INTRODUCTION: GRAD SCHOOL DIDN'T PREPARE YOU FOR THIS

A recent post on one of the therapist listservs I belong to read: "ISO therapist to work with lesbian couple, one partner transitioning, both partners kinky, wanting to work on adjustment to the transition and possibly opening up the relationship"

This is not the gay affirmative psychotherapy you may have learned about in graduate school.

In 2018, Gallup reported that:

- 4.5 % of Americans self-identify as gay, lesbian, or bisexual, and 11% report some same sex attractions
- 0.7% are transgender, and 4% identify as nonbinary
- 1% identify as asexual
- One in five Americans have participated in consensually nonmonogamous relationships, 5% in the last year
- More than half are interested in being dominated sexually, and 36% use masks, blindfolds, and/or bondage tools during sex

In the 21st century, everyone will likely meet, know, or have as a family member someone with unconventional sex or gender behavior or identity. And this means every therapist may have clients who diverge from mainstream expectations of sex or gender.

If you are a therapist, this book will prepare you to work in this new world. It will help you deal with the broad group of clients who today might be considered 'queer:' not just gay and lesbian

clients, but transgender, nonbinary, asexual, bisexual, pansexual, 'mostly heterosexual,' kinky, swinging, or polyamorous, to name a few. You will understand how the LGBTQ+ community has evolved over the last fifty years, why it changed in this particular direction, and where it's headed. You will become familiar with concepts like gender and sexual orientation fluidity and see how many people are sex and/or gender diverse without identifying as such. You'll learn how this big-tent community has influenced the 'mainstream,' and what new mainstream trends you can anticipate.

Most importantly, each minority group will be described and explained with information about the most common clinical issues you will encounter and practical therapeutic strategies for helping.

Who I Am

I am a clinical psychologist and certified sex therapist with nearly four decades of experience working with sex and gender diverse clients and training therapists to work with this population. I am myself queer – I often introduce myself as a 'bisexual lesbian mother who is kinky and non-monogamous.' In 1983 I founded a therapy clinic specializing in work with LGBTQ+ clients, the Institute for Personal Growth in New Jersey, and I directed IPG for 35 years. I now have a small private practice of sex and gender diverse clients. More and more, I find myself working with the "+" in "LGBTQ+". In the last few months, for example, my clients have included:

- A lesbian couple learning to experiment with BDSM to keep the passion alive in their relationship
- A pansexual non-binary teen who is struggling to get the adults around them to use “they/them/theirs” pronouns
- A couple with a twenty year history in the ‘swingers’ community that is entering into a polyamorous relationship with another couple
- A ‘heteroflexible’ millennial man trying to decide whether to tell a prospective girlfriend that he occasionally hooks up with men

I understand these clients not only because I have lived and worked in the ‘queer’ community for decades – but also because my personal journey has included lots of twists and turns off the mainstream road of sex and gender.

By the end of this book, I promise that you will understand these clients and many more, as well.

I am uniquely qualified to take you on this journey. Besides being a licensed clinical psychologist, I am a certified sex therapist, and I have spent my life and career in the LGBTQ+ community. I came out as lesbian in 1975 and in subsequent decades I have acknowledged that I am bisexual, kinky, and nonmonogamous. I saw my first lesbian client in 1975 while still a psychology intern, and almost immediately realized that I wanted to devote my professional life to helping other ‘queer’ people. In the 1970s it was difficult to find a therapist who did not consider homosexuality a disease, and so since that time, as soon as gay men and women in New Jersey discovered me, my practice never lacked for clients. Eventually, in 1983, I founded the Institute for Personal Growth, a private practice organization specializing in therapy for, at first,

lesbians and gay men, and eventually, all others who are sex and gender diverse. I completed a post doctoral program in sex therapy in 1983 as well, and under the guidance of my mentor Dr. Sandra Leiblum began writing papers on queer sexuality for journals and professional books. In 1985 I helped start the Hyacinth Foundation, New Jersey's largest social service program for people with HIV, and was its first director. Over the years I've trained and supervised hundreds of other mental health professionals in LGBTQ+ issues around the country and abroad.

Some Themes of This Book

Today's practitioners are light years ahead of where we were in the 1970s when I did my graduate work. Few still regard homosexuality as a disease, and most have personal familiarity with gay people. But even as practitioners have kept pace with the times – the community has expanded even more rapidly. As a therapist, you may not need me to tell you about how lesbian couples are different from other couples (although I will). But you probably still need help understanding nonbinary people and those in the BDSM community, not to mention men who identify as 'mostly straight.' In this book, you'll learn about it all, from the most basic principles of sex and gender diverse affirmative care to the complexities of gender expansive children and adolescents.

You will see some common themes in this book. In general, I believe that to understand the mental health needs of diverse groups you must understand the social and cultural forces impinging upon them, and how these forces change over time. I hope to show you the narrowness of the lens through which you were taught to view gender and sexual orientation, and how much diversity exists in Nature, throughout history, and across cultures.

You will also come to understand how the expansion of the gay community over the last half century has reflected changes in the culture at large. Two major mainstream social changes that are reflected in LGBTQ+ emergence are: the growth of what is often disparagingly called 'identity politics;' and the tendency for conditions previously viewed as illnesses to be seen as identities. Andrew Solomon (2012) noted in his book about children who differ dramatically from their parents, "Far From The Tree," that since the latter half of the twentieth century, there has been a cultural trend towards viewing what were once considered 'disabilities' or 'diseases', as distinctive identities, identities that mark membership in a tribe. This has dovetailed with a more general trend, described by Francis Fukuyama in "Identity: the Demand for Dignity and the Politics of Resentment" (2018). Fukuyama maintains that in developed countries, concerns about economic survival have been replaced by concerns about equal treatment and by what he calls 'thymos,' the need to be recognized, seen, and acknowledged as having basic human dignity.

At the same time, the breakdown of institutions like religion have left many people feeling a need for stronger social affiliations and seeking them in a variety of different places outside of organized communities of worship. One way that many people who feel marginalized – unequal - form social connections is to do so based on the aspects of their identities that leave them feeling socially stigmatized. Some marginalized people share identities with their parents – most people of color, for example – and their families and neighborhoods may provide them with the connection they need.

But some people feel isolated in part because they do NOT ‘fit into’ their families of origin - e.g., most sex and gender diverse people. These people affiliate on the basis of what Solomon calls ‘horizontal identities,’ as distinct from the ‘vertical identities’ inherited from one’s parents and kin. Those with similar horizontal identities form communities of support, and these communities not only support their members but advocate for social change towards equal rights and recognition. As I will show you, this perfectly describes LGBTQ+ people, whose subgroups follow a common trajectory over time: first, labeled ‘bad’ or ‘immoral,’ then ‘mad’ or psychiatrically ill, then ‘normal’ but ‘separate,’ and finally, at least in theory, integrated within the mainstream culture.

As the trajectory of change unfolds, the mental health needs of these subgroups change. For example, gay affirmative therapy first developed after homosexuality was removed from the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, in 1973. In the early stages after this happened, ‘internalized homophobia’ - inner shame produced by accepting society’s negative view of gay people - was the biggest mental health problem gay people faced. My practice in the 1980s was full of clients who, first and foremost, needed validation that their sexuality did not make them evil or sick, and help to understand that it was a bigoted culture that had inculcated these feelings. Now, unless you practice in deeply conservative areas, your gay clients probably feel relatively okay about their orientation, though they may still deal with prejudice from family members, employers, or the larger community in which they live. Internalized homophobia is not as likely to be their biggest problem. Today, you are more likely to be working with gay clients whose problems are not much different from your straight clients, albeit with some twists.

Today, a clinician is much more likely to find internalized self-hatred in transgender people, those whose sexual orientation is kinky, or people who practice nonmonogamy, because the culture still holds highly ambivalent and/or negative views of these people.

Sex and Gender Diverse Affirmative Psychotherapy

The example above elucidates one theme that repeats throughout the book: it is impossible to divorce the mental health issues of LGBTQ+ people from politics. This is true on a macro level: e.g., research indicates that the mental health of LGBTQ+ people deteriorates after states pass statutes allowing anti-gay discrimination (Hatzenbuehler,2010). And it is true on the individual level as well. For example, without knowing the shameful history of how transgender people were harmed by psychiatry, it is hard to understand the mistrust many trans folk still have of the mental health community. Knowing that BDSM practitioners are still considered 'paraphiliacs' by psychiatry helps explain that, in treatment, some kinky clients will still refer to themselves as 'sick' and harbor deep shame about their sexuality- and others are afraid to tell their therapists about their kink.

The relationship between culture and politics and the mental health of sex and gender diverse people informs the practice of what I call "*sex and gender diverse affirmative psychotherapy,*" the therapy described in this book. While specific issues and techniques vary, there are some principles common to the treatment of all LGBTQ+ people. Here are some of these principles:

1) Sex and gender diversity is normal, not a pathology or illness. Such diversity is found among thousands of animal species, including non-human primates, and in all cultures throughout history. The idea that this diversity is 'abnormal' derives from the belief that the biological function of sex is solely procreation, and that forms of sexuality or gender that do not further the reproductive goal are 'against Nature'. But today most contemporary scientists recognize that sex in the animal world is not simply about reproduction; in fact, the majority of sex acts in Nature are non-procreative. Many biologists believe that sex is more about connection and affiliation than reproduction. If this is true, the major argument against considering sex and gender diversity 'sick' or 'pathological' is demolished.
2) Sex/gender diverse people have grown up in a culture that negates their value, for the most part, often in traumatic ways. This negation is not simply attitudinal, i.e., prejudice or bigotry. It is often institutionalized: sodomy laws were not ruled unconstitutional by the Supreme Court until Lawrence v. Texas in 2003; in many states, it is perfectly legal to fire or deny housing to anyone from the LGBTQ+ community; transgender people are not recognized legally in their affirmed gender in many states. Part of an affirmative therapist's role is to validate and empathize with the traumatizing experiences LGBTQ+ people are subjected to.
3) A primary task of therapy is to affirm and validate the client's identity and, when present, to help unearth and resolve socially-induced feelings of worthlessness. Affirmative therapists do not agree to therapeutic contracts that include efforts to change the client's identity or orientation- so-called 'reparative' or 'conversion' therapy.

4) Sex and gender diverse people, like everyone else, need to feel they are living authentically, i.e., that their inner experience of themselves is expressed whenever possible in their interactions with others. This may involve 'coming out' to others, or it may involve finding safe spaces where they can 'be themselves.'
5) Therapy often includes advocacy – e.g., the therapist must be prepared to interact with a school system that is allowing bullying of LGBTQ+ students; therapists for transgender clients will need to write letters for medical providers to prescribe hormones or surgical procedures
6) Therapy includes knowing and directing clients to community resources. For many LGBTQ+ clients, a good support group is worth years of treatment. If you work with this population, you must know what is available in your area: support groups and supportive organizations, medical resources, legal help, political groups
7) While many LGBTQ+ clients come to treatment for the same reasons as other clients– depression, anxiety, relationship problems, stress, parenting issues – there are some issues more commonly faced by sex and gender diverse minorities. For example, at least half of gay male couples are nonmonogamous and may need help negotiating their open relationship; many LGBTQ+ clients are estranged from their family of origin, and the 'family' with which they identify is one created from friends and allies. LGBTQ+ affirmative approaches include a great deal of specific knowledge – which you will gain from this book

Let's focus for a moment on the first principle: that sex and gender diversity is normal – i.e., a naturally occurring, non-pathological phenomenon. Increasingly, we have scientific data

supporting this. A full discussion of this is beyond the scope of this book, but interested readers are directed, for example, to Bruce Baghamihl's book 'Biological Exuberance' (1999) which enumerates many of the thousands of animal species that regularly exhibit not only homosexual sexual activity, but unusual non-procreative sexual behaviors. Readers can gain insight as well from Joan Roughgarden's work in 'Evolution's Rainbow'(2013) and 'The Genial Gene'(2009), in which she catalogs the extraordinary range of gender expression in animals and posits the use of sex among animals as a mechanism to promote affiliation and cooperation. Ann Fausto Sterling has documented the gender ambiguities inherent in the human body in her acclaimed book, 'Sexing the Body' (2000). And a 2019 article in the American Psychologist (Hyde et al) listed evidence from five sources – neuroscience, behavioral neuroendocrinology, psychological findings on similarities between men and women, psychological research on transgender and nonbinary individuals, and developmental research – that contradict the notion of a gender binary. In brief, the more we learn both about the diverse range of animal behavior and the complexity of gender determination, the more science supports the non-pathological viewpoint. In future chapters of this book, I will discuss some of the cross cultural, historical evidence for this point of view in humans.

A Word About Identity: Fingers Pointing At the Moon

According to Francis Fukuyama, the concept of identity is only a few hundred years old (2018). "*The foundations of identity were laid with the perception of a disjunction between one's inside and one's outside. Individuals come to believe that they have a true or authentic identity hiding within themselves that is somehow at odds with the role they are assigned by their surrounding*

society. The modern concept of identity places supreme value on authenticity, on the validation of that inner being that is not being allowed to express itself." P.25

So the concept of identity is rooted in internal, lived experience, not external roles or behaviors. It is important to understand how this impacts LGBTQ+ identities - and why it makes research on sex and gender diverse minorities difficult. Let us take the example of sexual orientation. There are, in general, three different measures of sexual orientation used by scientists: attraction to same sex vs. opposite sex people; same vs. opposite sex sexual behavior; and identity. Most commonly, social science research uses identity – a person's self-labeling. The problem is, identity is not a 'stand in' for the others. Two self-identified lesbians may share the same identity, but one may have a long history of bisexual behavior and attractions, and one may have only experienced same sex attractions and relationships.

But we often behave as if identity reflected a real, material 'thing.' It is useful to remember the Buddhist saying about words and spiritual teachings: they are like fingers pointing at the moon, they are not the moon itself. Sex and gender variations are real, but the identities people use to describe them are merely rough analogies. Moreover, these identities vary by time period and culture. Indian hijiras, Native American two spirits, and Thai 'ladyboys' are all identities that express gender variance, but the realities they represent, while similar, are not exactly the same, and efforts to make simple one to one comparisons will be inaccurate. And while sex and gender diversity are universal, because different cultures define the parameters for expression, the identity labels are different. People must assume the identity that is available for them within

their culture. No one identified as ‘genderqueer’ a hundred years ago; no one identifies as an ‘Uranian’ – Karl Ulrichs term for a homosexual in the 1800’s – today.

Moreover, identity is a different level of experience from feelings and behavior. To the extent that an identity is stigmatized, one can expect fewer people to choose that identity than are theoretically eligible. For example, surveys of people’s same sex attractions, behavior, and self-identification always show the highest number of respondents acknowledge attraction, followed by same sex experience, and finally, the lowest number choose a gay or lesbian identity. In later chapters I will discuss the process that individuals follow that transforms feelings into identities. But any culture that stigmatizes variant gender and sexuality incentivizes its members to hide their diversity. Therefore, research that uses identity labels as measures of variant behavior will underrepresent the number of people that actually exhibit that behavior or those attractions.

The Rest of This Book

The first section of this book is about the history of the LGBTQ+ community, and the second is on the science - what we know, and don’t know, about what it means to be sex and/or gender diverse, who fits in these categories, and the origins of sex and gender variation. You can skip these chapters if you want and go straight to the clinical stuff. But I recommend that you read them first, in the order intended. This is because I believe that to understand how to be a queer-affirmative therapist, you need to have this background.

Chapters 1,2 and 3 focus on history, including the history of how sex and gender diverse people were viewed by psychiatry. We are taught that mental health and therapy are apolitical, 'scientific,' and free from bias. Nothing could be further from the truth. Psychiatry has a shameful history of oppressing women, non-white people, and sex and gender diverse minorities. In the mid nineteenth century, slaves who tried to run away were said to be suffering from 'drapetomania,' a disease caused by masters who were too 'familiar' with their slaves and treated them like equals. The cure was 'whipping the Devil' out of them or cutting off both big toes to prevent running. Women were considered constitutionally prone to 'hysteria,' and thousands of Victorian women were locked in asylums for daring to rebel against their subordinate, submissive roles. As you will see in the following chapters, during the 20th Century and to an extent today, psychiatry labeled homosexuals, transgender people, and those with unusual sexual interests as 'mad,' and treatments ranged from institutional confinement to lobotomies to electric shock. As psychiatrist Thomas Szasz argued decades ago, the mental health field replaced religion as the enforcer of traditional social norms, labeling as 'mad' those who had previously been considered 'bad.' Understanding the history of our field's maltreatment of sex and gender minorities helps us comprehend why 'reparative therapy' still exists and why so much of our work today focuses on correcting the damage done by mental health labeling.

Just as negative biases dominated the mental health field, the scientific study of sex and gender diversity has been warped by prejudice as well. Chapters 4 and 5 present some of the newer research on animals and humans that describes and explains in non-pathologizing ways how diversity operates in the natural world. If you read these Chapters, you will forever more be

skeptical of both the pronouncements of evolutionary psychologists about how homosexuality has no evolutionary value, and of articles about the 'gay gene.'

Chapter 6 through 24 will teach you what you need to know as a mental health practitioner about working with sex and gender diverse clients, from gay men and lesbians to those who are polyamorous, kinky, and/or asexual. They will prepare you to conduct effective therapy sessions with anyone who walks into your office with an unconventional identity or lifestyle. You will learn how to make sex and gender diverse people feel safe and comfortable in therapy with you, and you will know about the most common issues these clients may face. Finally, the last chapter presents some ideas on where we are going – will assimilation rule, or will we travel towards an ever-increasing proliferation of new identities and ways of being? Will there be a time when being sex and/or gender diverse is not the defining characteristic of one's sense of self? How will bodies of the future look if gender diverse people continue to push the boundaries of conventionality? It is my hope that this book will help your clinical practice today as well as prepare you for the future.

There are some omissions from this book. I have not written about therapy with intersex people because, frankly, I am inexperienced with this population. Moreover, I have omitted some groups that have caught the public's eye: I don't write about 'furries,' because it is not a primarily sexual phenomenon. I haven't talked about 'findoms' (BDSM play that involves submissives giving dominants money) because it strikes me as just one of many less common kinky activities, even if it is currently enjoying fifteen minutes of fame. I'm sure there are other omissions I don't realize now. They will have to wait for a future edition of this book.

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