Butler, C. & Byrne, A. (2004). A clinical psychological perspective in counter sexual prejudice in institutional systems and client's lives. *Lesbian & Gay Psychology Review*, 5 (3), 89-94

**Abstract:** This paper addresses how theoretical approach, policy strategy and clinical practice are used to counter lesbian and gay oppression on both a 'systems' level and through therapeutic work with individuals. We locate our work in the context of a sexual health psychology service in central London, where the majority of clients are gay men. This paper highlights our stance on countering hegemonic practices and heterosexism by providing a transparent account of our thinking and action. Our approach may be broadly described as 'systemic' and 'social constructionist'. We describe how these frameworks may be applied in clinical practice using a composite example of a 'typical' case that may be referred to a clinical psychologist working in sexual health. We also discuss the ways in which we work with wider systems in order to challenge sexual prejudice.
*Keywords: homophobia, heterosexism, sexual health, psychology, social constructionism.*

## Introduction

THE TERM 'HOMOPHOBIA' has been criticised by a number of authors (e.g. Kitzinger 1997) as depoliticising and individualising anti-lesbian/gay discriminatory practices. As an alternative, the term 'heterosexism' may be defined as 'a world view, a value-system that prizes heterosexuality, assumes it is the only manifestation of love and sexuality and devalues all that is not heterosexual' (Herek, 1990). This term is preferable in our practice as it acknowledges the contextual, political and social/cultural influences that contribute to the oppression of our clients. Furthermore, as this definition does not specify the non-heterosexual practices that are oppressed, it enables the inclusion of oppression against a diverse range of sexual practices.

Heterosexism is prevalent in the history and practice of psychology, for example, in normative theories of development (e.g. Freud, 1905), family and relationship functioning (e.g. family life cycles, Carter & McGoldrick, 1989), and mental health (McFarlane, 1998). Psychology has also been criticised for de-politicising oppression through its individual and internal focus (e.g. Kitzinger, 1997), and for the invisibility of lesbian and gay lives and experience in psychological theory and research. Sandford (2000) notes 'several introductory psychology textbooks still do not address homosexuality at all. At the same time, homosexuality remains a compulsory topic for textbooks on abnormal psychology' (p. 32).

Mainstream clinical psychology is based on a 'scientist-practitioner' model, emphasising that therapeutic practice should be based on empirical research. There is a long history of psychodynamic therapies in the profession, and the arrival of cognitive-behavioural therapy in the 1970s has grown from strength to strength, particularly with the recent emphasis on evidence-based practice. These models are commonly used in sexual health services. Less frequently used is the more recent model of 'reflective-practitioner' (Schön, 1987), which invites the therapist to reflect on their impact on the work and the impact the work is having on them. This model connects with 'social constructionist' ways of working, which we go on to describe. We discuss the ways we work as clinical psychologists in sexual health services where issues of gender, sexuality and difference are foregrounded to a greater extent than in other settings (where clinical psychologists might work with lesbian and gay clients). We will elucidate this argument by describing our context and approach to our work and illustrate this with a clinical example.

## Our context: Sexual health services

Prior to the identification of the Human Immunodeficiency Virus (HIV), sexual health, or genitourinary medicine (GUM) services were focused on disease control. The emotional and relational aspects of sexual health were not considered and there was little role for psychological intervention. With the advent of HIV in the 1980s, the gay community led the initiative for the development of HIV services and changed the face of service delivery to include a more holistic approach involving a recognition of the emotional, relational and political aspects of sex and sexuality. The voluntary sector plays an extremely important role at all levels of HIV provision and campaigning. Many of those involved in both voluntary and statutory services have multiple roles as service users, service providers, volunteers, and campaigners. In fact, lesbian and gay staff are visible at all levels of service provision where many choose to work in the area because they assume that their sexuality will not be under scrutiny and in this way they provide some level of accountability with respect to service provision. However, heterosexist practice is still prevalent, as we shall illustrate in our case example.

## How we work as 'constructionists'

The approach we take to our work with clients may be broadly described as social constructionist. We are influenced by the post-Milan systemic theories and therapies, such as those described by Cronen and Pearce, (1980), Anderson and Goolishian (1993) and the narrative therapy approach described by Michael White and colleagues (e.g. White, 1988, 1991). Such approaches allow us to address the 'systems' that surround our clients, focusing on their social context and not just an individual's 'internal world'. Thus lineal ideas of cause and effect (and blaming and shaming narratives), are bypassed as more circular ways of viewing clients' difficulties are considered (Freedman & Combs, 1996). This post-modern epistemology means that there are no essential truths, but that an individual's 'realities' are socially constructed and constituted through language. Thus we invite a 'multiverse' rather than a 'universe' of ideas and options without privileging and so subjugating alternative discourses (White, 1991). The meaning given to any event will depend on the cultural, social and historical context in which the event occurs. According to Simon and Whitfield (2000), a social constructionist approach offers a 'coherent framework for therapeutic work with lesbians, gay men and bisexuals because it pays attention to practices of power and challenges assumptions about pathology, sexuality, gender and life choices' (p.145). This consideration of the context and power influencing clients' is well suited – we feel – to countering prejudice and discrimination with our lesbian, gay and bisexual clients.

Adopting this approach also requires us to examine our own influences on the therapeutic system including those things that inform our ideas and practice. Within a social constructionist framework, therapists are seen as – to some extent – acting out of their own beliefs, cultural context and experience. Therefore, we do not consider ourselves to be objective observers but as part of the 'system' that is operating within the client's life. We have adapted Cronen and Pearce's (1980)

model of the Co-ordinated Management of Meaning (CMM) to provide a framework through which we can work with the layers of meaning which emerge through the therapeutic encounter. This model proposes a hypothetical hierarchy of levels of context in which the meaning of any level can be understood by reference to a higher level. The higher the level, the stronger the influence this has on understanding meaning, however the relationship between the levels is circular and reflexive over time rather than vertical and linear.

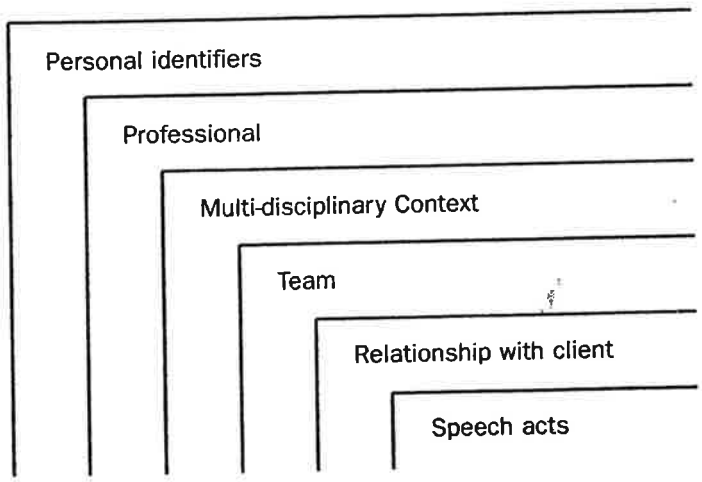
Our work as therapists will be influenced by difference levels of meaning including the words we use, the relationship we have established with the client, how we view and are viewed by our colleagues and the ethos of the team (see Figure 1). Meaning will also be understood within the culture and ethos of our work-place and our professional system, its training, forms of 'knowledge' and code of conduct regulations. In addition to the professional framework that influences the therapeutic system, our personal identifiers, such as our 'race'/ethnicity, gender, sexuality, will also have an impact on what meanings are attributed to our words and actions. It is important that, as therapists, we examine each contextual layer to explore whether any one of these might be discriminatory or prejudiced against lesbian, gay or bisexual lives. This includes orientating ourselves to the local arrangements of contextual levels that our clients may use, for example not privileging 'traditional' family meanings over those of self-defined 'families' of friends. As therapists we also need to be explicit to ourselves about our own assumptions and by publicly declaring these as hypotheses or musings we make them available for deconstruction and exploration as to their usefulness in each therapeutic encounter.

## Case example

To help us to illustrate how we would apply these ideas to the actual work we do, a composite case example is presented below. This represents a 'typical' referral made to clinical psychology in our service, the text in speech marks being copied from actual referral forms.

Brian, a 34-year-old white British gay man, attended the clinic with a sexually transmitted disease. On the referral form, Brian's situation is described as follows: *'$^{0}$RMP, UAI with CMP's'*. This is medical shorthand and translates as 'no regular male partner', has 'unprotected anal intercourse' with 'casual male partners'. Brian was also described as having *'issues with his sexuality and difficulties with emotional intimacy'*. The referrer suggested that the aim of therapy should be *'to change his self-destructive unsafe sexual behaviour'*.

**Figure 1: Influences on therapeutic system.**



Within a social constructionist approach, language is seen as both expressing and constructing our experience, (e.g. Freedman & Combs, 1996). It is possible to identify some of the techniques used to depersonalise and ignore the emotional and psychological aspects of sex for this man, particularly with the use of abbreviations, which place the client's behaviour within a medical discourse. It also illustrates how embedded and subtle heterosexist ideas are in terms of what is seen as problematic for different groups. In our experience, this idea of 'problems with emotional intimacy' is a phrase often used with men who have casual sex, and gay men in particular tend to be seen as a high-risk group. It is interesting to note that it is the identity of being a 'gay man' that is classified as a risk group, rather than the particular sexual practices that some gay men may engage in that place them at a greater risk of contracting HIV (e.g. unprotected anal intercourse). The referrer also makes it clear that he views this man's sexual practice as 'self-destructive', without any indication of what its meaning might be for the client. It is interesting to note that the referrers for these example quotations were gay men with many years experience as health professionals, again illustrating how subtle such oppressive practices can be in that they invade the professional discourse of even those who are potentially oppressed by them.

Freedman and Combs (1996) have developed a set of questions to help them maintain a narrative/social constructionist position. Following these authors' example, we have begun to develop a set of questions that we feel are relevant to our context. Therefore, on receiving a referral like the one outlined above, our first line of action would be to ask ourselves some questions which enable us to consider the referral through the lens of the referrer's and client's relationship. These questions are also ones we ask ourselves during therapy, in order to maintain a social constructionist stance. We ask ourselves the following questions: *Who is this a problem for? Whose language is being privileged? What are the client's/referrer's ideas about help? Are there dominant stories oppressing or limiting this person's life? What are the marginalised stories? Am I allowing for multiple perspectives? Am I being transparent about my context, values, intentions?*

## Interventions

The basis of our interventions with clients is to use systemic and narrative therapy techniques, such as deconstructive questioning (e.g. White, 1991) to try to introduce curiosity into the assumptions and narratives that might be restricting and restraining the client (or referrers/staff) and to bring forth alternative accounts and this may be done in a number of different ways. Within this approach, it is 'the problem' that is evaluated and not the person (White, 1988). This allows us to create a non-blaming dialogue of curiosity and exploration. We employ certain questions in order to locate 'problems' in a social, political, personal and historical context. Examples of these include: *How, when and where did the behaviour come to be seen as problematic? Who would agree/disagree? What does this view enable/prevent? Where do ideas about 'emotional intimacy' and 'sexual safety' come from?*

Such questions help demonstrate how ideas such as 'sexual safety' are socially constructed and that dominant discourses may function to maintain power imbalances.

An important aspect of our approach involves enabling the client to access alternative knowledges and discourses. This involves moving away from problem-saturated and pathologising views of clients, so that they begin to be able to re-author their lives and relationships (e.g. White, 1988). We might ask questions like the following: *In which relationships does the client have/want 'emotional intimacy'? Which aspects his sexuality/identity does he value? What other discourses are there about gay men, e.g. as intimate, supportive, etc.?* In addition to therapeutic conversation, we may introduce different views through exploring resources like literature or films. We have developed a small resource library, which clients have also contributed to. We might set tasks such as exploring different aspects of the 'gay scene'. We might explore ideas such as 'negotiated safety' as an alternative discourse to one of 'safe' or 'unsafe' sex. Negotiated safety refers to the practice of unprotected sex in a rela-

tionship where both partners know their serostatus (HIV status) and there is an agreement not to have unprotected sex outside the relationship (these and other related issues are discussed in more detail by Hodges & Rodohan in their paper in this issue).

Our systemic and social constructionist approach takes a non-expert stance (e.g. Anderson & Goolishian, 1993). By this we mean that, while we may have expertise in certain therapeutic approaches, the client is the expert on his or her life and experience. We invite clients' expertise to inform our work and as a resource to others (e.g. via our service user forum or contributing to our resource library). It is recognised that, in the face of widespread discrimination and heterosexism, coming together in groups, building networks for action, support and resistance are extremely important for lesbian and gay people (e.g. Neal, 2000). We often encourage clients to link with voluntary organisations such as Gay Men Fighting AIDS, PACE or Naz Project London. Even when we are working with individual clients the linguistic practices that we employ can serve to connect clients to others. An example of this is employing wider system questions using a hypothetical audience (Simon 1996, 1998). 'Hypothetical audiences' refer to groups of people who are not physically present in the room but whose imagined experiences and ideas can be drawn on by the client, thus creating alternative ideas to those more immediately available in the client's life.

This account of therapeutic practice may seem somewhat unusual to other clinical psychologists. However, we do not wish to suggest that these are the only interventions we employ. We find it useful to think of our work in terms of distinguishing between 'approach', 'method' and 'technique', as suggested by Burnham (1992). 'Approach' can be seen as the assumptions, values, theories and working ideas one draws on, 'method' as the organisational patterns and ways of working one employs and 'technique' as the practical activities and tools one uses. According to Burnham (1992), these distinctions make it possible to employ a greater range of methods and techniques while remaining coherent in one's preferred theoretical orientation. Thus, in our clinical practice we use a variety of techniques, including more traditional procedures borrowed from cognitive behavioural therapy (CBT) interventions, anxiety management and so on, while maintaining a stance that can be described as social constructionist.

Finally, given our systemic approach, it is important to extend our interventions beyond the consulting room. We also see it as being part of our role to intervene with referrers and other staff. We do this in a number of formal and informal ways, for example:

- Promoting curiosity and questioning;
- Suggesting alternative views of 'problems';
- Using reframed language;
- Offering joint work, consultation, training;
- Campaigning;
- On occasion directly challenging what we see as oppressive practice.

## Conclusion

Sexual prejudice is subtle and ever-present in the systems that influence our work and the lives of our clients. To challenge this in our clinical work requires an acknowledgment of power and context in our clients' lives and the therapy itself. Questions and curiosity open up space for the examination of subjugated narratives and alternative ways of being. We acknowledge that professionals do not have all the answers and are indebted to our clients who constantly challenge and teach us through the work we do together.

## References


Anderson, H. & Goolishian, H. (1993). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. Gergen (Eds.), *Therapy as social construction* (pp.25–39). London: Sage.

Burnham, J. (1992). Approach – method – technique: Making distinctions and creating connections. *Human Systems: The journal of systemic consultation & management, 3,* 3–26.

Carter, B. & McGoldrick, M. (1989). *The changing family life cycle: A framework for family therapy.* London: Gardner Press.

Cronen, V. & Pearce, W.B. (1980). *Communication, action and meaning: The creation of social realities.* New York: Praeger.

Freedman, J. & Combs, G. (1996). *The social construction of preferred realities.* New York: W.W. Norton.

Freud, S. (1905). Three essays on the theory of sexuality. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (24 vols.), Vol. 7 (pp.123–245). London: The Hogarth Press.

Herek, G.M. (1990). The context of anti-gay violence: Notes on cultural and psychological heterosexism. *Journal of Interpersonal Violence, 5,* 316–333.

Kitzinger, C. (1997). Lesbian and gay psychology: A critical analysis. In D. Fox & I. Prilleltensky (Eds.). *Critical psychology: An introduction* (pp.202–216) London: Sage.

McFarlane, L. (1998). *Diagnosis: homophobic.* London: PACE.

Neal, C. (2000). We are family: Working with gay men in groups. In C. Neal & D. Davies (Eds.), *Pink Therapy 3: Issues in therapy with lesbian, gay, bisexual and transgender clients* (pp.102–114). Buckingham: Open University Press.

Sandford, T. (2000). Homosexuality, psychology and gay and lesbian studies. In T. Sandford, J. Schuyf, J.W. Duyvendak & J. Weeks (Eds.), *Lesbian and gay studies: An introductory, interdisciplinary approach* (pp.14–45). London: Sage.

Schön, D. A. (1987). *Educating the reflective practitioner.* San Francisco: Jossey Bass.

Simon, G. (1996). Working with people in relationships. In D. Davies & C. Neal (Eds.), *Pink Therapy: A guide for counsellors and therapists working with lesbian, gay and bisexual clients* (pp.101–115). Buckingham: Open University Press.

Simon, G. (1998). Incitement to riot? Individual identity and group membership: Some reflections on the politics of a post-modernist therapy. *Human Systems: The journal of systemic consultation & management, 9*(1), 33–50.

Simon, G. & Whitfield, G. (2000). Social constructionist and systemic therapy. In D. Davies & C. Neal (Eds.), *Pink Therapy 2: Therapeutic perspectives on working with lesbian, gay and bisexual clients* (pp.144–162) Buckingham: Open University Press.

White, M. (1988). The externalising of the problem and the re-authoring of lives and relationships. *Dulwich Centre Newsletter,* 5-28.

White, M. (1991). Deconstruction and therapy. In Epston, D. & White, M. (Eds.), *Experience, contradiction, narrative and imagination: Selected papers of David Epston & Michael White 1989–1991* (pp.109–151). South Australia: Dulwich Centre Publications.