplorable that those convening and presenting the courses have not considered the diversity of living in modern Britain. The financial burden of therapy training, and the normative nature of many courses, clearly puts off people from all kinds of marginalised groups, and exacerbates this 'lone voice' phenomenon. For that reason, training courses could usefully consider offering bursaries particularly to members of such groups.

Of course part of the problem here is that the counselling training world is dominated by middle class, white, cisgender (people who remain in the gender they were assigned at birth), heterosexual women! Also, many of the theories we draw on developed in another time when there was not the understanding of GSD that we have today, and LGBT+ identities and practices were explicitly pathologised and even criminalised. However, most staff do not have the knowledge and understanding – from their own lives or training – to offer something different to that, resulting in a stagnation which perpetuates itself.

What should be included in GSD training?

GSD is a lot wider than simply having a couple of sessions talking about lesbian and gay experiences! In addition to the issues with bi and trans which we mentioned before, sexualities and genders which do not fall into the LGBT acronym, are very rarely covered in training, for example kink or BDSM practices (Strick, 2015), and openly non-monogamous forms of relationships (Barker, 2015).

Beyond this, we need to challenge the common assumption that gender and sexuality are only relevant issues for minority or marginalised groups. In truth they affect cisgender and heterosexual people at least as much as they do LGBT+ people. This is the reason why Richards and Barker, in their two recent books on GSD (2013, 2015), included chapters on cisgender, heterosexuality, and monogamy. They make the point that endeavouring to adhere to rigid scripts – of sexual behaviour or gender norms for example – is a major aspect of many mental health problems which is often overlooked. Including all sexualities, genders, and relationship forms in training would be an excellent way of ensuring awareness of this, and including everybody.

Finally, Butler et al. (2009) make the point that therapists and counsellors are notoriously poor at talking about sex in therapy unless specifically trained as psychosexual therapists.

Given what a major dimension of human experience this is, it is important that therapy courses include training on how to discuss sex and sexuality with clients (the process) as well as specific information about gender and sexuality (the content).

In summary, at the end of their training, students should be able to:

- Speak explicitly about sex;
- Understand the full range of experiences under GSD, including various sexualities, genders, sexual practices, and relationship forms;
- Appreciate the role of heteronormativity, shame, and internalised oppression on marginalised people;
- Recognise how other identities and practices intersect with gender and sexuality in ways that are vital for people's experience and mental health (das Nair & Butler, 2012);
- Know the evidence base regarding requests for 'treatment' for sexuality and gender 'cure'.

Who should provide the training?

We need to leave behind the current tokenism of students providing training on GSD based on their own personal experiences. We are left with two possibilities: either courses can ensure that they have faculty with expertise in this area, or they can bring in outside specialists to cover these topics.

However, neither of these things are happening on many of the course that we are aware of. For this reason Pink Therapy (in addition to its extensive CPD programme) now runs two specialist Diplomas, one on GSD issues generally (two years online), and another on GSD relationship therapy (offline) to prepare therapists for the range of issues facing a modern therapist. Also, groups like London Sex and Relationship Therapy have developed a number of plug-in training days on specific GSD topics which they offer to training courses.

Add-on versus integrated training

We are arguing that GSD issues need to be both integrated throughout training as well as being covered in a specific module or set of sessions. This training should be practical rather than theoretical in emphasis – imparting knowledge, information and skills.

There is a long history of therapy neglecting people's social context in its focus on individual experience and the universality of human experience (Barker, 2010). Instead of adding it on in the form of specific sessions, it would be better if courses were mindful of the social element of human experience throughout. This could be done, for example, by ensuring a diverse range of case material, all of which lends itself to discussions of gender, sexuality, race, class, etc (das Nair & Butler, 2012).

Summary

It's a major task to prepare therapists to work with gender and sexual diversity, and therapists need to be prepared to augment their initial training with further specialist training if they want to work at a deeper level with GSD populations. Some courses probably feel overwhelmed, others may have little commitment or motivation to change the status quo.

We need to work towards a place where GSD and intersections are woven throughout and there should be a minimum of six days additional training to fulfill the requirements made by the Memorandum of Understanding all our professional bodies have signed up to.

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Further Resources

You can find out about the training and CPD on GSD issues on the Pink Therapy website:

<http://www.pinktherapy.com/en-gb/training.aspx>

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

<http://www.londonsexrelationshiptherapy.com/training>

Therapists who are looking for an accessible overview of all of the main gender and sexual identities and practices may find the following book useful:

Richards, C. & Barker, M. (2013). *Sexuality and gender for mental health professionals: A practical guide*. London: Sage.

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