Good Practice across the Counselling Professions 001

Gender, Sexual, and Relationship Diversity (GSRD)

Dr Meg-John Barker

bacp | counselling changes lives

BACP Good Practice across the Counselling Professions 001
Gender, Sexual, and Relationship Diversity (GSRD)

Author Meg-John Barker

Updated April 2019

Copyright information:

Good Practice across the Counselling Professions 001: *Gender, sexual, and relationship diversity (GSRD)* is published by the British Association for Counselling and Psychotherapy, BACP House, 15 St John's Business Park, Lutterworth, Leicestershire LE17 4HB.

T: 01455 883300 **F:** 01455 550243
E: bacp@bacp.co.uk **www.bacp.co.uk**

BACP is the largest professional organisation for counselling and psychotherapy in the UK, is a company limited by guarantee 2175320 in England and Wales, and a registered charity, 298361.

Copyright © 2017–19 Dr Meg-John Barker

Permission is granted to reproduce for personal and educational use only. Commercial copying, hiring and lending are prohibited.

Design by Steers McGillan Eves.

Contents

Context 6

Using Good Practice across the Counselling Professions Resources 6

1. Introduction Gender, Sexual, and Relationship Diversity (GSRD) 7

1.1 How does British culture understand gender, sexuality, and relationships? 7

1.2 Why this is relevant to mental health and therapy 10

1.3 Situating the current view in time and place 11

1.4 What is Gender, Sexual, and Relationship Diversity (GSRD)? 13

1.5 Why an intersectional understanding is vital 14

1.6 The legacy of non-affirmative and pathologising practice 15

1.7 Working affirmatively across GSRD 16

2. Sex/Gender 19

2.1 What is sex/gender? 19

2.2 A biopsychosocial understanding of sex/gender 21

2.3 Gender assignation: intersex and diversity of sex development (DSD) 22

2.4 Gender status: trans 23

2.5 Gender status: cisgender 25

2.6 Gender identity: woman 26

2.7 Gender identity: man 28

2.8 Gender identity: non-binary **28**

2.9 Good practice across sex/gender diversity **30**

3. Sexuality 31

3.1 What is sexuality? **31**

3.2 Identities, practices/experiences, and attractions **32**

3.3 Extent of attraction: the asexual spectrum **34**

3.4 Gender of attraction: bisexuality, pansexuality and queer **35**

3.5 Gender of attraction: lesbian and gay sexuality **37**

3.6 Gender of attraction: heterosexuality **38**

3.7 Sexual practice: BDSM, kink, and beyond **40**

3.8 Consent **41**

3.9 Good practice across sexual diversity **43**

4. Relationships 44

4.1 Relationship diversity **44**

4.2 Solo-ness and singledom **46**

4.3 Monogamies **47**

4.4 Secret non-monogamies **49**

4.5 Open non-monogamies **50**

4.6 Aromantic experience **52**

4.7 Relationship anarchy **53**

4.8 Sex work **54**

4.9 Good practice across relationship diversity **56**

5. Summary of good practice for culturally competent work across GSRD 57

Further Resources 60

References 63

About the Author 68

Acknowledgements 68

Context

This resource is one of a suite commissioned by BACP to enable members, and other counselling and psychotherapy professionals to develop good practice in the field of gender, sexual and relationship diversity.

Using Good Practice across the Counselling Professions Resources

BACP members have a contractual commitment to work in accordance with the current *Ethical Framework for the Counselling Professions*. The Good Practice across the Counselling Professions resources are not contractually binding on members, but are intended to support practitioners by providing information on specific fields of work including good practice principles and policy applicable at the time of publication.

Specific issues in practice will vary depending on clients, particular models of working, the context of the work and the kind of therapeutic intervention provided. As specific issues arising from work with clients are often complex, BACP always recommends discussion of practice dilemmas with a supervisor and/or consulting a suitably qualified and experienced legal or other relevant practitioner.

In this resource, the word 'therapist' is used to mean specifically counsellors and psychotherapists and 'therapy' to mean specifically counselling and psychotherapy.

The terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include the practice of counselling, psychotherapy, coaching and pastoral care.

The aim of this resource is to give information to practitioners about what may be required in order to work with cultural competency across gender, sexual, and relationship diversity.

Author's note on referencing and further resources

I've kept the referencing through this resource light for readability, mostly providing references only to signpost you to further guidance and information on specific topics. If you're interested in following up the evidence for the points made in this resource then the further resources provided at the end offer thoroughly referenced accounts of the same information, in greater depth.

For each GSRD identity or practice I've briefly summarised definitions, common concerns, and further resources in this resource. For more detailed chapters aimed at practitioners on each of these identities and practices, see Richards and Barker (2013). For a summary of the relevant research and theory see the chapters written by experts in each area in Richards and Barker's (2015) edited collection. Both these texts are included in the further resources at the end of the resource.

Author's note on terminology

I've attempted to explain new terms as I go along, or to make their meaning obvious by the context. Definitions are given at the start of each subsection on a specific identity or practice. There's a full glossary of key terms in Richards and Barker (2013), listed in the further resources at the end of this resource.

1. Introduction Gender, Sexual, and Relationship Diversity (GSRD)

1.1 How does British culture understand gender, sexuality, and relationships?

Gender, sexuality, and relationships are all given a high level of importance in 21st century western culture. We're generally asked to identify ourselves on the basis of our gender, sexual 'orientation', and relationship status on forms and on social media, and there are moral panics over those who step outside the perceived norm in any of these areas. Consider recent news stories, TV documentaries, and social media 'storms' around trans people or sex addiction for example.

Gender, sexuality, and relationships are likely to be of great significance in our clients' lives, and it is important to have a good working knowledge of the diversity of forms they can take. Before going into this however, we need to have a clear sense of the understanding of gender, sexuality, and relationships that dominates in our current cultural context. This understanding will shape how we – and our clients – make sense of ourselves and others, and how we experience the world.

Current understanding

The following table summarises the way gender, sexuality, and relationships are widely understood in mainstream western culture and this understanding also underlies most of our therapeutic approaches.

		Attracted to	
		Man	*Woman*
Person is	Man	*Gay*	Straight
	Woman	Straight	*Gay*

So, we generally understand:

- **Gender** to refer to whether a person is a man or a woman.
- **Sexuality** to refer to whether they are straight or gay.
- **Relationship** to refer to forming a lifelong monogamous bond with a person of the opposite/same sex to whom you are both sexually and romantically attracted.

Gender, sexuality, and relationships are inextricably linked, which is why we need to consider them together as GSRD, rather than separating them out. For example, what's regarded as a normal gender requires a normal sexuality in order to express that gender, and a normal relationship in order to express that sexuality.

The elements on the table in italics remind us that men, and straight people, are generally understood as the norm of humanity from which women and gay people deviate, therefore it is a *heteronormative* and *androcentric* model. Consider how the street sign for person and the toilet door sign for man are identical, for example, or how data from men (or straight people) are almost always displayed in graphs or tables prior to that from women (or gay people). Research has found that, when asked to describe a healthy woman and a healthy man, practitioners' definitions of a healthy man are very similar to their descriptions of a healthy human being, while their descriptions of a healthy woman are quite different (less independent, aggressive and persuadable, and more emotional, submissive, and conceited about appearance). There is evidence that this can also be true for therapist descriptions of straight and gay clients.

The understanding depicted in the table above rests on several further assumptions, which may be more implicit, but are also important to keep in mind. These will be explored throughout the rest of the resource:

Gender

- A person must have a gender, it is not possible to be a person without one.
- That gender is binary: a person can only be a man or a woman.
- Gender remains the same throughout life, based on what it was assumed to be at birth depending on a person's visible genitalia (i.e. people are assumed to be cisgender – remaining in the gender that was assumed at birth). In some cases their genitalia will have been altered surgically to make them fit cultural norms for a boy or a girl.
- Men will be masculine, women will be feminine.

Sexuality

- A person must have a sexuality, it is not possible to be a person without one.
- That sexuality is binary: a person can only be straight or gay.
- Sexuality remains the same throughout life: people are 'born gay' or 'born straight'.
- Sexuality is all about gender: our gender and the gender we are attracted to. Related to this, being 'same-sex' attracted may also make gay men more feminine or lesbians more masculine.

Relationships

- A person must have romantic attractions, it is not possible to be a person without them.
- These map onto their sexual attractions, so people are sexually and romantically attracted to the same people.
- It is normal and healthy to form a long-term monogamous couple relationship, perhaps after a period of shorter-lived monogamous couple relationships.
- Deviations from this are seen as less healthy or even abnormal, e.g. non-monogamous relationships, remaining single, or having sexual relationships for reasons other than romantic love (e.g. casual sex or sex work).

Working with cultural competency across GSRD means understanding the problems with these listed assumptions, and their impact on the lives and mental health of people who are marginalised in relation to their GSRD.

1.2 Why this is relevant to mental health and therapy

This binary, hierarchical, interlinked understanding of gender, sexuality and relationships relates to mental health struggles in a number of ways, which will be explored throughout this resource. It can be broken down into three main issues:

- *Those who fit the norms of gender, sexuality, and/or relationships* may well adhere to these rigidly in ways that adversely impact their mental health, due to fear of the stigma of stepping outside the norm. An example of this is the impact on cisgender heterosexual men of not expressing fear or sadness in order to be seen as masculine, and the links between this and the high suicide rate in this group (Kimmel, 2009).

- *Those whose gender, sexuality, and/or relationships fall into the less 'normal' side of the various binaries* (e.g. woman rather than man, gay rather than straight, trans rather than cisgender, non-monogamous rather than monogamous) will likely experience struggles due to being marginalised, discriminated against, or otherwise viewed as less normal. An example of this is the impact of marginalisation (or minority) stress on lesbian and gay people, meaning they have higher rates of most mental health problems than straight people (see stonewall.org.uk/media/lgbt-facts-and-figures).

- *Those whose gender, sexuality, and/or relationships do not fit these binaries at all* (e.g. bisexual, pansexual, queer, non-binary) will likely experience struggles due to being invisible in wider culture, assumed not to exist, or treated with suspicion. Those who fall outside of the normative assumptions that human beings have genders, are sexual and form romantic relationships (e.g. agender, asexual and aromantic people) are likely to struggle for similar reasons. An example of this is the way bisexual people's identities are erased and they are assumed to be gay if they are in a 'same-sex' relationship or straight if they are in an 'opposite-sex' one, with partners and communities often pressurising them not to be open about their bisexuality. This partially accounts for the fact bisexual people have higher rates of mental health problems than either straight, or lesbian and gay, people (see 3.4).

1.3 Situating the current view in time and place

The current cultural understanding of gender, sexuality, and relationships that I have described is omnipresent in our everyday lives from billboard sign to Hollywood movie to social media. For this reason it – or at least a version of it – may well just seem like the truth of how things are. Many people take it for granted whenever they pick a toilet cubicle, announce the gender of their baby, tease a family member about whether they have met a nice boy/girl yet, or ask a friend when they are planning to tie the knot.

A way of demonstrating that our current way of understanding gender, sexuality and relationships is only one way of understanding things is to look at how understandings have varied across time and place. This is relevant to our clients' experiences because their own understandings and experiences of gender, sexuality, and relationships will vary according to the generation they grew up in, and their cultural background.

Historical shifts

Despite a common view that the version of gender, sexuality, and relationships we have explored is the 'normal' – or even 'natural' – way of being, it is actually relatively recent within our western context. Up until the last century or so, British people understood there to be one gender, rather than two 'opposite sexes': women were regarded as merely a somewhat inferior version of men. Even linking colours to gender: pink for girls and blue for boys used to be the other way around in Victorian times. Back in Ancient Greece it was considered appropriate for a man to have sex with anybody of a lower status than him, whether by age, class, or gender. The concepts of homosexuality and heterosexuality were only invented in the late 19th century. Before that sex was widely understood in terms of the sex acts a person engaged in; the gender they were attracted to did not define a person as having a particular identity. Over the course of the 20th century homosexuality was regarded as a sin, a crime, a sickness, and then an acceptable sexuality – albeit inferior to heterosexuality. The idea of forming a lifelong monogamous bond with one person on the basis of romantic love and sexual attraction really only came into its current form in the 1950s.

We can trace much of our current understanding of gender and sexuality to the scientific categorisation of people which began in the late 1800s with the publication of a number of sexological texts classifying sexual and gender 'deviance'. This was intrinsically linked to British Imperialism, which was justified on the basis of categorising peoples into superior and inferior races. We can see how gender, race, and sexuality became bound together by this colonial practice in the lingering tendency to see some racial groups as being more masculine and more sexual than the white male 'norm' (e.g. black people), and some as more feminine and less sexual (e.g. South and East Asian people).

The current model of coupled romantic monogamy also emerged in the late 1800s and early 1900s linked to the requirements of industrial capitalism. This required women to work unpaid in the home caring for the current workforce, and producing the next generation of the workforce. Thus gender, sexuality, and relationships are also intrinsically connected to class, and the financial valuing of some (male, upper/middle class) labour more than other (female, working class) labour. Stigma around sex work – or whorephobia – can also be linked to this historical model of relationships and femininity.

Finally, historically the project of categorising people's sexualities and genders into 'ordered' and 'disordered', 'normal' and 'abnormal' is intrinsically linked with the way in which certain bodies have been defined as normative in western culture, rendering other bodies disordered. We can see the legacy of this in the way that some disabled people experience others regarding them as non-sexual or inappropriate if they are sexual, not sexually attractive, and/or less of a man/woman; as well as in the legacy of regarding some sexual experiences and practices as dysfunctional and paraphilic (Barker and Iantaffi, 2015).

For these reasons when we talk with clients about gender, sexuality, and relationships, it is also important to talk with them about race, class, and disability as they are all interconnected (more on this in 1.5).

Cultural variation

Around the world today our way of understanding gender, sexuality, and relationships is just one among many: something that is particularly vital to be mindful of when working with clients from diverse cultural backgrounds.

In addition to cultures having a wide variation in what they regard to be masculine or feminine behaviours and roles, some cultures have more than two gender categories. For example third gender options are available on passports in several Asian and Australasian countries. Similarly, several cultures do not understand sexuality to be all about gender of attraction, or do not categorise it into gay and straight. Many do not separate gender and sexuality in the white western way. For example in 1990 diverse Native American and First Nations people chose the intertribal term 'Two Spirit' as an umbrella category for a culturally specific gender/sexual/spiritual experience which has always existed within these communities. Here again we see the link between gender, sexuality, race, and colonialism, as white settlers had endeavoured to eradicate this group because they did not match the western binary gender model.

Turning to relationships, it is very clear that the current western model is just one possible model. Only 43 out of 238 societies worldwide are monogamous, with polygamy of some kind being a much more common model (Rubin, 2001). Similarly arranged marriages of some form are more common worldwide than marriage on the basis of romantic love.

Given the impact of understandings of gender, sexuality, and relationships on people's mental health, it is important therefore to explore with clients what the dominant understandings are in their cultural context. Many British clients whose preceding generations emigrated from other countries will be operating with two or more sets of dominant understandings in play. Different understandings will mean that different experiences of gender, sexuality, and relationships are seen as normal/good, abnormal/bad, or simply are not available. For example, we have seen how monogamy or romantic love relationships might be viewed as abnormal in some contexts. In some, gender transition is far more accepted than 'same-sex' attraction, which might mean some opting for transition rather than facing criminalisation or even death penalties for homosexuality. In some cultural contexts 'same-sex' sexual attraction is so unimaginable that close ties and physical affection between men is paradoxically far more culturally approved of than it generally is in western cultures.

1.4 What is Gender, Sexual, and Relationship Diversity (GSRD)?

These days therapeutic training on sexuality and gender – when it happens – usually involves coverage of the mental health issues and therapeutic needs of LGBT people (Lesbian, Gay, Bisexual, and Trans). British counselling bodies like Pink Therapy have suggested the alternative terminology of GSRD for a number of reasons (see Davies and Barker, 2015b):

- The focus on LGBT assumes that sexuality and gender are only relevant – and potentially linked to mental health problems – for people of marginalised sexualities and genders. Actually sexuality and gender are highly relevant – and linked to struggles – for normative groups such as heterosexual and cisgender people too.

- The LGBT abbreviation is ever-expanding into a kind of alphabet soup to incorporate all marginalised genders and sexualities. For example, LGBTQQIP2SA or QUILTBAG include some or all of: queer, questioning, intersex, asexual, pansexual, and Two Spirit people. GSRD is both shorter and more expandable to include emerging communities as wider culture becomes more aware of them.

- LGBT does not cover relationship diversity which, as we have seen, is intrinsically linked to gender and sexual diversity. For example, people who are polyamorous (in multiple relationships), in open relationships, who do not experience romantic attraction, or who privilege platonic love are also marginalised. LGBT also does not cover sexual identities/practices like kink/BDSM.

- The acronym LGBT represents a particular white western understanding of sexuality and gender. As we have seen we need to be cautious not to impose this on people of different cultural backgrounds who may not understand sexuality as an identity, for example, or may have more diverse gender options available to them.

- GSRD captures an important point in time – at the beginning of the 21st century – when we are seeing an explosion of GSRD identities, terminologies, and experiences. For example, Facebook now offers users over 70 gender terms to choose from, nearly half of young people see themselves as somewhere on a spectrum between 'exclusively homosexual' and 'exclusively heterosexual', and there are hook-up apps and social media communities for a wide range of relationship styles including solo polyamory, relationship anarchy, and monogamish. We will cover all of these later in this resource.

GSRD is an important leveller as it reminds us that we are all gender, sexuality, and relationship diverse. Therefore, we all need to reflect on:

- The understandings that are available to us in our cultural context and communities,

- How we are personally positioned in relation to these,

- How they affect our lived experience, and

- How we are likely to relate to clients with similar/different lived experiences.

Just as GSRD training is not just about marginalised clients, it is also not just relevant to heterosexual, cisgender, monogamous therapists. We all need to reflect on this, as we can all fall into making or imposing assumptions in these areas.

Gender, sexuality, and relationships should be aspects we explore with all clients, recognising that they are relevant to everyone, but not necessarily any more relevant to some groups than others.

1.5 Why an intersectional understanding is vital

Hopefully section 1.2 began to give you a sense of why our understanding of GSRD needs to be located in a wider understanding of *intersectionality*. Intersectionality is Black feminist Kimberlé Crenshaw's term for the set of overlapping social identities we all have, and the related systems of privilege and oppression that impact our lives.

So a person's experience of gender, sexuality, and/or relationships – and the options that are available to them in how they express or label their gender, sexuality and/or relationships – will be intrinsically bound up with their race, class, disability, nationality, cultural background, faith, age, generation, geographical location, body shape and size, survivor status, and many further dimensions.

For example, research (Greene, 2000) explored the effects of racism, sexism and hetrosexism. The author found a link between the high levels of sexual harassment, and the historical legacy of both black people, and women being treated as property and black women being regarded as hypersexual. The experience of 'outness' occurs at the intersection of race, gender and sexual identity (Bowleg, Burkholder, Teti and Craig, 2009)

Another example would be whether people have access to supportive communities around their gender, sexuality and/or relationships which, as we know, acts as a vital buffer in relation to mental health struggles. For example, LGBT, polyamorous, and kinky events are often overwhelmingly white and middle class (Sheff & Hammers, 2011). People of colour, and working class people frequently feel excluded by the lack of people like them, by implicit norms about the way things are done and the things people are expected to be interested in, and by the financial outlay required to access such spaces. The body ideals which dominate on hookup and dating apps contribute to many older, disabled and obese people feeling that they are excluded from sexual and romantic relationships, as well as perpetuating racist, classist, disablist and transphobic perceptions of what is and is not attractive.

Just as we need to explore gender, sexuality, and relationships with all clients, we also need to bring each of these other aspects of their intersectional experience into the therapy room. All of them are highly relevant – both alone and combined – to the client's lived experience (see das Nair and Butler, 2012; Collins and Bilge, 2016). Overall therapist cultural competency requires a similar level of understanding and working knowledge of race, culture, class, and disability as it does of GSRD.

1.6 The legacy of non-affirmative and pathologising practice

In addition to being aware that the current cultural model will likely shape our – and our clients' – understandings of GSRD, we also need to be mindful of the legacy of past and present non-affirmative and pathologising practice on clients who are marginalised in relation to their GSRD.

'Same-sex' attraction was pathologised in the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) until the early 1970s, and in the World Health Organisation (WHO) International Classification of Diseases (ICD) until the early 1990s, with attempts at 'conversion therapy' being commonplace until recent decades (King et al., 2007). Only the most recent version of the DSM (5) has categorically stated that asexuality is not pathological, and many sex therapists remain unaware of this and assume that not experiencing sexual attraction is a disorder to be treated. Similarly, being trans has only recently been recategorised as gender dysphoria in the DSM-5 – thus no longer being regarded as a disorder there, although it remains classified as a disorder in the ICD at the time of writing. Sexual sadism and masochism remain in the DSM list of paraphilias, although it is now clear that they are only to be classed as disorders if they cause distress or harm to self or others. Several categories of disorders imply that having multiple sexual partners is pathological.

It is important to remember that even including certain genders or sexual practices – rather than others – in a list of 'mental disorders' reflects and perpetuates the common cultural belief that they are somehow abnormal or unhealthy (Moser and Kleinplatz, 2006).

The evidence on the therapeutic experiences of people who are marginalised in terms of their GSRD, suggests that it is virtually certain that such clients will have prior experiences of being explicitly or implicitly pathologised by practitioners. For example, even though most would no longer attempt gay conversion therapy, and BACP together with other professional bodies opposes any psychological treatment such as 'reparative' or 'conversion' therapy, many still endeavour to make asexual clients sexual, non-monogamous clients monogamous, bisexual clients 'pick a side', and 'cross-dressing', kinky, and sex-worker clients cease these behaviours. Moon (2008) also found that the language therapists use often belies implicit biases against those who are marginalised in terms of their GSRD, even if the therapists believe themselves to be affirmative practitioners.

1.7 Working affirmatively across GSRD

Affirmative practice across GSRD involves offering all clients the same level of comfort in their therapeutic work. For those who are marginalized in relation to GSRD this may require counterbalancing cultural stigma by explicitly affirming marginalised identities, experiences, and practices (Langdridge, 2007).

Therapeutic approaches

The overwhelming majority of our current therapeutic approaches are rooted in the work of white, western, mostly male, thinkers, who were steeped in the western understanding of gender, sexuality and relationships summarised earlier, and in some cases contributed to it.

For this reason, many of our texts and trainings assume that clients will be cisgender, heterosexual, monogamous men and women, and promote understandings of psychological healthiness that involve remaining in the gender assumed at birth, seeking monogamous romantic coupledom, and engaging in penis-in-vagina intercourse. There may be tokenistic mention of LGBT people – perhaps in a single case-study or one-off training day – but that is often the extent of it (Davies and Barker, 2015a).

The clinician illusion means that much that has historically been written – across therapeutic approaches – about people who are marginalized in relation to their GSRD has focused on those who struggle with it. The practitioners writing have generally only engaged with clients from these GSRD groups who have difficulties rather than the wider communities who may well not.

In addition to addressing the class bias in who can afford to access therapy and therapeutic training, and decolonising our curricula to include theories and practices from beyond the white western 'usual suspects' (Jankowski et al., 2017), it is important that we work towards a truly GSRD curriculum. This involves separating out and letting go of the elements of our therapeutic approaches that were 'of their time' and which pathologised or excluded certain GSRD experiences, and drawing on research literatures beyond the client case study.

Systemic and narrative therapies offer perhaps the most socially embedded understanding of client distress, in a way that has the potential for GSRD affirmative practice. However, even these approaches do not entirely escape from normative assumptions (Iantaffi and Middleton, 2018). Until curriculum shifts have been made, you may well find it valuable to supplement your training with specific CPD and reading provided by those with GSRD expertise.

Matching clients and therapists

Due to negative past experiences, some clients may find it valuable to be matched with a therapist who has a similar GSRD identity or practice to their own. While this is not always possible, and of course client and therapist may differ in other important ways, it is a very understandable response given the current level of therapeutic practice, and should be facilitated where possible.

Coming out and self-disclosure

Therapists all make different decisions about how open to be about their own GSRD positions in their materials and in conversations with clients. It is worth being mindful that normative gender, sexuality, and relationship style is often assumed unless people 'come out' otherwise. This can be gently challenged for example by not assuming the gender of a client's partner, or their number of partners, or by sharing your pronoun with a client and asking which they use.

Books and images in a therapy venue can usefully signal awareness of GSRD and being a safe-enough space for clients to speak openly. It is also often valuable to raise key similarities and differences between client and therapist frankly and to invite the client to reflect on how those are for them, and how they affect the power dynamics in the room, rather than letting them go unspoken. Such openness can enable important conversations about intersections which they may have found difficult to bring up.

In the western world there is often an assumption that 'coming out' about one's position in relation to GSRD is the most psychologically healthy thing for a marginalised person to do. We need to be careful not to perpetuate this assumption, as coming out has very different implications for different GSRD identities and practices, and within different intersectional contexts. For example, coming out as kinky or as a sex worker may be received very differently to coming out as gay, and it is not appropriate to expect a trans person to come out to family as a condition of their transition if that family are likely to be violent towards them, or render them homeless (Choudrey, 2016).

Good practice

The rest of the resource will outline good practice in order to work with cultural competency across the range of GSRD identities and practices (that I am currently aware of!). Each section will end with a summary of good practice in the areas of gender (section 2), sexuality (section 3) and relationships (section 4). The list of good practice at the end of the resource (section 5) summarises elements that apply across the board, therefore these are not necessarily repeated at the end of each section.

2. Sex/Gender

2.1 What is sex/gender?

It is commonly assumed that sex refers to whether a person is biologically male or female, and gender to whether they identify as a man or a woman. Under this assumption, the majority of people (cisgender) have matching sex and gender, while a minority of people (transgender) do not. There may be an awareness of a further minority of people who are born with sex characteristics that do not fit typical binary notions of male and female bodies (intersex), or identify as something other than a man or a woman (non-binary).

However, the situation is actually far more complex than this, hence the decision to title this section Sex/Gender (following biologist Fausto-Sterling, 2012). A person's bodily sex, their psychological experience of gender, and the cultural norms and ideals of gender in the world around them, are so inextricably linked that it is probably impossible to ever fully tease them apart. This also means that the common binaries of male/female, man/woman, trans/cisgender, and even binary/non-binary could be called into question (Iantaffi and Barker, 2017).

Here there is a brief overview of the diversity of sex/gender that exists at each level of human experience. In section 2.2 we will see how the bio, psycho, and social elements of sex/gender are interconnected, before going on to briefly overview the range of sex/gender identities and experiences therapists need to be aware of.

Chromosomes

While sex is generally assumed to be dictated by the sex chromosomes (male = XY, female = XX), there are actually various sex chromosome combinations possible (e.g. X, XXY, XYY) and some of us have different chromosomal make-up in different parts of our bodies. Also, our sex/gender characteristics are now understood to be influenced by a number of genes beyond the sex chromosomes, which may be epigenetically 'switched on or off' by our environment (Fine, 2017). It is also worth bearing in mind that few of us actually know our chromosomal make-up.

Hormones

Similarly, sex is generally assumed to be dictated by our circulating hormones (particularly androgens like testosterone for males, and oestrogens for females). Again the situation is more complicated than this as we all have different levels of these various hormones, with some women having higher levels of circulating testosterone than some men, for example. Levels of hormones at various stages of life are also influenced by environmental factors and the roles we take (van Anders, 2012). Many people – cisgender and trans – take external hormones at some point in their life, in the form of birth control, steroids for bodily change, hormone replacement therapy, etc.

Bodies

The sex of a baby is medically assigned depending on the person's visible genitalia. In the past anyone with 'ambiguous genitalia' has been surgically altered to fit a male/female binary. Although this is illegal in some countries, in the UK and other countries where it is still legal, intersex activists continue to fight for any medically unnecessary and potentially damaging surgeries to wait until a person is capable of giving informed consent.

In addition to genital structures (primary sex characteristics), other parts of the body develop in sex differentiated ways at puberty, such as height, weight distribution, having breasts or not, depth of voice, hairiness, etc. (secondary sex characteristics). However, it is worth remembering that on all these aspects some women will appear more 'masculine' than the average man, and vice versa.

Some people, both cisgender and trans, have surgical or other temporary or permanent physical interventions at some point in their lives to alter their bodies in specific sex/gender directions, e.g. shaving/laser treatment, enhancement or reduction of breast tissue, labiaplasty, vaginoplasty, phalloplasty, penis enlargement, voice training, weight-loss surgery, exercise regimes, use of mechanisms such as bras and binders, makeup, etc. Other medical interventions – such as some cancer treatments and psychiatric drugs – can have unwanted bodily 'masculinising' or 'feminising' side effects.

Brains

Research has shown that the vast majority of us combine aspects of what were previously thought of as 'male' and 'female' brains, and there are many men who fit a more 'female' pattern and vice versa (Joel and Fausto-Sterling, 2016). Relatedly there are very few cognitive abilities where consistent sex/gender differences are found, and where there are, they tend to be small (Wood, 2015).

Identity, expression, role, experience

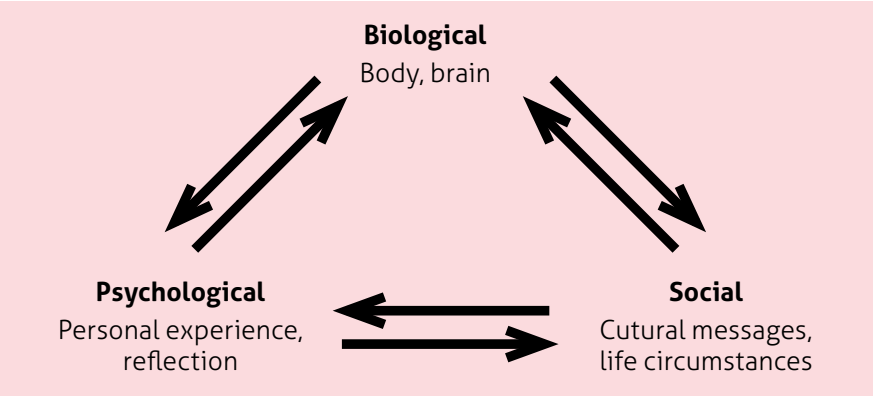
At the psychological and social levels, sex/gender is diverse, with multiple gender identity terms available, various ways of expressing gender through appearance and behaviour, many different possible gender roles, and vastly different experiences of gender depending on a person's cultural context and other intersecting identities.

2.2 A biopsychosocial understanding of sex/gender

It is commonly assumed that a person's biological sex determines their gender identity and experience. However, it is vital to remember that the reverse also happens: our experience of the world around us influences our biology. For example:

- Epigenetics refer to the way environmental factors, such as how safe the world around us is, impact whether certain genes are 'switched on' or not (Carey, 2012).
- Neuroplasticity refers to the way our brain structures, chemistry, and activity are influenced by the world we are in and what we do over the course of our lifetime. Any form of learning alters the connections in our brain, for example learning 'appropriate' gender roles, being encouraged into different interests or school subjects, playing with differently gendered toys as a child, or participating in different jobs and leisure activities as an adult (Fine, 2010).
- Our bodies and brains are shaped by our gendered experiences in the ways described in section 2.1 (e.g. hormonal, surgical, and other physical interventions), and by the gendered ways in which we live our lives, e.g. engaging in certain sports, having a baby, doing manual labour vs. caring jobs, the opportunities afforded by earning more or less money, etc.
- Our bodies and brains are shaped by the constant repetition of the gendered ways in which we have learnt – from wider culture – to speak, to dress, to move through the world, to take up space or not, to express emotion, to find pleasure in things, to relate to others, and a myriad other micro-actions we engage in many times a day (Butler, 2011).

This is a useful diagram to help us – and our clients – to be mindful that all aspects of our biology, psychology, and social context shape each other. The same model holds for our sexuality (section 3), and our relationship patterns (section 4), so it is worth keeping this in mind when reading those sections of this resource too (see Lantaffi and Barker, 2017, and Barker, 2018a for more detailed descriptions of this).



This understanding can be useful to offer to clients who are concerned whether their sex/gender, sexuality, or relationship style is down to 'nature' or 'nurture'. It is also important to question our cultural assumption that things that are 'natural' or 'biological' are more legitimate than those that are 'socially learnt' and/or 'chosen' because (1) it is never a simple nature/nurture binary but rather biopsychosocial, and (2) the foundation of a person's gender, sexuality, or relationship style should be irrelevant to their right to be treated as an equal human being.

For simplicity I will use the word 'gender' rather than 'sex/gender' for the remainder of this resource, but do continue to hold in mind that it is biopsychosocial, and therefore sex/gender cannot be teased apart.

Given the complexities and nuances that we have covered, it is useful to think of gender using the following dimensions:

- Gender assignation: the gender a person was assumed to be at birth, and whether there was any question about this, or any interventions made.
- Gender status: whether a person has remained in the gender they were assumed to be at birth or not.
- Gender identity: how a person identifies their gender – if at all. Here it is useful to explore how this manifests in terms of gender expression, gender roles, and gender experience (Iantaffi and Barker, 2017).

The rest of this section briefly introduces key identities and experiences within each of these dimensions.

2.3 Gender assignation: intersex and diversity of sex development (DSD)

Definitions

Intersex is a broad umbrella term for people who are born with sex characteristics (such as genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies. Some prefer the term 'intersex'; some prefer the phrase 'disorder of sex development' as they prefer to frame it as a medical condition; others point to the fact that we are all diverse in terms of sex development, and prefer the term 'diversity of sex development' (DSD) (see 2.1).

Estimates of the number of intersex people are hard to make due to different definitions, and the fact that many may be unaware of their DSD status, but the figure is often put at around one to two percent of the population. Many intersex people identify as men or women, while some identify as non-binary. Some intersex people are also trans, some are not.

Common concerns

While a person's position in relation to DSD will often be irrelevant to their presenting issues, some may want support around this. The wider cultural assumption of binary gender rooted in binary biological sex may well leave some with insecurities, shame around perceived difference, and/or fear of stigma. Some only find out about their DSD later in life, either because it went unnoticed up to that point, or because it was kept a secret from them. They may want help considering the implications for their sense of themselves, or to deal with the damage done by family secrets, or discovering that they were subject to non-consensual surgeries. Some may want support dealing with the physiological implications of their DSD, and/or medical interventions, in relation to their identity, appearance, reproductive capacity, sexual experience, and/or navigating intimate relationships.

Find out more

- Chapters on Intersex/DSD in Richards and Barker (2013 and 2015)
- Liao, L.M., Roen, K. (2014). *Intersex*. Psychology and Sexuality, 5(1).
- Holmes, M. (Ed.) (2016). Critical intersex. London: Routledge.
- Intersex UK: www.oiiuk.org
- Accord Alliance: www.accordalliance.org

2.4 Gender status: trans

Definitions

Trans, or transgender, is a broad umbrella term for all those who do not remain in the gender that was assumed when they were born. Some may express their gender only at certain times or in certain contexts, others full time. Some may express their gender publicly, through names, pronouns, appearance, documents, etc. (known as social transition), others may not. Some may go through hormonal, surgical and/or other physical procedures to align their body with their gender (known as medial transition), others may not. Some have a fixed sense of their gender, for others it is more fluid.

Estimates of the number of trans people are difficult to make because not all identify as trans after completing their transition, and many people with trans experiences do not go through transition due to cultural transphobia, financial and social barriers to accessing healthcare, or other reasons. The number of people identifying as trans is estimated at around 0.5-0.6% (Flores et al., 2016). Some trans people are intersex, many are not. Trans people may identify as women, men, or non-binary.

Where their trans status is relevant, the terms trans woman/man, woman/man with a trans history, and non-binary trans person are appropriate. Trans masculine and trans feminine are also terms used by non-binary people and others to refer to a broader sense of masculinity and femininity, without necessarily identifying as a man or woman. It is a criminal offence to disclose somebody's trans status in an official capacity without their permission.

Common concerns

While a person's trans status will often be irrelevant to their presenting issues, some trans people seek out therapy in relation to their gender. For example, they may want to explore their options in relation to identity, expression, social transition, or medical transition. Gender dysphoria refers to the distress many trans people feel when their body does not match their gender identity. However, this is on a spectrum from no distress to high distress, may shift over time, and may apply to different parts of the body for different people.

Many trans people experience problems in relation to cultural transphobia, discrimination and violence, or dealing with relationships with people in their life who struggle with their trans status. Young trans people very rarely escape bullying, and around one in 10 have experienced death threats. Because of this, rates of mental health difficulties, self-harm and suicide are shockingly high among trans people. Nearly half of trans people under 26 have attempted suicide (Stonewall, 2015).

Trans people might want support around physical changes, or changes in relation to how other people treat them. As with all GSRD areas, intersectionality is important to keep in mind as it will impact on a person's experience, and how available different options feel for them.

Find out more

- Chapters on transgender in Richards and Barker (2013 and 2015)
- Krieger, I. (2017). *Counseling transgender and non-binary youth*. London: Jessica Kingsley Publishers.
- Vincent, BW. (2018). *Transgender health*. London: Jessica Kingsley.
- Lester, CN. (2017). *Trans like me*. London: Virago.
- Burns, C. (2017). *Trans Britain*. London: Unbound.
- Gendered Intelligence: genderedintelligence.co.uk
- Scottish trans: scottishtrans.org
- Tranz wiki: gires.org.uk/the-wiki

2.5 Gender status: cisgender

Definitions

Cisgender, or cis, is an umbrella term for those who remain in the gender that was assumed when they were born. The term was coined because it is marginalising only to label those who differ from a cultural norm: trans people in the case of gender status. The cis prefix means 'on this side of', as opposed to trans which means 'across from'. As with heterosexuality, monogamy, or whiteness, naming cis-ness, enables us to open it up for discussion in terms of its impact on an individual and their social level.

Few cis people identify as cis, unless they are part of LGBTQ communities, or in relationships with trans people. As with trans men and women, cis men and cis women should simply be referred to as men and women unless their cis status is pertinent. The extent of cisgender is hard to estimate because few people identify in this way, and because it is hard to draw clear lines between those who remain in the gender assumed at birth and those who do not. Trans/cis may be more usefully regarded as a spectrum on which people might place themselves depending on the extent to which they have shifted from the gender identity and roles assumed at birth. For example, we could consider where those who engage in a job or other role assumed to be perceived as a different gender would put themselves, or those who engage in drag or other gender performance, or those who go through the kinds of 'masculinising' or 'feminising' gender-related experiences described in 2.2.

Common concerns

Despite rarely claiming a cis identity, a person's cis-ness may well still be relevant to their mental health and wider lived experience. Many people feel pressure to adhere to the stereotypical gender roles associated with being a woman or a man (see 2.6 and 2.7 for details). This can have a negative impact on their mental health. Some cisgender people may become very concerned over whether or not they are 'normal' if they find themselves having experiences that fall outside of cultural gender roles, for example some men after treatment for prostate cancer struggle with being less able to 'perform' sexually and feeling more emotional. Some cis people may be thinking about making temporary or permanent gender transitions of some kind but still identify as cis for now.

Find out more

- Chapters on cisgender in Richards and Barker (2013 and 2015)
- Connell, R. and Pearse, R. (2014). Gender: in world perspective. Cambridge. Polity.
- Fine, C. (2010). Delusions of gender. London: Icon Books.
- Gill, R. (2006). Gender and the media. London: Polity Press.

2.6 Gender identity: woman

Definitions

As with all gender identities, it is vital not to make assumptions about what being a woman means to any individual. For example, for some women, physical attributes relating to menstruation, childbirth and specific body parts are of paramount importance to the experience of being a women, for other women, these are not important, or not part of their experience.

Being a woman in a British cultural context can often mean defining oneself against a backdrop of cultural norms and stereotypes which are bound up in the historical legacy of patriarchal oppression where, for millenia, women have had fewer rights over their bodies and lives than men (Barker & Scheele, 2019). For example, the gender pay gap means that women still get paid less for the same work as men, and the #MeToo movement highlights the ways in which women's bodies are still often treated as property and women are defined by others in terms of their appearance, sexuality, and relationships with men. Haines, Deaux & Lofaro (2016) found that gender stereotypes of women as nurturing, caring, social, emotional, vulnerable and concerned with appearance were as prevalent in 2014 as they were in 1983. These stereotypes still play out within the media and influence opinion and experience. The epitome of femininity in media and wider culture remains white, youthful, non-disabled, heterosexual, cisgender, and thin. As always, an intersectional understanding is vital and we need to be mindful of the cultural and historical factors that strongly shape all women's experience of womanhood. These will influence, to varying degrees, how we define women, and how women define themselves.

Common concerns

While gender may not always be relevant to a woman's presenting issues, mental health struggles are often gendered. Women have such high rates of body image issues that this has been labelled 'normative discontent' (Rodin, Silberstein and Striegel-Moore, 1984). It has been related to both narrow ideals of feminine beauty, and the contradictory pressures on women today to conform to stereotypical femininity and to be independent and successful. Food and body can represent one potential area of control in an uncontrollable and contradictory world. Women are more likely than men to be diagnosed with depression, anxiety, and many other emotional disorders (Kohan, 2014). This has been linked to the way women's identities are often bound up with other people, for example, rates of depression often peak for mothers when children leave home.

Find out more

- Chapters on transgender and cisgender in Richards and Barker (2013 and 2015)
- Kohan, D. (2014). *Women and mental health*. London: Routledge.
- Adichie, C.N. (2014). *We should all be feminists*. London: Vintage.
- Bates, L. (2016). *Everyday sexism*. Basingstoke: Macmillan.
- Wiesner-Hanks, M. E. (2010). *Gender in History: Global Perspectives*. London: Wiley-Blackwell.
- Lerner, H.G. (2014). *The dance of anger: A woman's guide to changing the patterns of intimate relationships*. New York, NY: William Morrow Paperbacks.
- Penny, L. (2011). *Meat market*. London: John Hunt Publishing.

2.7 Gender identity: man

Definitions

It is important not to make assumptions about what being a man means to an individual. For some men physical attributes relating to size and shape, having certain genitals, or physical strength may be an important part of their experience of being a man, for other men these are not at all important, or not part of their experience.

Being a man in a British cultural context can often mean defining oneself against a backdrop of cultural norms and stereotypes which are bound up in the historical legacy of patriarchal culture globally. For example, it is sometimes assumed to be 'manly' to provide for the family, to be physically able to protect others, and to be attracted to women and to act on these attractions. Men who act differently are often regarded as lesser (Barker & Scheele, 2019). Common gender stereotypes which are still perpetuated in mainstream media and everyday conversation include men being regarded as competitive, ambitious, independent, rational, tough, sexual, confident, dominant, non-emotional, taking risks, and caring about their work. These may well not be part of an individual's lived experience. The epitome of masculinity in media and wider culture remains white, youthful, non-disabled, heterosexual, cisgender, and physically fit. As always, then, an intersectional understanding is vital and we need to be mindful of the cultural and historical factors that strongly shape all men's experience of manhood. These will influence, to varying degrees, how we define men, and how men define themselves.

Common concerns

While gender may not always be relevant to a man's presenting issue, mental health struggles are often gendered. The National Mental Health unit found that being a man was a primary risk factor for several specific mental health problems (Wilkins, 2010). We also know that men are less likely to access therapy than other groups. Suicide rates are high among men. This has been linked to - among other factors - difficulty expressing emotion and old stereotypes of breadwinning, protective men persisting in a time when the types of jobs and relationships that would enable that kind of masculinity are in decline (Beattie & Lenihan, 2018). Vossler and colleagues (2017) point out that men are also likely to express distress through anger and drug/alcohol use, meaning they are more likely to be diagnosed with disorders linked to anti-social behaviour and addiction than depression and anxiety, for example, and that this could contribute to why men are more likely to be criminalised, whereas women are more likely to be pathologised.

Find out more

- Chapters on cisgender and transgender in Richards and Barker (2013 and 2015)
- Beattie, M., & Lenihan, P. (2018). *Counselling Skills for Working with Gender Diversity and Identity*. Jessica Kingsley Publishers.
- Lomas, T. (2014). *Masculinity, meditation and mental health*. Basingstoke: Palgrave Macmillan.
- Connel, R. (2005). *Masculinities*. Cambridge. Polity Press.
- Hooks, B. (2004). *The will to change*. New York, NY: Washington Square
- Press.
- Kimmel, M. (2009). G*uyland: The perilous world where boys become men.* New York, NY: HarperTorch.
- Urwin, J. (2016). *Man up*. London: Icon Books.

2.8 Gender identity: non-binary

Definitions

Non-binary is an umbrella term for people who do not experience themselves as male or female (in the US the umbrella term genderqueer is more commonly used). As with 'man' and 'woman' this term is a big umbrella covering a wide range of different experiences, including people who:

- Do not have a gender (e.g. agender, gender neutral)
- Feel partially male or female (e.g. demi boy/girl)
- Are both masculine and feminine (e.g. bigender)
- Are located somewhere between male and female (e.g. androgynous)
- Have an additional – or third – gender,
- Move between genders (e.g. gender fluid)
- Reject the western binary gender system (e.g. genderfuck*)

* this term is the groups preferred identity descriptor

Technically all non-binary people are trans because virtually all babies are assumed to be male or female at birth, however, not all non-binary people identify as trans.

The extent of non-binary gender is difficult to estimate because many official censuses, surveys, and other documents do not offer a choice beyond male and female. When they do offer a further option, around 0.4% of people choose this (Barker, Vincent & Twist, 2017). However, this statistic is likely to change as cultural awareness of non-binary gender is increasing at a rapid rate, and greater numbers of young people see gender as a spectrum and locate themselves as somewhere between extremes of masculinity and femininity. In the general population, over a third of people say they are to some extent the 'other' gender, 'both genders' and/or 'neither gender' (Joel et al., 2014), therefore exploration of gender beyond a binary understanding may well be relevant to a far larger group of clients than those who identify as non-binary.

Common concerns

While a person's non-binary identity or experience may well be irrelevant to their presenting issues, the world is so binary when it comes to gender that most non-binary people will experience some struggles navigating it, such as the cumulative impact of constant everyday misgendering and microaggressions (Sue, 2010; Nadal, 2013).

Those who identify as non-binary and/or express themselves in ways that challenge binary gender face similarly high levels of mental health difficulties and suicide attempts as trans people more generally, linked to common experiences of transphobia (see 2.4) and non-binary invisibility (see 3.4). Three quarters of non-binary people avoid situations for fear of being misgendered, outed, or harassed, two thirds feel that they are never included in services, and very few feel able to be out in their workplace or educational context (see 'Find out more', bullet 2). As with other trans people, non-binary people may appreciate help navigating the options available to them, dealing with cultural marginalisation, and considering their relationships with others. An open, affirming, normalising therapeutic space can be invaluable for this.

Find out more

- Chapters on further genders in Richards and Barker (2013 and 2015)
- Barker, M-J., Vincent, B., Twist, J. (2017). *Non-binary: A British History*. In C. Burns (Ed.) Trans Britain. London: Unbound.
- Richards, C., Bouman, W., Barker, M.J. (Eds.) (2017). *Genderqueer and non-binary genders*. Basingstoke: Palgrave Macmillan.
- Beyond the Binary: beyondthebinary.co.uk
- The Non-Binary Exclusion Project: nonbinary.co.uk

2.9 Good practice across sex/gender diversity

In addition to the overall good practice guidelines listed in section 5, the following are particularly important points in order to work in a culturally competent way across sex/gender diversity:

- Reflexively engage with your own assumptions – and cultural norms – about sex/gender.
- Engage in CPD around intersex/DSD, trans, and non-binary gender if you want to work with clients from these groups affirmatively. If you have not done this work, refer on to somebody who has where possible.
- Do not expect your client to educate you, but do be open to the nuances of their unique lived experience of their gender.
- Be careful not to assume the gender of a client based on appearance. Check out their sense of their gender, and how they would like you to refer to them, and make sure that you respect this. If you get it wrong, simply apologise and move on.
- Be aware of the cultural norms around gender, and the variety of possibilities within each gender – or agender – category, rather than perpetuating a fixed notion of what people of a certain gender status or identity should be like.
- Be aware of intersections, acknowledging the difference in how gender is experienced across race, class, culture, disability, sexuality, age, generation, body type, etc.
- Encourage clients to consider any gender expectations and assumptions they have, and where these come from.
- Normalise gender diversity, and diversity of options in relation to gender identity and expression.

- Do not assume that the gender of somebody with a non-normative gender will be relevant to their presenting issue. Do not assume that the gender of somebody with a normative gender will not.
- Be prepared to share information about online and offline gender communities and resources clients might find useful.

3. Sexuality

3.1 What is sexuality?

It is generally assumed that sexuality refers to a person's 'sexual orientation': whether they are attracted to the 'same sex' (gay), the 'opposite sex' (straight), or possibly both (bisexual) – although the existence of such a non-binary sexuality has often been questioned (Barker, et al. 2012). This 'orientation' is commonly regarded as something we are born with which remains fixed over time.

Recent research and theory has challenged all these assumptions, suggesting an alternative model where our sexuality operates on a number of dimensions (van Anders, 2015), all of which are fluid rather than fixed, meaning that our place on them may vary over time (Diamond, 2009).

Key dimensions can include:

- Our degree of attraction, from none to high levels.
- The physical sex of the people we are attracted to, if any.
- The gender of the person we are attracted to, if any (how masculine, feminine or androgynous they are, if indeed we can tease sex and gender apart in this way, see section 2).
- Whether we are attracted to those who mirror our own gender, those who differ from it, both or neither (Bettcher, 2014).
- The number of people we can be attracted to at the same time, from none to many (see section 2).
- Aspects of people we are attracted to which are not linked to gender, such as physical and psychological characteristics, age, body shape and size, etc.
- Where we like to be on a spectrum from active to passive during sex, if anywhere.
- How dominant or submissive we are, if either.

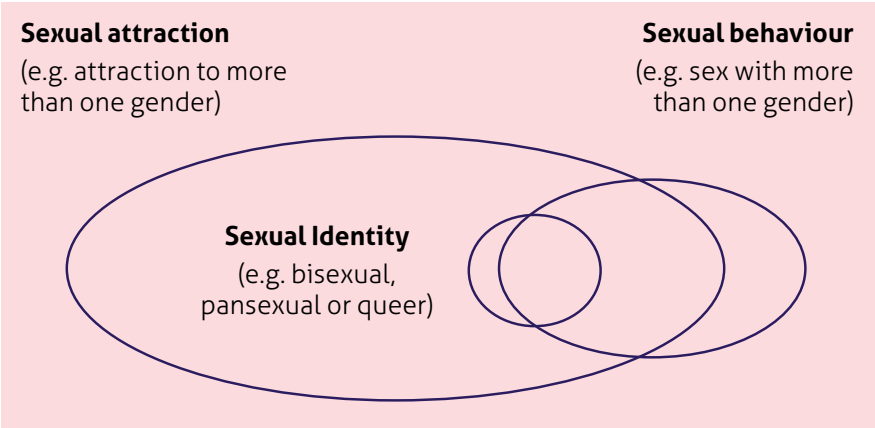
Van Anders suggests that our sexual attraction (who we want sex with, if anyone) and our emotional attraction (who we want relationships with, if anyone) may be in different places on many of these dimensions. So this is also relevant to the subsequent section of this resource on relationships (section 4). There may similarly be variety in terms of where we are in relation to sex with others, and in relation to solo sex and/or what we fantasise about. Klein et al. (1985) suggested we might also distinguish people in terms of social and political sexual identities, which can differ from their actual sexual attractions or behaviours (see 3.2).

Even these dimensions may well fail to capture all the nuances of sexuality. Eve Kosofsky Sedgwick (1990) summarises the problems with the 'sexual orientation' model like this:

It is a rather amazing fact that, of the very many dimensions along which the genital activity of one person can be differentiated from that of another (dimensions that include preferences for certain acts, certain zones or sensations, certain physical types, a certain frequency, certain symbolic investments, certain relations of age or power, a certain species, a certain number of participants, and so on) precisely one, the gender of the object choice, emerged from the turn of the century, and has remained, as the dimension denoted by the now ubiquitous category of "sexual orientation". (p.8)

3.2 Identities, practices/experiences, and attractions

To complicate matters further, people may well be in different places with their sexual identities, from where they are with their sexual behaviours, experiences or practices, and from where they are with their sexual attractions or desires.



For any aspect of sexuality the largest proportion of people have that desire or attraction without necessarily acting on it or identifying with it.

A smaller group behave in that way or practice that sexuality, and a smaller subset actually identify as that sexuality.

For example, YouGov has found that over 40% of young people are attracted to more than one gender while only around two percent identify bisexual, pansexual, or queer. Far more than two percent engage in sex with more than one gender, while identifying as gay or straight (see 3.4).

The overlaps on the diagram are because some people identify with a sexuality without necessarily having acted upon it (e.g. some young people and celibate people), and some behave in a ways that do not match their sexual attraction (e.g. some actors, sex workers, and people learning about their sexuality).

Therefore it is worth exploring identities, practices, and attractions with all clients, as well as being cautious not to assume one on the basis of another. For example many people practise kink without identifying as kinky, and many people engage in sexual activity with more than one gender while identifying as straight or gay (Ward, 2016).

Biopsychosocial

As with sex/gender, all dimensions of sexuality can best be understood as biopsychosocial (see 2.2). Again this can be a helpful understanding to share with clients who are struggling to figure out whether they are 'really' a certain sexuality, or whether they were 'born this way'. A good example to demonstrate this might be the specific kind of person we find physically attractive. It becomes very clear when considering this how wider cultural notions of beauty weave together with our own early and later sexual experiences, and with the ways our bodies and brains respond (Barker, 2018a).

Conversion therapy

As with sex/gender, it is important to question our cultural assumption that things that are 'natural' or 'biological' are more legitimate than those that are 'socially learnt' and/or 'chosen'. (1) it is never a simple nature/nurture binary but rather biopsychosocial, and (2) the foundation of a person's gender, sexuality, or relationship style should be irrelevant to their right to be treated as an equal human being. Similarly, being – to some extent – socially constructed, or personally chosen, does not make a particular sexuality any less 'real', or more amenable to attempts to change it.

Some clients may be drawn to 'conversion therapy' due to societal homophobia, biphobia, kinkphobia, or pressure to be sexual, for example. However, all the major UK therapeutic bodies are united against the practice of such conversion therapies (see Further Resources). The same applies to attempts to change a person's gender (e.g. from trans to cisgender, see section 2).

Exploration of wider cultural messages, intersectional experience, and acceptance and kindness towards self may be useful conversations to bring into the therapy room with clients who feel uncomfortable in their sexuality, in addition to the biopsychosocial model.

The rest of this section briefly introduces key sexual identities and practices.

3.3 Extent of attraction: the asexual spectrum

Definitions

Asexuality, or ace, is an umbrella term for people who do not experience sexual attraction. The concept of an asexual spectrum also includes those who have little sexual attraction or rarely experience it (grey-A people), and those who experience it only under certain conditions, such as when they have a strong emotional connection (demisexual people). The notion of a spectrum opens up our understanding of sexual attraction to range from none at all, to very high, without any place on that spectrum being indicative of a 'disorder' or 'pathology'. For this reason DSM-5 made it very clear that asexuality should not be treated as a sexual dysfunction, and refused to include any category relating to 'sex addiction' (see Brotto and Yule, 2017; Ley, 2012).

Asexual people may be celibate or not. Some are averse to sex, whereas some are willing to have it for other reasons than sexual attraction, for example to give a partner sexual pleasure, or in return for other forms of pleasure. Some may have solo sex, others do not. Some experience their asexuality as fluid, others as fixed. Many asexual people want romantic relationships, whereas aromantic people do not (see 4.6). Romantic asexuals may describe their romantic attractions as biromantic, heteroromantic or homoromantic, while for others it is related to other aspects than gender, such as intellectual connection. The extent of asexuality is impossible to estimate given that many people do not experience sexual attraction but would not identify in this way, but it is suggested that around one percent of people explicitly identify as asexual.

Common concerns

While a person's place on the asexual spectrum will often be irrelevant to their presenting issue, our culture still operates under a strong sexual imperative which assumes that it is normal, natural and healthy to be sexual, and that partner relationships must be sexual. Neither of these things is the case and it is worth normalising this with clients who are struggling under such pressures.

Asexual people may be treated in hostile ways by others, e.g. being told that their sexuality is 'just a phase', that they have not 'met the right person yet', being given sex toys, or even being sexual assaulted by people who want to 'cure' their asexuality (Carrigan, 2015).

As with all GSRD areas, intersectionality is important to keep in mind as it will impact on a person's experience, and how available different options feel for them. It is important not to make stereotypical assumptions in respect of a person's sexuality. These stereotypes however will influence how we view others, and how others view us. For example, assumptions are often made that men, young people above 16 and black people are highly sexual, whereas people who are older, disabled or under 16 are not. These are not true reflections of individuals experiences, and can make navigating asexuality, or sexuality, difficult for these groups.

Find out more

- Chapters on asexuality in Richards and Barker (2013 and 2015)
- Carrigan, M., Gupta, K. and Morrison, T.G. (Eds.). (2015). *Asexuality and sexual normativity: An anthology.* London: Routledge.
- Decker, J.S. (2015). *The invisible orientation: An introduction to asexuality.* New York, NY: Skyhorse Publishing.
- Andrews, A.K. (Ed). (2015). *Ace and proud: An asexual anthology.* Purple Cake Press.
- The Asexual Visibility and Education Network (AVEN): asexuality.org

3.4 Gender of attraction: bisexuality, pansexuality and queer

Definitions

There are a number of terms for people who are attracted to more than one gender, or for whom the gender of the person they are attracted to is irrelevant, or not particularly relevant. Some prefer the word bisexual (with the 'bi' standing for attraction to 'the same gender as me' and 'different genders to me'). Others prefer 'pansexual' to capture the irrelevance of a person's gender, or queer to challenge the whole idea of binary gender and sexuality (see 2.1, Barker and Scheele, 2016). 'Bisexuality' is often used as the umbrella term for these kinds of identities and experiences given it is the term recognised by official bodies as part of LGBT.

The extent of bisexuality is difficult to determine because the numbers would be very different depending on whether you were talking about identity, attraction, or behaviour (see 3.2). The Office for National Statistics finds that 0.4% of British adults identify as bisexual, but the proportion rises to 1.8% in young people (more than the numbers identifying as lesbian or gay). Stonewall estimate that around 5-7% of people are LGB, with bisexual people being the largest group within that. When asked by YouGov where their attractions lie, 43% of young people place themselves as between exclusively homosexual and exclusively heterosexual on a scale. This demonstrates the importance of going beyond identity when talking with clients about their sexuality.

Common concerns

While a person's bisexual identity, experience, or attraction will often be irrelevant to their presenting issues, like people with non-binary genders, bisexual people are often erased by the binary understandings of wider culture (see 1.1 and 2.8). This takes a significant toll on their mental health with global studies consistently finding higher rates of mental health difficulties among bisexual people than either straight or lesbian/gay people. Double discrimination is also a significant problem as bisexual people are frequently discriminated against in both straight, and lesbian/gay communities (Barker et al., 2012).

Biphobic assumptions include seeing bisexuality as a phase or confusion on the way to a 'mature' gay/straight identity, treating bisexual people with suspicion, or regarding them as inherently greedy or promiscuous.

Bisexual people who are out often have to come out repeatedly to the same people who 're-closet' them by assuming that they are 'really' gay or straight, perhaps on the basis of a current partner. Many bisexual people in relationships feel unable to be open about their sexuality due to disapproval by a partner or community. All this means that it is particularly important for therapists to affirm the legitimacy of bisexual identities and experiences their clients have, and the range of ways of understanding and labelling these.

Find out more

- Chapters on bisexuality in Richards and Barker (2013 and 2015)
- Firestein, B.A. (2007). *Becoming visible: Counseling bisexuals across the lifespan.* New York, NY: Columbia University Press.
- Fox, R.C. (2014). *Affirmative psychotherapy with bisexual women and bisexual men.* London: Routledge.

- Barker, M., Richards, C., Jones, R., Bowes-Catton, H., Plowman, T. (2012). *The Bisexuality Report: Bisexual inclusion in LGBT equality and diversity.* Milton Keynes: The Open University, Centre for Citizenship, Identity and Governance. Available from: www.open.ac.uk/ccig/sites/www.open.ac.uk.ccig/files/The%20BisexualityReport%20Feb.2012_0.pdf

- Harrad, K. (Ed.). (2016). Purple prose: *Bisexuality in Britain.* Portland, OR: Thorntree Press LLC.

- Bisexual Index, list of British bisexual organisations: bisexualindex.org.uk/index.php/Links

3.5 Gender of attraction: lesbian and gay sexuality

Definitions

The words 'lesbian' and 'gay' refer to a monosexual attraction to the 'same' gender. Women who are attracted to women may use the word lesbian or gay, whereas men generally use the word gay. However, it is important to remember that due to biphobia (see 3.4), binary understandings of sexuality (see 1.1), and the non-binary and fluid way sex/gender works (see 2), some of those who identify as lesbian or gay do have some attraction to other genders. Some may experience this but feel a strong political or social affiliation to the lesbian and gay community. Also, there are many people who have same-sex attractions and activities who do not identify as lesbian or gay. This may be due to cultural homophobia or heteronormativity. Or it might be because they do not understand sexual attraction as dictating identity if they come from cultural contexts where this does not make sense, or have a more queer understanding (see 3.4).

For these reasons, the extent of lesbian and gay sexuality is hard to estimate. British statistics find that 1.1% of adults, and 1.4% of young people, explicitly identify as lesbian or gay, although YouGov found that four percent of adults, and six percent of young people, rate themselves as 'exclusively homosexual' when asked to place themselves on a spectrum of sexual attraction. Stonewall estimates that the figure is more like five to seven percent of people being LGB altogether.

Common concerns

While a person's lesbian or gay identity or experiences will often be irrelevant to their presenting issues, we still live in a heteronormative and homophobic society, which means that rates of mental health problems are higher for lesbian and gay people than for straight people (King et al., 2008).

For example, the assumption that people are heterosexual unless they say otherwise means that lesbian and gay people have to choose either the stress of coming out and facing unknown reactions from others, or the stress of remaining in 'the closet' and keeping their identities or attractions a secret. Both of these take a toll. There is also homonormativity to be navigated, which is the set of norms about appropriate gay/lesbian experience that has emerged as wider culture has become less overtly homophobic. People may feel pressure to be the 'good gay citizen' by conforming to norms of attractiveness, getting married, and so on.

As with all GSRD areas, intersectionality is important to keep in mind as it will impact on a person's experience, and how available different options feel for them. For example, somebody who was assigned female at birth who is attracted to women and is masculine of centre may identify in different ways depending on their community and cultural context. Some may transition to be trans men, others may adopt a trans masculine non-binary identity. Some may embrace a butch lesbian or dyke identity. Some in the Black community may see themselves as a stud. Some within the queer community may use a term like 'boi'. Within any of these understandings, there is still a range of options, for example 'soft butch', 'stone butch', or 'futch' (feminine butch). Similarly there are a range of femme/feminine identity terms for women who are attracted to women – and others – and multiple terms for varieties of gay male identity.

Also considering intersectionality, for gay men who live in urban areas and engage in casual sex, issues around chemsex and HIV may be key, and it would be worth therapists knowing about the latest party scene drugs and their impact, and the current situation regarding the availability of PrEP (Pre-Exposure Prophylaxis). However, for a gay monogamous couple these issues may be irrelevant, and they may be more concerned with the available options regarding parenting (e.g. adoption, surrogacy, or co-parenting). For a young gay trans man, the concerns may be far more around navigating dating other men, who may be unfamiliar with trans bodies.

Find out more

- Chapters on lesbians and gay men in Richards and Barker (2013 and 2015)
- Ritter, K.Y. and Terndrup, A.I. (2002). *Handbook of affirmative psychotherapy with lesbian women and gay men*. New York, NY: The Guildford Press.
- Skinta, M.D. and Curtin, A. (Eds.) (2016). *Mindfulness and acceptance for gender and sexual minorities*. Oakland, CA: New Harbinger Publications.
- Calman, S. (2016). *Cheer up love*. London: Two Roads.
- Todd, M. (2016). *Straight jacket*. London: Random House.
- Stonewall: stonewall.org.uk/media/lgbt-facts-and-figures

3.6 Gender of attraction: heterosexuality

Definitions

The term heterosexual, or straight, refers to a monosexual attraction to the 'other' gender: men who are attracted to women, and women who are attracted to men. However, it is worth remembering that, due to cultural heteronormativity, homophobia, and biphobia, many people who are attracted to the 'same' gender, or more than one gender, will say they are heterosexual. Also, if we take a more diverse understanding of sex, gender, and sexuality, many people's attractions and relationships may look straight from the outside but be experienced as pretty queer on the inside, for example those involving trans and non-binary people, those involving submissive men and/or dominant women, or feminine men and/or masculine women, and those involving a variety of sex practices (see 3.7).

For these reasons the extent of heterosexuality is hard to estimate. The British Office of National Statistics finds that 93.5% of adults identify as heterosexual, but only 72% of adults and 46% of young people say that they are 'exclusively heterosexual' when offered a spectrum from heterosexuality to homosexuality.

Common concerns

Despite rarely claiming a heterosexual identity, a person's heterosexuality may well still be relevant to their mental health or wider lived experience. Many heterosexual people feel pressure to rigidly adhere to the societal gender roles associated with being a straight woman or man in ways that can negatively impact on their mental health (see 2.6 and 2.7 for details).

Some heterosexual people may become very concerned over whether or not they are 'normal' if they find themselves experiencing some attraction to the 'same' gender or to a non-binary person. Some people who identify as straight may be thinking about coming out as another sexuality, but remain straight-identified for now.

In addition to concerns about straying outside heterosexuality, and what that would mean for their identity, many straight people experience problems due to rigid norms about what counts as heterosexual sex: penis-in-vagina penetration (Mitchell et al., 2013). Around half of people see themselves as having a sexual difficulty, mostly due to the narrow range of sexual activities that are considered acceptable for straight people, and the requirements of this (e.g. erect penises, penetrable vaginas, orgasms, Barker, 2018a). Also this is a sexual practice with a high risk of STI and HIV transmission, which is exacerbated if people assume they are in a monogamous relationship which is actually secretly non-monogamous (see 4.4): a common relationship situation among heterosexuals.

There is generally a wider sense of possible sexual practices and relationship styles among LGBTQ people than among cisgender heterosexuals. Heterosexual people may also feel societal pressure to have children.

Find out more

- Chapters on heterosexuality in Richards and Barker (2013 and 2015)
- Dean, J.J. (2014). *Straights: Heterosexuality in post-closeted culture.* New York, NY: NYU Press.
- Beasley, C., Brook, H., Holmes, M. (2012). *Heterosexuality in theory and practice.* London: Routledge.
- Holland, J., Ramazanoglu, C., Sharpe, S., Thomson, R. (2004). *The male in the head: Young people, heterosexuality and power.* London: Tufnell.
- Jackson, S. (Ed.). (2009). *Heterosexuality in question.* London: Sage.
- Segal, L. (1994). *Straight sex: Rethinking the politics of pleasure.* Oakland, CA: University of California Press.

3.7 Sexual practice: BDSM, kink, and beyond

Definitions

BDSM stands for Bondage and Discipline, Dominance and Submission, Sadism and Masochism. The umbrella terms 'BDSM', 'kink', and sometimes 'fetish' or 'leather', encompass a range of consensual erotic, sexual, or sensual practices which may involve heightened sensations or pain, and/or the exchange of power, and/or some form of restraint or role-play, and/or watching other people (exhibitionism) or being watched (voyeurism). Role-playing such as being an animal (furry) or being older or younger (age-play) are also common, although not always considered part of kink/BDSM. Some people regard their BDSM status or kink to be an identity, e.g. being a top or dom/me (dominant), a bottom or sub (submissive), a switch (who tops and bottoms), or a kinkster or sadomasochist. Others regard it as a practice they engage in which is not an identity. Some may keep their kink in the realm of fantasy and/or erotic reading/writing/viewing, while some engage in kink practices in solo sex and/or with others.

The extent of BDSM is hard to estimate, but the massive popularity of the Fifty Shades books and films suggest that some interest in kink is incredibly common. Around two thirds of people have fantasies about bondage, and other common interests like spanking and roleplay are not far behind (Renaud and Byers, 1999). Over a third of people sometimes use masks, blindfolds and bondage equipment during sex (Durex, 2005).

Common concerns

While a person's kink identities or practices will often be irrelevant to their presenting issues, they may well be nervous about working with a therapist – or revealing these interests – due to the continued pathologisation of BDSM (1.6), and the likelihood of having bad prior experiences with therapists (Kolmes, Stock and Moser, 2006; Kelsey et al., 2013). Kinky people are no more psychologically unhealthy than anyone else. Indeed the most recent research suggests that they may even be more healthy (Wismeijer and Assen, 2013). Nor do their childhoods differ in any meaningful way from non-kinky people (Nordling, Sandnabba and Santtila, 2000).

If people do want to discuss their kink practices or identities in therapy it may be because they are struggling due to cultural kinkphobia or people in their life who are unaccepting of their kink. Kink-affirmative therapy can be very helpful under such circumstances, as is an awareness of the various online and offline kink communities that people might find useful and supportive. Some people find their kink practices to be healing and/or therapeutic, for example as a form of stress reduction, as a way of dealing with past shame or trauma, or as a way of accessing different sides of themselves. In such situations therapy working in parallel with kink play can be very useful (Barker, Gupta, and Iantaffi, 2007). Some people may be concerned about their kink fantasies or whether they should act upon them. In these situations a good knowledge of consent and power is vital (see 3.8).

This quote from Gayle Rubin (1984) is worth keeping in mind when working across diverse sexual desires and practices:

Most people find it difficult to grasp that whatever they like to do sexually will be thoroughly repulsive to someone else, and that whatever repels them sexually will be the most treasured delight of someone, somewhere... Most people mistake their sexual preferences for a universal system that will or should work for everyone' (p.283).

Find out more

- Chapters on BDSM/Kink and further sex in Richards and Barker (2013 and 2015)
- Shahbaz, C., Chirinos, P. (2016). *Becoming a kink aware therapist.* London: Taylor and Francis.
- Taormino, T. (Ed.). (2012). *The ultimate guide to kink: BDSM, role play and the erotic edge.* Jersey City, NJ: Cleis Press.
- Harrington, L., Williams, M. (2012). *Playing well with others: Your field guide to discovering, exploring and navigating the kink, leather and BDSM communities.* Eugene, OR: Greenery Press.

- Langdridge, D., Barker, M. (Eds.) (2007). *Safe, sane and consensual: Contemporary perspectives on sadomasochism.* Basingstoke: Palgrave Macmillan.

- Moser, C., Kleinplatz, P. (2006). *Sadomasochism: Powerful pleasures.* New York: Harrington.

3.8 Consent

An important thread to keep in mind when working with all sexualities, in terms of practice, is consent. Psychiatrist Chess Denman (2003) points out that practitioners are often so focused on whether a sexual practice is culturally normative or not that they can lose track of the far more important issue of whether it is consensual or not. This is further muddled by the inclusion, within the DSM-5 'paraphilic disorders' and other similar lists, of some behaviours which are there by virtue of being regarded as nonnormative or transgressive (e.g. disorders relating to consensual BDSM and 'cross-dressing') and some which are there by virtue of being nonconsensual (e.g. disorders relating to sex with children and adolescents).

It is vital not to assume that non-normative sexualities are any more likely to be practised non-consensually than normative ones. In fact the emphasis on consent, and nuanced understanding of it, in kink, queer, and asexual communities may well mean that quite the opposite is the case (Barker, 2013).

Consent should not be simply regarded as a matter of free, independent, agentic adults saying 'yes' or 'no' to a particular practice. Rather it should be recognised that it is much more difficult to create the conditions under which informed consent is possible in the following situations (Barker, Gill and Harvey, 2018):

- Where there is a sexual imperative in place so people feel that they must perform sex – or a certain kind of sex – and pleasure in order to demonstrate their normality, to perform masculinity/femininity, or to keep a relationship, for example.

- Where there is a clear sense of a 'proper' sexual script which should be followed, otherwise sex is regarded as having failed, and the person/relationship may be seen as a failure. In this case there is often also a lack of any sense of the diverse range of erotic, sexual, and sensual practices that are possible.

- Where there are power imbalances between the two – or more – people involved, for example one being much older than the other, gender/race/class imbalances, one being regarded as less attractive than the other, one being under the influence of drugs/alcohol and others not, etc.

- Where the wider relationships and/or culture is non-consensual, for example where attempts to control, manipulate or persuade other people are normalised (e.g. making somebody eat food they do not want, attend social functions they are not interested in, have physical contact they may not be comfortable with, smile when they are not happy, and/or work in ways that are not congruent for them).

If you, and/or a client, has concerns around whether their sexual desires are possible to be acted upon consensually, whether they are behaving ethically and consensually themselves, and/or whether their past sexual experiences may have been non-consensual or abusive, it can be useful to raise these listed points. Be mindful that:

1) non-consensual fantasies are extremely common and may even be helpful survival strategies in life (Morin, 2012);

2) they may never be acted upon, or people may find consensual ways of acting upon them through accessing erotica, ethical porn, or kink spaces; and

3) people often feel a good deal of shame about them, meaning they may find them hard to talk about. Bringing them out into the open in the safe-enough space of therapy can be incredibly helpful both in terms of exploring the rest of the client's lived experience, dealing with past trauma, enhancing their sexual experience, and ensuring that their future sexual behaviour will be ethical and consensual

(Barker, 2018a; Barker and Hancock, 2017).

3.9 Good practice across sexual diversity

In addition to the overall good practice information listed in section 5, the following are particularly important points in order to work in a culturally competent way across sexual diversity.

- Reflexively engage with your own assumptions – and cultural norms – about sex and sexuality.

- Engage in CPD around lesbian, gay, bisexual, pansexual, queer, asexual spectrum, and kinky identities and practices if you want to work with clients from these groups affirmatively. If you have not done this work, refer on to somebody who has where possible.

- Do not expect your client to educate you, but do be open to the nuances of their unique lived experience and meanings of their sexual identities and practices. Aim to demonstrate comfort discussing the variety of GSRD sexual practices.

- Be careful not to assume the sexuality of a client based on heteronormative assumptions, or on their appearance, the gender of a partner mentioned, expectations about normal sexual practices, or anything else. Check out their sense of their sexuality and make sure that you respect this. Be open to them choosing any label – or no label – for their experiences or attractions.
- Be aware of the cultural norms around sexuality, and the variety of possibilities within each sexual – or asexual – category, rather than perpetuating a fixed notion of what people of a certain sexual identity or practice should be like.
- Be aware of intersections, acknowledging the difference in how sexuality is experienced across gender, race, class, culture, disability, age, generation, body type, etc.
- Encourage clients to consider any sexual expectations and assumptions they have, and where these come from.
- Normalise sexual diversity, and diversity of options in relation to sexual identities, desires, and practices, including a person being anything from not sexual at all to highly sexual. Do not imply that lack of sexual attraction, or high sexual desire, is a problem to be treated.
- Do not assume that the sexuality of somebody with a non-normative sexuality will be relevant to their presenting issue. Do not assume that the sexuality of somebody with a normative sexuality will not be relevant.
- Be prepared to share information about online and offline sexual communities and resources clients might find useful.
- Be open to bringing consent into the conversation with all clients – rather than just those engaging in non-normative sexual practices. Recognise the reasons why consent can be challenging in the current cultural context, normalise non-consensual fantasies, and openly engage with clients around how they can ensure ethical and consensual practice with themselves and others.

4. Relationships

4.1 Relationship diversity

Under the current interconnected cultural understandings of gender, sexuality, and relationships it is generally assumed that it is normal, natural, and healthy for people to pair-bond: to form a romantic, coupled partnership (see 1.1).

This relationship is prioritised over other relationships in life – with the possible exception of relationships with children. It is assumed that people's sexual and romantic attractions will occur with the same person: so their romantic relationship will also be the relationship where their sexual needs and desires are met. It is also generally assumed that this relationship will be sexually – and possibly emotionally – monogamous: couples will not have sex with anybody else, and may well have limits about how emotionally close they are allowed to be with other people too. It is often expected that couples will commit to each other in the form of marriage and will cohabit and raise a nuclear biological family together.

The way these norms play out in therapy can be seen in the fact that 'relationship therapy' is generally assumed to mean therapy for romantic/sexual/partner relationships, it is frequently used synonymously with 'marital therapy' and 'couple therapy', and is often linked with 'sex therapy', as in 'sex and relationship therapy'.

The current state of relationships

However, all these understandings of relationships are currently under question as the majority of people are not living their relational lives in ways that meet these assumptions (see Barker, 2018b; Barker and Gabb, 2016). For example:

- A third of adults live alone, not in a partnership.
- Increasing numbers of partners are LATs (Living Apart Together) through choice and/or circumstances.
- Between a quarter and a half of relationships in which people agree to be monogamous are actually secretly non-monogamous (in the form of affairs and infidelities), and around five percent of relationships are openly non-monogamous.
- Around half of marriages end in divorce, and many people are engaged in some form of step-parenting and/or extended/adopted family.
- Many people have sexual relationships and encounters outside of love/romantic relationships.
- Many people do not experience romantic attraction and/or prioritise platonic or other relationships in their lives.

As with the other areas covered in this resource, we can also question simple binary distinctions in this area, for example between single/coupled, monogamous/non-monogamous, and platonic/romantic. Many people are engaged in dating and hook-up relationships – often via online apps – which make it difficult to categorise them as single or in a relationship. Relationship styles such as 'monogamish' and 'the new monogamy' blur the lines between monogamy and non-monogamy, and there is little agreement over which side of the line things like online porn, cybersex, friendships with ex-partners, and flirting with colleagues fall.

Relationship anarchists, friends-with-benefits arrangements, and queer platonic relationships challenge the platonic/romantic distinction and the way romantic relationships have been prioritised.

As with gender and sexuality, the implications for therapy are to hold all consensual relationship styles and structures as equally valid, rather than perpetuating a sense of the 'right' or 'ideal' way of doing relationships. Intersectionality is also key here as the relationship norm described above is a white western norm. Working in a multicultural context, many of our clients will come from cultural and faith backgrounds where, for example, arranged marriages and/or polygamy are the standard way of doing relationships (see 1.3; Rambukkana, 2015).

The rest of this section briefly introduces key relationship identities and practices.

4.2 Solo-ness and singledom

Definitions

'Single' is the standard term used for people who are not in a romantic relationship, on official documents and the like. Culturally it is often stigmatised and regarded as a state people would not choose to be in, particularly as they get older. However, some people embrace singledom. Recently the word 'solo' has emerged in some communities to reflect a choice to be your own primary relationship. This may involve a decision to retain independence, to live alone, to spend some time in solitude, and/or to avoid the relationship escalator model of increasing closeness in relationships, for example (Gahran, 2017).

Solo polyamorous people may have several romantic and/or sexual relationships (see 4.5). Solo monogamous people may be open to one romantic and/or sexual relationship while retaining their solo-ness (see 4.3). Unless they are aromantic and/or asexual, single and solo people may well also engage with romantic and/or sexual encounters, for example through dating, hooking up with people for casual sex, having fuckbuddies* or friends-with-benefits relationships, seeing sex workers, engaging in cybersex or online porn/erotica, etc. They may also challenge the common misconception that solo-sex and self-pleasure are less 'proper' kinds of sex than sex with another person (Barker and Hancock, 2017).

*this term is the groups preferred identity desciptor

Common concerns

For many people, their single/solo status will be irrelevant to their presenting issues. However, the cultural relationship imperative means that some singles and solos, particularly those who have not chosen to be that way, may feel immense pressure to find a romantic partner relationship. Solo polyamorous and solo monogamous people may appreciate support in articulating their relationship style to those in their lives who have normative assumptions, and considering how they will navigate their solo-ness, given that there are many potential ways to do so.

In all cases it is important to normalise singledom and solo-ness, and to challenge cultural narratives that insist that a partner relationship is necessary to be 'complete' or to live a happy life. It is useful to open up the losses and gains involved in both having partner relationships, and being single/solo, and to recognise that single and solo relationship styles can be a good fit for people at some intersections, for instance some younger people, some neurodiverse people, and some people with histories of trauma.

Find out more

- Gahran, A. (2017). *Stepping off the relationship escalator.* Off the Escalator Enterprises. (solopoly.net)
- DePaulo, B. (2006). *Singled out. How singles are stereotyped, stigmatised and ignored, and still live happily ever after.* New York, NY: St. Martin's Griffin.
- Witt, E. (2017). *Future sex.* London: Faber and Faber.
- Wade, L. (2017). *American hookup: The new culture of sex on campus.* London: WW Norton and Company.
- Farvid, P. and Braun, V. (2017). U*npacking the "pleasures" and "pains" of heterosexual casual sex: beyond singular understandings.* The Journal of Sex Research, 54(1), 73-90.
- psychologytoday.com/blog/the-polyamorists-next-door/201310/solo-polyamory-singleish-single-poly

4.3 Monogamies

Definitions

While people frequently assume that monogamy is one thing and that they know what it is, actually there is as much diversity under the umbrella of monogamy as there is under non-monogamy or singledom.

People frequently assume that they, and their partner, have the same understanding of monogamy only to realise that they do not when one of them inadvertently breaks the other's implicit rule (Warren, Harvey and Agnew, 2011), for example around flirting, kissing, solo sex, online porn or sexual encounters, close friendships, or friendships with ex partners.

The concepts of monogamish relationships and the new monogamy have emerged to capture relationships which are somewhat open to sexual contact and/or emotional closeness with others, often within certain boundaries (like the 50 mile rule where it is only allowed at a distance). Lifelong monogamy is relatively rare as people live longer and many relationships end in separation and/or divorce. Serial monogamy is a common relationship style in which people have many long and/or short-term monogamous relationships in their lives, one after the other. At the short-term end this may blur into dating.

Common concerns

Despite rarely claiming a monogamous identity, a person's monogamy may well still be relevant to their mental health or wider lived experience. There is currently a great deal of pressure on monogamous partners to meet all of each other's needs and desires (e.g. friendship, belonging, support, passion, cohabiting, co-parenting, excitement, validation, etc.). At the same time there is pressure for people to be atomised individuals with their own independent goals and desires for success. Life-long monogamy is challenging under these conflicting pressures (Barker, 2018b).

It can be helpful, with clients, to normalise the range of relationship styles and structures that are possible, both within and outside monogamy. It can also be useful to help them to clarify how they would like to do their relationships rather than taking this for granted, and then communicating about this with current or potential partners as they consider their relationship agreements (Barker and Hancock, 2016). One useful model for people to consider – across monogamous and non-monogamous relationship styles, is this spectrum model of emotional and sexual monogamy. People can locate themselves and others on these spectrums. Importantly there is no 'better' or 'worse' place to be, rather it is a matter of openly negotiating where each relationship will sit, given where the individuals involved are situated.

Spectrum of emotional closeness

Monoamorous ---------- Polyamorous

One emotionally close relationship, no close relationships beyond this

Multiple emotionally close relationships

Spectrum of physical/sexual contact

Monosexual ---------- Polysexual
One sexual relationship, no sex/physical contact beyond this — Multiple, sexual relationships

Like people in other relationship styles, monogamous people may also find it useful to openly explore the commitments they want to make in their relationship/s and their sense of what they expect from the relationship over time (Barker, 2018b).

Find out more

- Chapters on monogamy in Richards and Barker (2013 and 2015)
- Ansari, A. (2016). *Modern romance*. London: Penguin Books.
- Nelson, T. (2013). *The new monogamy*. Oakland, CA: New Harbinger Publications.
- Wilby, R. (2017). *Is monogamy dead? Rethinking relationships in the 21st century*. Mountain Ash CF. Accent Press.
- Barash, D.P., Lipton, J.E. (2001). *The myth of monogamy: Fidelity and infidelity in animals and people*. New York: W. H. Freeman and Co.
- Conley, T.D., Ziegler, A., Moors, A.C., Matsick, J.L., Valentine, B. (2013). *A critical examination of popular assumptions about the benefits and outcomes of monogamous relationships*. Personality and Social Psychology Review, 17(2), 124-141.
- Barker, M-J., Hancock, J. (2016). *Make your own relationship user guide*. www.megjohnandjustin.com.

4.4 Secret non-monogamies

Definitions

A relationship model that is at least as common as monogamy, if not more so, is secret non-monogamy, generally taking the form of affairs or infidelity. Conservative estimates put the rate of affairs in marriage at a quarter (Fincham and May, 2017), but other studies have estimated over twice that much, with higher numbers in unmarried relationships also (Vangelisti and Gerstenberger, 2004). There are popular apps and websites specifically designed for monogamous people seeking affairs. Adding to this the number of people who realise they had different monogamy rules, so it feels to one of them that infidelity happened, then we have a majority rather than a minority of people being non-monogamous.

Again secret non-monogamy takes a wide variety of forms in terms of number of other partners, frequency of affairs, whether one or both people engage in it, the extent of their knowledge, etc. It may be more useful to view secrecy to openness of non-monogamy as a spectrum. 'Don't ask, don't tell' arrangements, and situations where another lover is more of an open secret, shade into more open forms of non-monogamy.

Common concerns

With secret non-monogamy it is easy for therapists to become focused on the non-normativity of what is being done: going against the normative rules of monogamy. However, under a GSRD affirmative approach, non-monogamy is an equally valid form of relating to monogamy, and the boundaries between them are blurred anyway. Given this, the key issue with secret non-monogamy is its non-consensual nature (see 3.8) and the secrets, lies, and deception which are involved. There may also be non-consensual deception and invasion of privacy on the part of a partner who has 'discovered' another's infidelity.

Thus the goal of therapy is not to stop the non-monogamous person or people from being non-monogamous – just as we would not attempt to stop a gay or trans person from being gay or trans – rather it is helping them navigate their relationship such that non-monogamy can either be done consensually and openly, or the relationship can end or change if partners are too incompatible in terms of where they are at with non/monogamy for this to be possible.

It can be hugely helpful, with secretly non-monogamous people, to normalise how incredibly difficult lifelong monogamy is (see 4.3), how it is hard – if not impossible – to get warmth and heat in the same relationship (Perel, 2007), and how many diverse ways there are of navigating non/monogamy (see 4.3 and 4.5).

Find out more

- Chapters on monogamy and non-monogamy in Richards and Barker (2013 and 2015)
- Perel, E. (2017). *The state of affairs: Rethinking infidelity*. New York, NY: HarperCollins. (estherperel.com)
- Perel, E. (2007). *Mating in captivity: Sex, lies and domestic bliss*. London: Hodder and Stoughton. (estherperel.com)
- Duncombe, J., Harrison, K., Allan, G., Marsden, D. (Eds.). (2014). *The state of affairs: Explorations in infidelity and commitment*. London: Routledge.
- Barker, M-J., Hancock, J. (2016). *Make your own relationship user guide*. www.megjohnandjustin.com.

4.5 Open non-monogamies

Definitions

As with the other relationship styles and structures, there are a wide variety of ways of being openly, or consensually, non-monogamous. Common models are open relationships and polyamory.

Open relationships involve couples who have sexual – but not love – relationships with other people. For example, swingers have open relationships where they have sex with others in a social way, often at parties or clubs, either together or separately. Open relationships are the norm among gay men, and may involve couples cruising together or separately, meeting individuals on hook-up apps, and/or going to sex parties or saunas.

Polyamory, or poly, involves people having multiple love relationships which can also be sexual. For example, some individuals have two equal relationships (a V arrangement where they are the bottom point on the V). Some form a triad, quad, or family of people who are all are involved with each other. These are examples of egalitarian polyamory where partners are valued equally. Hierarchically polyamorous people have one primary relationship and other, more secondary, ones.

Common concerns

A person's open non-monogamy will often be irrelevant to their presenting issues, and sadly many people have the experience of therapists latching onto their relationship style when it is not relevant, or even trying to convert them to monogamy (Graham, 2014). The main issue that many non-monogamous people will appreciate support with is navigating the mononormative world, and dealing with a wider culture, and people in their lives, who question or challenge their relationships. Given the lack of legal protections around non-monogamous relationships, they may have anxieties, for example, around childcare or being out at work, despite the many benefits non-monogamy has for both adults and children in such set-ups (Sheff, 2013).

Some may also want help with navigating their own particular way of doing non-monogamy, and with relationship agreements. The three self-help texts at the end of the resources below will be particularly helpful with this. It is also important to know that non-monogamous communities can develop their own 'rules' and 'norms' about the best way to do relationships, which will not fit everyone. This has been called 'polynormativity'. It is good to help a client tune into their own meanings around relationships, and motivations for non-monogamy, to find the best way of doing things for them. People of colour and working-class people may particularly struggle with the privileging of white middleclass ways of relating within non-monogamous communities (Sheff and Hammers, 2011), and it may be useful to help them to explore the various more diverse communities which now exist (e.g. see the black and poly Facebook group and online magazine, and Ruby Bouie Johnson's writing).

Find out more

- Chapters on non-monogamy in Richards and Barker (2013 and 2015)
- Labriola, K. (2010). *Love in abundance: A counselor's advice on open relationships.* California, CA: Greenery Press.
- Weitzman, G. (2009-2010). *What psychology professionals should know about polyamory.* National Coalition for Sexual Freedom. Available from: http://ego.thechicagoschool.edu/s/843/images/editor_documents/What%20therapists%20should%20know%20about%20Polyamory.pdf
- Barker, M. and Langdridge, D. (Eds.) (2010). *Understanding non-monogamies.* New York: Routledge.
- Veaux, F., Rickert, E. (2014). *More than two: A practical guide to ethical polyamory.* Thorntree Press, LLC. (morethantwo.com)
- Easton, D., Hardy, J.W. (2017). *The ethical slut.* Berkeley, CA: Celestial Arts
- Taormino, T. (2008). *Opening up: A guide to creating and sustaining open relationships.* San Francisco: Cleis Press, Inc.

4.6 Aromantic experience

Definitions

Perhaps the most insidious assumptions around gender, sexuality, and relationships currently are that people inevitably have a gender (see 2.8), and sexual and romantic attractions (see 1.1). The sexual and romantic imperatives make life very hard indeed for asexual people who do not experience sexual attraction (see 3.3) and aromantic people who do not experience romantic attraction.

There is very little research on aromantic experience to date, and no estimates of the numbers of people who are aromantic. It is likely that many of those who do not experience romantic attraction are either single (see 4.2) or have established monogamous or non-monogamous relationships where they feign romantic interest, or negotiate their aromanticism with specific partners. Like asexuality (3.3), aromanticism can usefully be regarded as a spectrum, with grey-romantic people experiencing some romantic attraction and demiromantic people only experiencing romantic attraction when they have a strong emotional connection.

Common concerns

While a person's place on the aromantic spectrum will often be irrelevant to their presenting issue, aromantic people may well struggle with the cultural romantic imperative. It is worth normalising the range of romantic and aromantic experience with clients who are suffering from such pressures. Aromantic people may be treated in hostile ways by others, e.g. being told they are immature or that they have not 'met the right person yet', or being pressured into dating. Intersectionally there may be particular pressure on aromantic women given that romantic relationships are seen as such an intrinsic part of femininity (see 2.6).

Aromantic people who are also asexual may struggle with the multiple marginalisation of the combined sexual and romantic imperatives. Aromantic people who are sexual may find it challenging to form sexual relationships with others who will not pressure them into becoming romantic partners. Some people cope with these challenges by meeting with other aromantic people; friends-with-benefits, fuckbuddy*, sex work and hook-up options (see 4.2); and various openly non-monogamous arrangements such as being a secondary partner to a romantic partner who gets their romantic needs met with a romantic primary (see 4.5). Relationship anarchy models may also appeal to aromantic people (see 4.7), as may queerplatonic or quasiplatonic models, where people form close platonic emotional connections with people, which may have a similar level of commitment to a romantic relationship.

*this term is the groups preferred identity descriptor

Find out more

- Chapters on asexuality in Richards and Barker (2013 and 2015)
- wiki.asexuality.org/Aromantic_FAQ
- aromantic.wikia.com
- aromanticaardvark.tumblr.com
- qpadvice.tumblr.com

4.7 Relationship anarchy

Definitions

Relationship anarchy (RA), and relationshipqueer, are words for relationship styles, which question the idea that romantic relationships should be privileged over other kinds of relationships – both culturally and in individuals' lives.

Of course many people have relationships that are as close and/or valued as romantic relationships, e.g. relationships with family, friends, colleagues or work partners, companion animals, etc. However, they may struggle to find ways for these relationships to be recognised by others, and by wider society. RA and queer platonic relationships explicitly challenge the hierarchical view of relationships and commitments (Barker, 2018b). Relationshipqueer relationships are queer in the sense that they challenge relationship normativity (see 4.1), just as queer sexuality challenges heteronormativity (3.1) and homonormativity (3.5), and genderqueer challenge gender normativity (2.1). Like fluid sexuality and gender fluidity, relationship anarchists have also pointed out that relationships and relationship styles are fluid and can change over time: relationship fluid being another potential label for some.

In addition to valuing all the different kinds of relationships in a person's life, there is emphasis on freedom in RA models, rather than anybody belonging to another person. Therefore any relationship agreements are seen as something to be made within each relationship, rather than being imposed on anybody else and RA people are likely to be openly non-monogamous rather than monogamous. However, they might not necessarily choose to have multiple romantic and/or sexual relationships if they are aromantic or asexual, or if they simply prefer to put their time and energy into a diverse range of relationships. There is an emphasis on trust, respect, and intentional ongoing negotiation in RA relationships of all kinds (Barker, Hancock, 2016).

Common concerns

People are likely to have thought hard about their relationships to reach an RA relationship style. As with any form of open non-monogamy, this will be irrelevant to the presenting issue for many clients. However, clients may appreciate support with exploring what RA means for them, with accessing online or offline support from like-minded people, and with navigating relationships with others, who may not be RA, or who may have different understandings of what such terms mean. For example, there may be tensions if an RA person regards a friendship as a close queerplatonic bond, but that friend treats them very differently after getting into a romantic relationship.

Like some aromantic and asexual people, RA people often decouple romance and sex in a way which seems unusual to somebody who is unfamiliar with this. For example, it is common in RA and queer communities for friends to have sex together, for sex to happen at parties, and for people to have casual hook-ups, without that necessarily being linked to any kind of ongoing commitment or romantic connection. Similarly, non-sexual relationships may be experienced in very romantic ways.

Find out more

- Chapters on non-monogamy in Richards and Barker (2013 and 2015)
- Nordgren, A. (2006). *The short instructional manifesto for relationship anarchy.* https://theanarchistlibrary.org/library/andie-nordgren-the-short-instructional-manifesto-for-relationship-anarchy
- Barker, M., Heckert, J. and Wilkinson, E. (2013). *Queering polyamory: From one love, to many, and back again.* In T. Sanger and Y. Taylor (Eds.) Mapping intimacies: Relations, exchanges, affects. pp.190-208. Basingstoke: Palgrave Macmillan.
- Heckert, J. and Cleminson, R. (Eds.). (2011). *Anarchism and sexuality: Ethics, relationships and power.* London: Routledge.
- relationship-anarchy.com
- Wiley, C. (2016). *Relationship anarchy takes the judgment out of love.* The Establishment, https://theestablishment.co/relationship-anarchy-takes-the-judgment-out-of-love-96a9a7af9954

4.8 Sex work

Definitions

Sex work covers the broad range of occupations where people receive money for some form of erotic or sexual engagement. For example, this could include: acting in porn, erotic massage, webcam sex, escorting, sexual surrogacy, street-based sex work, tantric massage, sexological bodywork, professional domination, running cuddle parties, etc. Some of these are far more stigmatised and/or criminalised than others, impacting on the experiences of those involved.

Like aromantic people and relationship anarchists, sex workers trouble conventional understandings of relationships (see 4.1) because they engage in sexual encounters for reasons other than romantic love. Like asexual people (see 3.3) they also challenge the sexual imperative by having sex for reasons other than sexual attraction. It is important to remember that actually sometimes people regularly have sex for reasons other than sexual attraction, including receiving various forms of compensation. Sometimes couples implicitly or explicitly exchange sex for gifts, dates, housework, romance, or other forms of physical contact, for example. Initial negative reactions to sex work, and not these other exchanges, on the part of a therapist may be due to the cultural stigma termed 'whorephobia'.

Common concerns

While a person's occupation should be irrelevant to their presenting issues, some forms of sex work are surrounded by cultural stigma or criminalised, a report in Psychology Today described how therapists often struggle to respect sex work as a legitimate form of employment. Sex workers who have spoken out about their experiences in therapy, and on therapy training courses, have talked about being pathologised, attempts to convert them away from sex work, and therapists saying they feel like 'pimps' for taking their money (e.g. sex worker psych, 2017).

As with other identities and practices covered in this resource, dealing with cultural whorephobia is a concern for many sex workers (Minichiello, Scott and Cox, 2017), including navigating their relationships with partners, friends, families, and/or other employers, and decisions about whether to be 'out' or not about their sex work.

This perhaps all explains why some therapists struggle with sex worker clients. Both professions involve an intimate relationship with clients, exchanging money for emotional labour, and maintaining clear relational boundaries. Body therapies, somatic therapies, sexological bodywork, tantric practice, and surrogacy blur the boundaries still further, and there remains much debate within therapy about whether it is ethical or not to touch clients or to refer clients to professionals who do, when in the best interests of the client.

Media representations often suggest a binary when it comes to sex work: sex workers can only be happy 'high class' call girls or trafficked women victims. It is important to remember that the vast majority of sex workers do not fit either of these categories. Some sex workers do have issues around their work and how it affects their life and relationships but struggle to seek help because the advice is often simply to exit the profession. It is important to remember that many people, in all forms of employment, dislike some aspects of their jobs, or even hate them.

Working affirmatively with sex worker clients involves respecting their occupation as any other, and exploring the meaning of sex work – for them – if it is something they want to discuss. It would also be useful to have a good awareness of the current legal situation for sex workers in their part of the profession in order to be able to support them as effectively as possible if they are considering their options or navigating the law in some way. The same is true for clients who see sex workers.

In relation to intersections, gender is important to consider. Remember that all genders engage in sex work, not just women (see Laing et al., 2015). Some trans people become sex workers in order to fund their transitions and/or because they find other employment hard due to transphobia. Also, some trans sex workers have to work as a different gender to the one they identify in, in order to find work, which can be hard and present a barrier to physical and medical transitions. Sex work also intersects with disability as other employment options may not be available for people who are only able to work for a certain amount of time, or in certain ways, and/or have to work from home.

Find out more

- Mac, J. (2016). *The laws that sex workers really want*. TED, ted.com/talks/juno_mac_the_laws_that_sex_workers_really_want
- Tyler, A. (2017). Sex work. In A. Vossler, C. Havard, G. Pike, M-J Barker and B. Rabbe (Eds.) Mad or Bad? *A critical approach to Counselling and Forensic Psychology*. London: Sage.
- Laing, M., Pilcher, K., Smith, N. (Eds.). (2015). *Queer sex work*. London: Routledge.
- Sanders, T. (2013). *Sex work*. London: Routledge.
- Sex Worker Advocacy and Resistance Movement (SWARM): swarmcollective.org

4.9 Good practice across relationship diversity

In addition to the overall good practice information listed in section 5, the following are particularly important points in order to work in a culturally competent way across relationship diversity.

- Reflexively engage with your own assumptions – and cultural norms – about love, relationships, and sex work.
- Engage in CPD around aromanticism, non-monogamy, relationship anarchy, and sex work if you want to work with clients from these groups affirmatively. If you have not done this work, refer on to somebody who has where possible.
- Do not expect your client to educate you, but do be open to the nuances of their unique lived experience of their relationships and employment.
- Be careful not to assume the relationship style or status of a client based on initial information (e.g. marital status or mention of a partner). Check out their sense of their relationships, and make sure that you respect this.
- Be aware of the cultural norms around relationships, and the variety of possibilities within each monogamous – or non-monogamous – category, rather than perpetuating a fixed notion of what people of a certain relationship style should be like.
- Be aware of intersections, acknowledging the difference in how relationships are experienced across gender, race, class, culture, sexuality, age, generation, body type, etc.

- Encourage clients to consider any relationship expectations and assumptions they have, and where these come from.
- Normalise relationship diversity, and diversity of options concerning relationship styles and sexual contact.
- Do not assume that the relationships of somebody with a non-normative relationship style will be relevant to their presenting issue. Do not assume that the relationships of somebody with a normative relationship style will not.

5. Summary of good practice for culturally competent work across GSRD

Reflexive work and training

- Engage in CPD and reading on GSRD if you want to work with GSRD clients.
- Examine the dominant understanding of gender, sexuality, and relationships in your cultural and/or community contexts, and recognise that this is only one way of understanding GSRD.
- Reflexively engage with your own position in relation to GSRD, and the relationship between this and your other intersections.
- Become aware of your implicit biases, and the structural inequalities in your wider society, and reflect on these in training and perhaps through contemplative practice (Barker, 2015; Berila, 2016).
- Engage with intersectional understandings of how GSRD is situated within intersecting social identities and dynamics of privilege and oppression, and bring this awareness into the room with clients.
- Be aware of the impact of gender, sexuality, and relationship normativity, stigma, and discrimination in the lives of marginalised clients, particularly the legacy of pathologising therapeutic practice.
- Be mindful of the power dynamics between client and practitioner, and the potential of reinforcing social structures of oppression.

Therapeutic environment

- If working in a clinic, centre or organisation, encourage all staff – including administrative staff – to have training and self-reflection around GSRD, and other intersections.

- Ensure online and offline materials reflect GSRD, e.g. posters on waiting room walls, magazines, books, images on website, etc.
- Ensure any forms for clients include all possible GSRD options where relevant, including options beyond 'male' and 'female', and that they do not make normative assumptions (e.g. that a client will be sexual, or will have only one partner).
- Ensure that any reception staff use people's correct names, titles, pronouns, etc.

Practice

- Be aware of your biases and the limits of your expertise. If you are concerned that you may not have the openness and expertise to work with a particular client, refer on to somebody who does where possible.
- Do not expect clients to educate you about their gender, sexuality, or relationship style in the sessions they are paying you for! Be prepared to do your homework, guided by the client where relevant. Therapy-time should not be used for your CPD and building your cultural competency.
- Respect clients' gender, sexuality, and relationship style, and be open to the diversity of ways in which they may, or may not, self-identify and/or practise these. Do not make assumptions based on limited information, e.g. about pronoun or sexual identity.
- Be careful not to implicitly or explicitly reinforce the pathologisation or stigmatisation of a client's sexuality, gender, or relationship style.
- Be aware that not all supervisors will necessarily have expertise on GSRD issues. In such cases it can be useful to access additional formal and/or peer supervision on top of your regular supervision, in relation to a particular client or client group.

Different positions of clients

For clients whose position in relation to GSRD is inside the cultural norm, be mindful of:

- The impact of cultural pressure to be 'normal'.
- The potential losses involved in disowning or repressing sides of oneself in order to fit perceived norms.
- The mental health implications of endeavouring to rigidly adhere to cultural stereotypes.
- The fear and/or shame that clients may well have around transgressing the norm in any way.

- The instability of the insider/outsider binary which means that clients may have unwittingly strayed outside the norm, or may have to work hard to police this binary and remain on the 'right side' of it, as the world around them changes.

For clients whose position in relation to GSRD is outside the cultural norm, be mindful that:

- For the vast majority of clients, this will be irrelevant to their presenting issue. Do not assume it is relevant unless the client brings it up.

- Where the client is struggling with their position in relation to GSRD the problem may well be more about the way they are treated by other people in their lives, or wider society. Normalising the range of GSRD options, and affirmatively counterbalancing cultural stigma is important here, as is rendering visible identities and practices that are culturally erased, such as bisexuality and asexuality.

- If their position in relation to GSRD is an issue for the client themselves, it can be useful to help them access support from others with similar identities and/or practices, and to openly explore where they would like to be in relation to GSRD. A focus on self-acceptance and kindness is often helpful. Be clear with clients that conversion therapy is not an option if they ask for that, and be up for exploring why this is wanted.

- Be careful not to individualise client's problems where these are clearly grounded in their social context (e.g. prejudice and alienation).

Further Resources

If you want to think more about your cultural competency in this area then this is a very useful article: pinktherapyblog.com/2017/07/13/running-a-culturally-competent-service

Therapy books

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

- Beattie, M., & Lenihan, P. (2018). *Counselling Skills for Working with Gender Diversity and Identity.* Jessica Kingsley Publishers.

- Butler, C., O'Donovan, A., Shaw, E. (Eds.). (2009). *Sex, sexuality and therapeutic practice: A manual for therapists and trainers.* London: Routledge.

- das Nair, R., and Butler, C. (2012). *Intersectionality, sexuality and psychological Therapies: Working with lesbian, gay and bisexual diversity.* Oxford: Wiley-Blackwell.
- Moon, L. (Ed.) (2007). *Feeling Queer or Queer Feelings: Counselling and Sexual Cultures.* pp106-124. London: Routledge.

Overviews of relevant research and theory

- Barker, M-J. (forthcoming 2018). *The psychology of sex.* London: Routledge and Psychology Press.
- Barker, M-J. and Scheele, J. (2019). *Gender: A Graphic Guide.* London: Icon.
- Barker, M-J. and Scheele, J. (2016). *Queer: A graphic history.* London: Icon Books.
- Richards, C. and Barker, M.J. (Eds.) (2015). *Handbook of the psychology of sexuality and gender.* Basingstoke: Palgrave Macmillan.
- Clarke, V., Ellis, S.J., Peel, E. and Riggs, D.W. (2010). *Lesbian, gay, bisexual, trans and queer psychology: An introduction.* Cambridge University Press.
- Dess, N., Marecek, J., Best, D. and Bell, L. (Eds.) (2017). *Psychology of gender, sex, and sexualities.* Oxford: Oxford University Press.

Self-help books and websites for therapists and clients

- Iantaffi, A. and Barker, M-J. (2017). *How to understand your gender: A practical guide for exploring who you are.* London: Jessica Kingsley.
- Barker, M-J. and Hancock, J. (2017). *Enjoy sex (how, when and if you want to): A Practical and inclusive guide.* London: Icon Books. (megjohnandjustin.com)
- Barker, M-J. (2018). *Rewriting the rules: An anti self-help guide to love, sex and relationships.* London: Routledge. (rewriting-the-rules.com)

Additional online resources

- Pink Therapy: pinktherapy.com
- Pink Therapy Conference presentations: youtube.com/user/pinktherapyuk
- Stonewall: stonewall.org.uk
- The Queerness: thequeerness.com
- The gender kit: genderkit.org.uk

Other relevant guidelines, reports, and memoranda

- British Psychological Society – Shaw. L., Butler. C., Langdridge. D., Gibson. S., Barker, M., Lenihan, P., Nair, R., Monson, J., and Richards, C. (2012). *Guidelines for psychologists working therapeutically with sexual and gender minority clients.* London: British Psychological Society. beta.bps.org.uk/news-and-policy/guidelines-and-literature-reviewpsychologists-working-therapeutically-sexual-and

- American Psychological Association. (2012). *Guidelines for psychotherapy with lesbian, gay, and bisexual clients.* American Psychologist, 67(1), 10-42.

- Australian Psychological Society. (2000). *Ethical guidelines for psychological practice with lesbian, gay and bisexual clients.* Melbourne: Australian Psychological Society.

- King, M., Semlyen, J., Killaspy, H., Nazareth, I. and Osborn, D. (2007). *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people.* London: British Association for Counselling and Psychotherapy.

- Taskforce, A.L.C., Harper, A., Finnerty, P., Martinez, M., Brace, A., Crethar, H.C. and Kocet, M. (2013). *Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling Competencies for counseling with lesbian, gay, bisexual, queer, questioning, intersex, and ally individuals.* Journal of LGBT Issues in Counseling, 7(1), 2-43. bit.ly/2vxFN8Q

- Burnes, T.R., Singh, A.A., Harper, A.J., Harper, B., Maxon-Kann, W., Pickering, D. L. and Hosea, J.U.L.I.A. (2010). *American Counseling Association: Competencies for counseling with transgender clients.* Journal of LGBT Issues in Counseling, 4(3-4), 135-159. bit.ly/2ve2OOX

- Farmer, L.B., Watson, J.C., Davis, R.J., Luke, M., Dispenza, F., Akers, W. and Reicherzer, S. (2012). *Standards of Care in Assessment of Lesbian, Gay, Bisexual, Transgender, Gender Expansive, and Queer/Questioning (LGBTGEQ+) Persons.* bit.ly/2vele28

- Hope, S. (2018). *Person-Centred Counselling for Trans and Gender Diverse People: A Practical Guide.* London: Jessica Kingsley Publications.

- Bradstreet, B., Calver, S., Kent, R., Klein, T., Mitchell, M.B., Parker, D. and Watson, V. (2014). *Working therapeutically with LGBTI clients: A practice wisdom resource.* National LGBTI Health Alliance: Australia. lgbtihealth.org.au/resources/working-therapeutically-with-lgbti-clients

- The Memorandum of Understanding on Conversion Therapy in the UK, Version 2 https://www.bacp.co.uk/news/news-from-bacp/2018/3-july-bacp-welcomes-end-to-conversion-therapy

References

Barker, M. (2013). *Consent is a grey area? A comparison of understandings of consent in 50 Shades of Grey and on the BDSM blogosphere.* Sexualities, 16(8), 896–914.

Barker, M-J. (2015). *Social mindfulness.* www.rewriting-the-rules.com/zines.

Barker, M-J. (2018a). *The psychology of sex.* London: Routledge and Psychology Press.

Barker, M-J. (2018b). *Rewriting the rules: An anti self-help guide to love, sex and relationships.* London: Routledge.

Barker, M-J. and Scheele, J. (2019). *Gender: A Graphic Guide.* London: Icon.

Barker, M.J. and Gabb, J. (2016). *The Secrets of Enduring Love: How to Make Relationships Last.* London: Penguin RandomHouse.

Barker, M-J., Gill, R. and Harvey, L. (2018). *Mediated intimacy: Sex advice in media culture.* London: Polity.

Barker, M. Gupta, C. and Iantaffi A. (2007). *The power of play: the potentials and pitfalls in healing narratives of BDSM.* In D. Langdridge and M. Barker (Eds.) Safe, Sane and Consensual: Contemporary Perspectives on Sadomasochism. pp.197-216. Basingstoke: Palgrave Macmillan.

Barker, M-J. and Hancock, J. (2016). *Make your own relationship user guide.* www.megjohnandjustin.com

Barker, M-J. and Hancock, J. (2017). *Enjoy sex (how, when and if you want to): A Practical and inclusive guide.* London: Icon Books.

Barker, M.J. and Iantaffi, A. (2015). *Social models of disability and sex.* In H. Spandler, J. Anderson and B. Sapey, (Eds.) Distress or Disability?: Madness and the Politics of Disablement. pp. 139-152. Bristol: Policy Press.

Barker, M., Richards, C., Jones, R., Bowes-Catton, H. and Plowman, T. (2012). *The Bisexuality Report: Bisexual inclusion in LGBT equality and diversity.* Milton Keynes: The Open University, Centre for Citizenship, Identity and Governance.

Barker, M-J. and Scheele, J. (2016). *Queer: A graphic history.* London: Icon Books.

Barker, M-J., Vincent, B. and Twist, J. (2017). *Non-binary: A British History.* In C. Burns (Ed.) Trans Britain. London: Unbound.

Beattie, M., & Lenihan, P. (2018). *Counselling Skills for Working with Gender Diversity and Identity.* Jessica Kingsley Publishers.

Berila, B. (2015). *Integrating mindfulness into anti-oppression pedagogy: Social justice in higher education.* London: Routledge.

Bettcher, T.M. (2014). *When selves have sex: What the phenomenology of trans sexuality can teach about sexual orientation.* Journal of Homosexuality, 61(5), 605-620.

Bowleg, L., Burkholder, G., Teti, M., & Craig, M. L. (2008). *The complexities of outness: Psychosocial predictors of coming out to others among Black lesbian and bisexual women.* Journal of LGBT health research, 4(4), 153-166.

Brotto, L.A. and Yule, M. (2017). *Asexuality: Sexual orientation, paraphilia, sexual dysfunction, or none of the above?* Archives of sexual behavior, 46(3), 619-627.

Butler, J. (2011). *Gender trouble.* London: Routledge.

Carey, N. (2012). *The epigenetics revolution.* New York, NY: Columbia University Press.

Carrigan, M. (2015). *Asexuality.* In C. Richards and M.J. Barker (Eds.) Handbook of the Psychology of Sexuality and Gender. pp. 7-23. Basingstoke: Palgrave Macmillan.

Choudrey, S. (2017). *Inclusivity: Supporting BAME trans people.* GIRES, http://www.gires.org.uk

Collins, P. H., Bilge, S. (2016). *Intersectionality.* Hoboken, NJ: Wiley

Davies, D. and Barker, M.J. (2015a). *How GSD is your Therapy Training?* The Psychotherapist, 61, 8-10.

Davies, D. and Barker, M.J. (2015). *Gender and sexuality diversity (GSD): respecting difference.* The Psychotherapist, 60, 16-17.

Denman, C. (2003). *Sexuality: A biopsychosocial approach.* Palgrave Macmillan.

Diamond, L.M. (2009). *Sexual fluidity.* Cambridge, MA: Harvard University Press.

Durex (2005). *Global sex survey.* London: Durex.

Fausto-Sterling, A. (2012). *Sex/gender: Biology in a social world.* London: Routledge.

Fincham, F.D. and May, R.W. (2017). *Infidelity in romantic relationships.* Current Opinion in Psychology, 13, 70-74.

Fine, C. (2010). *Delusions of gender.* London: Icon Books.

Fine, C. (2017). *Testosterone rex.* London: Icon Books.

Flores, A.R., Herman, J.L., Gates, G.J., and Brown, T.N.T. (2016). *How many adults identify as transgender in the United States?* Los Angeles, CA: The Williams Institute.

Gahran, A. (2017). *Stepping off the relationship escalator.* Off the Escalator Enterprises.

Graham, N. (2014). *Polyamory: A call for increased mental health professional awareness.* Archives of sexual behavior, 43(6), 1031-1034.

Greene, B. (2000). *African American lesbian and bisexual women.* Journal of Social Issues, 56(2), 239-249.

Haines, E.L., Deaux, K., Lofaro, N. (2016). The times they are a changing...or are they not? A comparison of gender stereotypes 1983-2014. *Psychology of Women Quarterly 2016.* March 9 2016. Sage.

Iantaffi, A. and Middleton, A. (Eds.) (2018). *Working systemically with trans, non-binary and gender expansive people.* Context, February 2018.

Jankowski, G., Gilbourn, S., Sandle, R., Hylton, K. and Bower, K. (2017). BME psychology, bmepsychology.com.

Joel, D. and Fausto-Sterling, A. (2016). *Beyond sex differences: new approaches for thinking about variation in brain structure and function.* Phil. Trans. R. Soc. B, 371(1688), 20150451.

Joel, D., Tarrasch, R., Berman, Z., Mukamel, M. and Ziv, E. (2013). *Queering gender: Studying gender identity in 'normative' individuals.* Psychology and Sexuality, 5(4), 291-321.

Kelsey, K., Stiles, B.L., Spiller, L. and Diekhoff, G.M. (2013). *Assessment of therapists' attitudes towards BDSM.* Psychology and Sexuality, 4(3), 255-267.

Kimmel, M. (2009). *Guyland: The perilous world where boys become men.* New York, NY: HarperTorch.

King, M., Semlyen, J., Killaspy, H., Nazareth, I. and Osborn, D. (2007). *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people.* London: British Association for Counselling and Psychotherapy.

King, M., Semlyen, J., Tai, S.S., Killaspy, H., Osborn, D., Popelyuk, D. and Nazareth, I. (2008). *A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people.* BMC psychiatry, 8(1), 70.

Klein, F., Sepekoff, B. and Wolf, T.J. (1985). *Sexual orientation: A multivariable dynamic process.* Journal of Homosexuality, 11(1-2), 35-49.

Kolmes, K., Stock, W. and Moser, C. (2006). *Investigating bias in psychotherapy with BDSM clients.* Journal of Homosexuality, 50(2-3), 301-324.

Laing, M., Pilcher, K. and Smith, N. (Eds.). (2015). *Queer sex work*. London: Routledge.

Langdridge, D. (2007). *Gay affirmative therapy: A theoretical framework and defence.* Journal of Gay and Lesbian Psychotherapy, 11(1-2), 27-43.

Ley, D.J. (2012). *The myth of sex addiction.* Washington DC: Rowman and Littlefield Publishers.

Minichiello, V., Scott, J. and Cox, C. (2017). *Commentary: Reversing the agenda of sex work stigmatization and criminalization: Signs of a progressive society.* Sexualities, 1363460716684510.

Mitchell, K.R., Mercer, C.H., Ploubidis, G.B., Jones, K.G., Datta, J., Field, N. and Clifton, S. (2013). *Sexual function in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles* (Natsal-3). The Lancet, 382(9907), 1817-1829.

Morin, J. (2012). *The erotic mind: Unlocking the inner sources of passion and fulfillment.* London HarperCollins

Moser, C. and Kleinplatz, P.J. (2006). *DSM-IV-TR and the paraphilias: An argument for removal.* Journal of Psychology and Human Sexuality, 17(3-4), 91-109.

Nadal, K.L. (2013). *That's so gay! Microaggressions and the lesbian, gay, bisexual, and transgender community.* Washington DC: American Psychological Association.

Nordling, N., Sandnabba, N.K. and Santtila, P. (2000). *The prevalence and effects of self-reported childhood sexual abuse among sadomasochistically oriented males and females.* Journal of Child Sexual Abuse, 9(1), 53-63.

Rambukkana, N. (2015). *Fraught intimacies: Non/monogamy in the public sphere.* UBC Press.

Renaud, C.A. and Byers, E.S. (1999). *Exploring the frequency, diversity, and content of university students' positive and negative sexual cognitions.* The Canadian Journal of Human Sexuality, 8(1), 17.

Rodin, J., Silberstein, L., & Striegel-Moore, R. (1984). *Women and weight: A normative discontent.* Nebraska Symposium on Motivation, 32, 267-307.

Rubin, G. (1984). *Thinking sex: Notes for a radical theory of the politics of sexuality,* in C.S. Vance (Ed.). Pleasure and danger: Exploring female sexuality. pp267-319. London: Pandora.

Rubin, R.H. (2001). *Alternative lifestyles revisited, or whatever happened to swingers, group marriages, and communes?* Journal of Family Issues, 22(6), 711-726.

Sedgwick, E.K. (1990). *Epistemology of the closet.* New Jersey, NY: Prentice Hall. p8.

Sex worker psych (2017). *The sex worker and the psychoanalyst: Stigma in the therapy room.* https://sexworkerpsych.wordpress.com/2017/06/27/sex-worker-psychoanalyst/

Sheff, E. (2013). *The polyamorists next door: Inside multiple-partner relationships and families.* London: Rowman and Littlefield.

Sheff, E. and Hammers, C. (2011). *The privilege of perversities: race, class and education among polyamorists and kinksters.* Psychology and Sexuality, 2(3), 198-223.

Stonewall (2015). *LGBT facts and figures.* Available from: stonewall.org.uk/media/lgbt-facts-and-figures.

Sue, D.W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation.* London: John Wiley and Sons.

van Anders, S.M. (2015). *Beyond sexual orientation: Integrating gender/sex and diverse sexualities via sexual configurations theory.* Archives of Sexual Behavior, 44(5), 1177-1213.

van Anders, S.M., Tolman, R.M. and Volling, B.L. (2012). *Baby cries and nurturance affect testosterone in men.* Hormones and Behavior, 61(1), 31-36.
Vangelisti, A.L. and Gerstenberger, M. (2004). *Communication and marital infidelity.* In J. Duncombe, K. Harrison, G. Allan and D. Marsden (Eds.). The state of affairs: Explorations in infidelity and commitment. Pp.59-78. New Jersey: Lawrence Erlbaum Associates.

Vossler, A., Havard, C., Pike, G., Barker, M-J. and Rabbe, B. (Eds.) (2017). *Mad or bad? A critical approach to counselling and forensic psychology.* London: Sage.

Ward, J. (2016). *Not gay: Sex between straight white men.* New York, NY: New York University Press.

Warren, J.T., Harvey, S.M. and Agnew, C.R. (2011). *One love: Explicit monogamy agreements among heterosexual young adult couples at increased risk of sexually transmitted infections.* Journal of Sex Research, 48(1), 1–8.

Wiesner-Hanks, M. E. (2010). *Gender in History: Global Perspectives.* London: Wiley-Blackwell.

Wilkins, 2010 Untold Problems: A review of the essential issues in the mental health of men and boys. https://www.bl.uk/collection-items/untold-problems-a-review-of-the-essential-issues-in-the-mental-health-of-men-and-boys (accessed 11 March 2019)

Wismeijer, A.A. and Assen, M.A. (2013). *Psychological characteristics of BDSM practitioners.* The journal of sexual medicine, 10(8), 1943-1952.

Wood, G. (2005). *Sex, lies and stereotypes.* London: New Holland Publishers.

About the Author

Dr Meg-John Barker is a writer specialising in sex, gender and relationships. Their popular books include the (anti-)self-help relationship book *Rewriting the Rules*, *The Secrets of Enduring Love* (with Jacqui Gabb), *Enjoy Sex (How, When and If You Want To)* (with Justin Hancock), and *Gender: A Graphic Guide and Queer: A Graphic History* (with Julia Scheele). Meg-John taught and researched as a psychologist in higher education for many years and has published hundreds of academic books and papers on topics including non-monogamous relationships, sadomasochism, counselling, and mindfulness, as well as co-founding the journal *Psychology & Sexuality* and the activist-research organisation BiUK. They were the lead author of

The Bisexuality Report – which has informed UK policy and practice around bisexuality – and have co-edited a book on non-binary gender with similar aims in that area. Meg-John also worked for many years as a UKCP accredited psychotherapist working with gender, sexually, and relationship diverse clients, and they blog and podcast about all these matters on www.rewriting-the-rules.com and https://megjohnandjustin.com. Twitter: @megjohnbarker.

Acknowledgements

Many thanks to H Howitt, Dominic Davies, and LJ Potter for their extremely helpful feedback on this resource, and to BACP members of the Good Practice EDI focus group, particularly Nikki Dhillon-Keane and Steve Rattray who drafted and reviewed early documents in respect of GSRD.