

Clinical Psychology, Sexuality and Gender

Jan Burns & Claudia Zitz

Introduction

Two essential elements to clinical psychological practice are firstly, the identification that something in a person's psychological well-being or behaviour is causing distress and then secondly delivering an intervention to ameliorate that distress. Within clinical psychology, societal understandings of gender and sexuality have both been reflected in, and influenced by, the professional positioning of the discipline, changing over time, with the defining gaze of distress moving from the imposition of a largely restrictive and medically orientated set of beliefs to more individual, self-defining representations of pluralistic identities. This chapter will chart this journey, making reference to the changing nature of the profession arising from the changes in the frameworks of understanding (ontology) in which psychology has been contextualised, and with it the shifting offerings in terms of therapeutic intervention.

History of clinical psychology, sexuality and gender and theoretical foundations

Understandings of the distinction between gender and sex have been in existence long before the arrival a type of psychology called clinical psychology, and with it the idea of 'practice' not just theory and research. As such clinical psychology had a foundation of ideas from which to draw upon offered by early sexologists. Of particular relevance is Krafft-Ebbing and his work *Psychopathia Sexualis* (1886), aimed at physicians, psychiatrists and judges, described as a 'medico-forensic study' and with parts written in Latin to 'discourage the lay reader'. This text was one of the first presentations of case studies describing 'sexual pathology', including fetishism, sadomasochism and homosexuality. Here, life, and hence sexuality is described as a 'never ending duel between animal-instinct and morality' (p6), with 'normal women' positioned as having little 'sensual desire' (p14), but desirous of spiritual 'love; and men, by nature, being the active sexual aggressor. Religiosity, anthropology and biological determinism are heavily drawn upon to justify the views presented, and as a result pathology is deemed as anything which deviates from the natural bringing together of men and women to fulfil the biological function of procreation. When deviation from the norm occurred it was seen as a product of a breakdown in morality brought about by psycho- or neuro-pathological conditions.

It was during this era that psychology in its different forms rapidly developed and clinical psychology as a professional discipline became distinct from psychiatry. The British Psychological Society (BPS) was formed in 1901, and the first edition of the *British Journal of Psychology* declared that 'Ideas in the philosophical sense do not fall within its scope; its enquiries are restricted entirely to fact.' (as cited in Pilgrim & Treacher, 1992, p23). Thus psychology welded itself tightly to a scientific belief structure based on 'truths' in which the scientific purpose was to uncover such truths through careful categorisation and measurement (positivism), with gender and sexuality being viewed through the lens of essentialism (as having unmodifiable characteristics) by researchers who were positioned as distinct and objective. There were many advantages to the neophyte discipline of

psychology attaching itself at the turn of the eighteenth century to the coat tails of the physical sciences, and once established it rose quickly in terms of power, status and wealth. Indeed, in the USA the term 'clinical psychologist' had been coined and the first 'clinic' established in 1896 (Strickland, 1988). As clinical psychology established itself as a science 'sexual deviancy' became a focus for its gaze and its practitioners happily took up the position as 'experts' on this topic.

Meanwhile a different type of science was establishing itself, stemming from the revolutionary thoughts of Freud. Whilst holding to many essentialist ideas, Freud moved away from trying to establish neurological 'facts' to talk about unseen and unmeasured internal drives which directed behaviour and feelings, the most central being a sexual drive (libido), and suggested that all adult psychological dysfunction stemmed from interruptions or deviations from libido development. Freud's theories have been much debated and developed since then, but at that time he made two startling assertions: a) that children are born sexualised beings, i.e. that sexuality does not develop as a consequence of physical development, but is there from the very beginning and b) sexuality is at the centre of our essence as humans, the expression of sexuality is normal and it is the repression of sexuality which is problematic, rather than its expression being an indication of pathology. From Freud and his followers psychoanalysis was born, and the idea that through intensive analysis unconscious, damaging events may be made conscious, repaired and pathology reduced.

Hence, by the end of the 19th century two parallel developments were occurring; clinical psychology with its labs, clinics, measurements and search for facts; and then psychoanalysis with its individual therapy, interpretations and search for the contents of the unconscious. As a consequence we started to see the development of psychological practitioners, psychoanalysts following in the footsteps of Freud but also hypnotherapists following the earlier work of Franz Mesmer and Jean-Martin Charcot. Within the psychology labs other forms of applied psychology were developing and one with a lasting legacy and specific applications within the field of sexuality was behaviourism. This school of thought developed partly in opposition to 'mentalist psychology' (i.e. psychology which concentrated on unobservable mental processes such as cognition) and espoused the belief that psychology should only focus on the observable, i.e. behaviour, which can be studied scientifically to understand the causal relationships behind conditioned responses to identified stimuli.

Psychology as an emerging discipline was highly successful, resulting in a proliferation of psychologists as expert practitioners. With this came a concern, to be able to regulate and govern what could and could not be counted as legitimate psychological practice, i.e. that which is based on 'true science' and hence, who were legitimate practitioners of psychology. Within clinical psychology this resulted in the famous Boulder¹ Conference of 1949, which drew together experts across the discipline to give their rounding endorsement that the profession of clinical psychology should be based upon the scientist-practitioner model and a common curriculum for training should be developed based on these principles, involving research, theory and practice, located very much within a medical model of psychological ill-health.

As the dominant research paradigm at this time was positivism the development within the field of clinical psychology in terms of approaches to problems of sexuality was based on the establishment of 'facts' produced from logically determined questions, followed by the application of scientific principles used to define, measure and operationalise relationships between discrete variables,

¹ Named in response to where it was held Boulder, Colorado, USA

resulting in causal, deterministic, generalizable theories. The embodiment of these views was the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM I)² in 1952 by the American Psychiatric Association. As clinical psychology at that time was heavily tied to the medical model the DSM became the major guide to assessment, delineating the 'normal' from the 'abnormal' and hence which behaviours required treatment and which did not. The DSM became the accepted taxonomy through which treatment practices and mental health services were organised both in the US and UK. A parallel system is that of the International Classification of Diseases and Related Health Problems (ICD), authored by the World Health Organisation (WHO), the aim of which is wider than DSM, endeavouring to be the "standard diagnostic tool for epidemiology, health management and clinical purposes" (WHO, 1992). Now in its tenth edition (ICD-10) it is the health classification system used by many countries, included the National Health Service (NHS) in the UK, and has a specific chapter 'Mental Health and Behavioural Disorders'.

Within DSM I 'deviant sexuality' was included under the heading 'Personality Trait Disturbance' and included 'homosexuality, transvestism, paedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation)' (p.36). Despite positivist claims to objectivity, the inclusion of certain marginalised types of sexual expression was clearly influenced by the value systems in place at that time, including religious belief structures and statistical beliefs about majority behaviours defining 'normality'. The unhappiness of those who practiced 'deviant sexual' behaviours was held up as further evidence of existing pathology and the need for treatment. It is perhaps unsurprising that the individuals practicing such 'deviant' behaviours were distressed given the dominant attitudes and indeed that many of these behaviours were outlawed, meaning the individual had to not only manage the stigma associated with their sexual interests but the stress of potential criminalisation if caught. Oral histories clearly capture the trauma of this positioning, such as this gay man's experience documented in Smith, Bartlett & King's (2004), study '*... I felt totally bewildered that my entire emotional life was being written up in the papers as utter filth and perversity.*' (p1). Such accounts point clearly to the amount and source of stress that people holding minority/marginalised positions experience, providing an explanation of the higher incidence of psychological problems often experienced by these groups, which is often misattributed to their difference as opposed to the societal reaction to such difference (King et al, 2008).

Treatments at this time very much echoed the two main streams of clinical psychological practice; one being dominated by psychoanalysis and the other by behaviourism. Both streams followed the medical model of diagnosis, underpinned by a theory of causality, leading to individual damage (psychological or neurological) and a treatment plan aimed at rectifying the damage located in the individual. For some, usually those who could pay privately, this resulted in extensive psychodynamic psychotherapy aiming to locate and re-balance the trauma which had interrupted normal psychosexual development and so place it back on the rails. However, the more likely treatment for those who did seek help, or were required to, was behavioural aversion therapy. This included shock treatment and drug induced nausea in response to stimuli which were expected to induce deviant sexual arousal (See Richards, Further Sexualities Chapter X this volume). Other treatments included the administration of hormones, electroconvulsive therapy, systematic desensitisation, hypnosis and religious counselling. Whilst occasional research reported some success with these methods it is

² The DSM 1 was 130 pages long and listed 106 mental disorders, the recent publication of DSM 5 is 927 pages and contains over 300 disorders.

unclear how much the impact of ceasing such unpleasant treatments affected reported efficacy (APA, 2009).

As the liberated values of the sixties and the impact of the 'sexual revolution' took hold, clinical psychology also started to develop a wider gaze, no longer just being interested in distress but also the promotion of well-being, and the hinterland between 'illness' and unhappiness. This was in part due to a challenge to the dominant discourse of positivism and psychology itself coming under the gaze of critical observers. One clear root of criticism came from feminists and with more women coming into psychology through the academic door, as opposed to just the clinical door, they started to ask questions about how women had been positioned in psychology especially with regard to their mental and physical health, and to critique the perspective of a largely androcentric profession. Feminist psychologists challenged not only how research questions were answered but also the very questions being asked and who was asking them.

With the enthusiasm shown towards psychology by the general public the discipline flourished and with this growth came an increasing pluralism, both in the terms of the epistemological coverage of the discipline and the clinical areas it now addressed. Clinical psychology as a profession had pivoted from a male dominated profession to one with more equal numbers of men and women, and would go on to be female dominated³ - bringing with it different types of challenges (Nicolson, 1992). Within clinical psychology the medical model was increasingly being challenged and with the emergence of critical and community psychology the profession became confident enough to re-position itself as independent and distinct from psychiatry. Whilst the 'scientist-practitioner' model remained central what was deemed 'science' widened and the focus of interest became the person in the social, cultural and economic context, not always the individual per se. Evidence such as the Black report (Inequalities in Health, 1980) in the UK, served to clearly demonstrate that individual health trajectories were dependent upon the economic and social context of the individual, including mental health, and that certain environmental contexts were particularly toxic for less economically powerful groups such as women and children. Such evidence provided the genesis for clinical psychology to also concern itself with the 'community' and not just the individual.

With these changes came a rejection of medical diagnosis and an affirmation of 'formulation' as being the starting point for all interventions in clinical psychology. Formulation, as opposed to diagnosis, does not try and fit a set of identifiable clinical symptoms to a pre-defined disorder, but to understand the feelings and/or behaviours of the person within the context of that individual and their history, and to use psychological theory to explain the interactions and outcomes within that person's world. Hence, in terms of clinical psychology and working with sexual issues the point of referral was no longer the type of sexual behaviour displayed, but whether the person was experiencing distress in terms of the expression of their sexuality. This change in orientation meant that it was legitimate to address not just what might be seen as statistically 'deviant' behaviours which caused distress to self or others, but also the promotion of pleasurable sexuality. Changing values were also being reflected within psychiatry such that 'Homosexuality' was removed from DSM I and replaced by 'sexual orientation disturbance' in DSM II (1973) and in that same year the APA issued a position statement supporting the civil rights protection of same sex attracted people.

³ UK entry into the profession is now about 85% female, of which around about 95% describe themselves as heterosexual/straight (www.leeds.ac.uk/chpccp/index.html accessed 3rd July, 2014).

'Sexual Orientation Disturbance' was replaced by 'Ego-dystonic Homosexuality' in DSM III (1980) and in 1986 it was removed completely from DSM IV. The World Health Organisation with its parallel taxonomy of the International Classification of Diseases (ICD-10) only followed suit in 1990.

Consequently, clinical psychologists started seeing people not because they were homosexual, but because they had difficulty coming to terms with their sexual identity. There was a certain irony that those who had been so damned for their sexuality were now in danger of being pathologised for finding it difficult to fully embrace their sexuality in a still largely prejudicial world. However, clinical psychologists also started to see people because of their lack of sexual behaviour, or perceived sexual dysfunction, and thus became involved in sexual counselling and sex therapy. The move away from the individual and the development of more systemic therapeutic approaches also opened the clinical door to couples or relationship therapy. The work of Masters and Johnson (1970) built the foundations to sex therapy, and focussed on reducing anxiety through clear, directive, behavioural, relatively brief, problem focussed techniques and exercises which concentrated on non-demand pleasuring (sensate focus) in the context of reduced self-monitoring (spectatoring).

This approach also started to draw on the emerging field of Cognitive Behavioural Therapy (CBT) where not just one's behaviours but also ones thoughts matter. The rise of CBT is emblematic of the departure within clinical psychology from a wholly essentialist perspective (immutable underlying shared essences) to more of an acceptance of constructionist influences, where there is greater acknowledgement that 'reality' is co-constructed. Here what we 'think about' or how we 'construct' our viewpoint is what is important and so to change our psychological state we must look towards challenging and changing our thoughts and the internal structures by which we judge relevance or importance. Nevertheless, it has also been argued that CBT still operates within an essentialist framework, with manualised protocols for 'conditions' such as depression and assumes there are rational i.e. 'right' thoughts in relation to an accepted, shared 'reality' (Gilbert, 2009).

Society's attitude towards sexuality became a global debate with the arrival of the originally named 'gay plague' of AIDS/HIV in the mid-eighties. The impact of this disease re-opened debates about 'gay morality' and particularly exposed gay men's lives to public scrutiny, comment and judgement. One essentialist viewpoint was that homosexuality was 'wrong', encouraging both religious (the 'wrath of God') and biologically deterministic (nature's way of eradicating faulty genes) discourses about its genesis to surface (Ruel & Cambell, 2006). As the disease became better understood, and a civil rights fight back occurred, it became apparent that it was not just a gay disease, but one that could affect anybody sexually active or undergoing certain medical procedures, and indeed the division between gay and straight was perhaps not so clear cut. With this acknowledgement came a diversification of possible identities, including 'men who have sex with men' (MSM) and bisexuality, and that sexual identities may be fluid and contextual, such as MSM in prison populations.

In terms of clinical psychology, the rise of services for people with HIV produced a whole new area of specialism. Within the Division of Clinical Psychology (DCP) of the BPS the HIV Special Interest Group was set up in 1989, then widened to include sexual health, and renamed the Faculty for HIV and Sexual Health. One of the purposes of the Faculty is to provide guidance for psychologists in the UK working therapeutically with sexual and gender minority clients and to influence the training of psychological practitioners with regard to working in this area.

[Insert Box 1: History here]

Key theory and research

When formulating with clients around maintaining factors for issues of distress relating to sexual or gender identity, there are some key theories and frameworks which are particularly relevant for clinical psychologists. Firstly, the theory of minority or marginalisation stress, proposed by Lindquist & Hirabayashi (1979), suggests that people who are part of a stigmatised minority group within a society are often exposed to compounded stress as a result of prejudice, discrimination and the threat of violence. There is a large body of evidence which links traumatic and stressful events, including micro-level stressors, such as minor everyday acts of aggression or discrimination, to the development of associated emotional and mental health difficulties (King et al., 2008). Hence non-heterosexual and non-cisgender⁴ people within a heteronormative society tend to be exposed to increased stress and as such have a higher vulnerability to the development of associated difficulties, such as anxiety and depression, substance use, eating disorders, deliberate self-harm and suicidality (King et al., 2008). A recent UK audit of referral data has shown that half of the young people with gender identity issues accessing the NHS have experienced bullying (Skagerberg, Holt & Dunsford 2014). Hence, the socio-political environment of sexual and/or gender minority individuals is a hugely important area to emphasize when clinical psychologists formulate and develop interventions.

[Insert Box 2: Formulation here]

A further theoretical framework which lends itself to therapeutic practice with gender/sexuality variant individuals is 'intersectionality', which takes the theory of minority or marginalisation stress further and offers a way to think about such experiences in more intricate, nuanced and individualised ways. The term intersectionality has been attributed to Crenshaw's seminal work (Crenshaw, 1989) originally outlining that single-axis frameworks which try to explain oppression and inequality of minority gender or racial groups render certain experiences invisible. For example, Crenshaw argued that black women's experiences were compounded by sexism *and* racism, and as such were in many ways different to white women's experience. Yet early feminist discourses did not account for these differences and hence rendered the particularities of black women's experiences invisible. Intersectionality can be seen as a multi-axial approach which explores how different social and identity categories such as gender, sexuality, class, ethnicity, religion, ability, etc., interweave and create unique experiences for individuals in terms of the effects of power, inequality, oppression and access to privilege. It thus transcends singular and presumed homogenous categories of identities. When applied to therapeutic work intersectionality can offer a richer understanding of a person's particular experiences within wider social contexts and makes relevant the clinical psychologist's own positioning, and hence their understanding and assumed knowledge.

⁴ Cisgender refers to someone whose gender identity matches the sex they were assigned at birth.

Both perspectives of marginalisation and intersectionality thus have particular relevance when assessing, formulating and creating collaborative interventions with gender or sexual minority individuals. In the therapeutic work with gender minority clients, for example, a formulation which does not take account of wider social factors of discrimination and how these impact on the person's distress would be at best severely limited and at worst unethical. A case formulation should not only locate the intra-personal distress of a gender and/or sexuality variant person, but also consider any relational experiences and effects of disparaging stereotypes, threats of violence and oppressive social structures which may well compound this distress⁵. Furthermore, a formulation will consider how the particularities of different identity and social categories such as class, ethnicity, religion, locality etc. will give rise to idiosyncratic experiences of oppression or privilege, and identify how these positions may concurrently locate people within, and outside of, liminal realms of a dominant culture (Fisher, 2003). Equally, a society which is to a large extent organised around binary notions of gender and heterosexuality (assigning male or female genders at birth, signifying male or female, married or unmarried, commonly depicting couples as male and female, etc.) will not only compound stress for sexual and/or gender diverse people through prejudice, discrimination or general invisibility, but affect how such individuals can actively engage in all aspects of society (Butler, 2004). Thus to practice ethically, the impact of marginalising and oppressive social structures and the respondent discourses of those affected need to be incorporated in any psychological formulations which try to understand and make sense of distress in relation to gender and/or sexual identity.

[Insert Box 3: Intersectionality here]

Clinical psychologists often work as part of a multi-disciplinary team offering interventions addressing psycho-social aspects of care, whilst working together with medical professionals, social workers, support workers, advocacy agencies, etc. For example, when working with individuals with a disorder or diversity of sex development (DSD) such as congenital adrenal hyperplasia (lack of a certain enzyme which affects hormone production and hence physical development) the clinical psychologist will likely work with endocrinologists, surgeons and important people in that person's life such as parents/guardians, as hormone treatment and/or surgical intervention may be recommended during childhood. Or for example, when working with trans* individuals clinical psychologists may deliver affirmative therapeutic interventions for trans* children and adolescents, and their families. The therapeutic aims of such approaches may be to foster non-judgemental acceptance of a person's gender identity; alleviate associated emotional, relational difficulties; break cycles of secrecy; allow mourning to occur; manage uncertainty about gender; and engender hope (Di Ceglie, 1998). In such situations multi-agency working and a supportive network model approach is advocated (Eracleous & Davidson, 2009). In practice this may occur in different ways. For example in the work with trans* youth this includes organising network meetings with schools and other

⁵ It should be noted however, that many individuals occupying marginalised sexual or gender positions are extremely resilient despite such challenges and as they do not appear within clinical services it is sometimes easy for practitioners to draw over-conclusive conclusions about the psychological vulnerability of such marginalised groups.

professionals, challenging binary and heteronormative assumptions, offering psycho-education, advising on practical concerns such as toilets, , use of names and pronouns, writing to institutions and organisations to challenge trans* discriminatory policies. Thus affirmative interventions by clinical psychologist not only entail the clinical engagement with gender diverse young people and their families, but also taking a proactive role to challenge the marginalising effects of wider societal and cultural practices and structures of discrimination. To influence the social barriers gender diverse people face on a societal level requires clinical psychologists to actively engage with policy change and to carry out more research at systemic levels rather than to focus on individual gender non-conformity, considering top-down and bottom-up processes of change, giving emphasis to a plurality of voices.

Current Debates

Training of clinical psychologists in the UK is now governed by guidance from the Department of Health (DoH), British Psychological Society (BPS) and more recently by the Health and Care Professions Council (HCPC). In line with wider political debates and legislative changes, notably the Equality Act (2010) making it unlawful for services and educational institutions to discriminate on grounds of sexual orientation, the DoH introduced sexual orientation as a core training standard as part of its equality and diversity training in the UK's NHS. Thus clinical psychology training programmes are required to include training on gender and sexuality (amongst ethnicity, culture and age) as a core competency in the curriculum (HCPC, 2012, p. 26).

The guidelines also reflected a shift within the profession towards a more critical and reflective stance, including more service-user led perspectives, highlighting the need to practice in a non-discriminatory manner and have an awareness of approaches such as community, critical and social constructionist perspectives (HCPC, 2012, p. 27). This stance endorses an explicit move away from expert-driven epistemologies towards more inclusive and collaborative practices, which take account of power imbalances within therapeutic relationships. In the United States, the APA Practice Guidelines for LGB clients (2000, 2011) similarly emphasize the need of psychologists to increase their understanding of issues relevant to LGB individuals through continuous professional development. Interestingly, most of these guidelines in the UK and the US respectively address concerns around sexualities other than heterosexuality, but do not explicitly include gender identifications other than male or female. Gender diversity was only addressed more recently in the comprehensive BPS guideline (2012) for psychologists working therapeutically with sexual and gender minority clients. In 2013 the Australian Psychological Society (APS) followed suit with a comparable guideline for work with sex and/or gender diverse clients (APS, 2013). One of the key messages of the BPS guidance is the importance of positioning individuals within their historical and cultural specific socio-political context and challenging psychopathological views of diverse gender and sexual identities.

In 2011 the Division of Clinical Psychology (DCP) in the UK published good practice guidelines on the use of formulation and proposed that formulations are used as an alternative rather than an addition to diagnosis (DCP, BPS 2011). This stance was a daring move by the DCP and reflected a wider debate about the usefulness and validity of diagnosis as well as the potentially actively harming effects through stigma of psychiatric diagnoses (Ben-Zeev, Young & Corrigan, 2010). Within an epistemological context it also points to a postmodern epistemology taking a critical stance

towards claims of truth, as well as questioning and opening up relations of power and the constitutive nature of language. Johnstone and Dallos (2014) argue that the process of formulation should be: collaborative; shared with the client; be useful rather than true; be culturally sensitive and show critical awareness of a wider social context.

Within gender identity clinics clinical psychologists have taken on an important role alongside other disciplines and it has become a discrete specialist field of professional practice. Even though many individuals with non-binary or trans*⁶ gender identifications never access specialist gender identity services, some do. In practice, clinical psychologists working in gender identity services in the UK will participate in diagnosing gender dysphoria (DSM-V) or transsexualism (ICD-10) in addition to formulating to, guided by the World Professional Association for Transgender Health Standards of Care (WPATH, 2011) and the Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria (Royal College of Psychiatrists [RCP], 2013). Linking formulation and diagnosis in this context may be reflective of such clinics' close integration into the medical establishment and the management of access to physical interventions such as hormones and surgery.

Implications for clinical psychology and the wider world

This multi-layered approach has implications for the positioning and clinical orientation of clinical psychologists who work with gender and sexual diverse clients. Clinical psychologists working with individuals who present to gender identity, DSD, sexual health and mainstream mental health clinics can play a pivotal role in determining whether clients receive treatment, and at times take on a 'gatekeeper' role. The challenge of such a role is well articulated through the debate about the inclusion of gender dysphoria, and previously gender identity disorder, in the DSM or transsexualism within the ICD. Opponents' main arguments stipulate that diagnosing through labelling and medicalization reinforces stigma, because it locates the problem in the individual and does not question society's perpetuating role of eliciting distress (BPS, 2011). Furthermore, it undermines individuals' right to self-actualise and self-designate their gender promoting a system of cisgenderism (Ansara & Hegarty, 2012), in addition to lacking reliability and validity. Proponents on the other hand argue that diagnosis helps people to access medical interventions and gives trans* people legal status to protect them from discrimination. They also argue that the change in the DSM from Gender Identity Disorder to Gender Dysphoria no longer classifies it as a 'disorder', but emphasises distress. Hence, one of the clinical challenges can involve managing this tension of a supposedly expert, gatekeeping position versus a more uncertain, imperfect perspective (Wren, 2014).

Future Directions

Richards, Barker, Lenihan and Iantaffi (2014) discuss in more detail the complex issues and tensions clinicians face by being gatekeepers, particularly when they hold clinical responsibility for the treatment decisions. Informed consent and the decision making processes attached to potentially irreversible physical interventions can be particularly potent when working with people with very complex needs, and especially in the context of additional histories such as forensic or severe mental

health issues. Clinical psychologists no longer hold onto the privileged position of experts but are expected to co-construct a formulation with the individual, within an expected breadth of explanation ranging from understanding the condition as described by the individual to the place of that condition in the broader social, economic and political world, and the reflexive impact of that positioning upon the individuals' experience and response. From this position they are then expected to assist the individual and those others involved in complex decision making about access and take up of treatment. This is no small requirement and it is also why continued registration with regulatory bodies is predicated on the expectation of continued professional development and access to sufficient, ongoing, quality clinical supervision, in addition to monitoring that one's own ability to practice is not impaired due to poor psychological or physical health status. However, despite the challenge and complexity of working in this area, the contribution of clinical psychology is well valued with opportunities for multidisciplinary working increasing and the breadth of the application of clinical psychology ever widening. Clinical psychology practice, especially in this area, requires examination of personal and societal values and a keen sense of justice. The psychological practitioners attracted to work in this area share the intersectionality of their professional status with their gender/sexuality identity, some of whom will not be heterosexual or cisgender and as such bring added value to their practice. Being able to recognise this demonstrates that clinical psychology has travelled some distance and undoubtedly offers a more promising future than one may have predicted from its early activities in relation to human sexuality and gender development.

Bullet point summary

- The positioning of sexuality and gender in clinical psychology has been heavily influenced by the evolving and changing nature of the discipline and profession.
- The conceptualisation of these topics has shifted from one of considering them as fixed, human entities (essentialism) to fluid, co-constructed and contested understandings (social constructionist).
- Clinical psychologists try to understand issues presented around sexuality and gender through collaboratively developing a formulation which make sense of a clients' experience, informed by historical and culturally specific socio-political contexts.
- Training clinical psychologists in theories and awareness of sexualities and genders has become a core competency at training institutions across a range of western countries, with professional psychological bodies taking an affirmative stance in relation to diverse sexual and gender practices and identities.
- A clinical psychologists' position may extend from a purely therapeutic role to a consultancy role, when intervening at an institutional or organisational level, to potentially the role of a political activist.

Box 1: Know your history

Important points for students:

Clinical psychology's take on gender and sexuality cannot be disentangled from the history of how the discipline, and then profession, developed and the paradigms of understanding that existed at that time. As clinical psychology has become well established and distinctive from the medical model and Psychiatry its approach to these topics has also become more enlightened and responsive to current perspectives.

Important point for applied professionals

Clinical psychology is a relatively new discipline and profession. As such perspectives have changed rapidly and approaches to gender and sexuality in clinical psychology are reflective of the prevailing values and understandings of the time. These have developed considerably, particularly over the last 20 years and continue to change, hence keeping abreast of the current literature is vital to practice in this area.

Important points for academics

Clinical psychology has not developed in isolation, but has emerged from the spaces between established disciplines, such as medicine, psychology, sociology and more latterly cultural studies. Hence, it is important when studying topics within clinical psychology to look without, as well as within, the discipline, to get a richer understanding but also to continue to enrich the discipline itself..

Box 2: Formulation is central

Important points for students:

Formulation is the way in which clinical psychologists try to understand the problems which people face. When a person comes with a problem related to their gender or sexuality it is the responsibility of the clinical psychologist to work with the person to build up a shared, rich picture which is informed by the changes which may have taken place in society's attitudes towards gender and sexuality over that person's lifetime and to understand the impact this may have had on them.

Important points for applied professionals:

Formulations should be grounded in up to date theory and evidence and should be person-specific not based on a specific categorisation of a problem. It should incorporate a person's context and history and draw out the implications of this in terms of understanding the individual's distress. It should also lead to a clear set action plan which is acceptable to the person. Understanding the changing history and cultural context of sexuality and gender is vital in developing a formulation when a person presents with distress relating to these issues.

Important points for academics

Formulations should be based on theory and evidence. The person's distress should be seen within their individual context, but placed within a framework of understanding which theory and evidence offers. Sexuality and gender research has much to offer in terms of understanding the impact of intersecting, competing and conflicting roles which may be central to the distress experienced by the person. Hence, it is vital that clinical psychologists are both active researchers and consumers of research. Clients can benefit from evidence based practice, but research can also benefit from practice based evidence.

Box 3: Intersectionality

Important points for students

Intersectionality is a theory which was originally developed in the field of sociology and Black American Feminism, but has influenced research and debate across a range of disciplines, including clinical psychology. Intersectionality is concerned with identities and explains how different social identity categories such as ethnicity, class, gender, religion etc. interrelate and position individuals in unique and sometimes concurrent, multiple positions of oppression and/or privilege. Hence individuals with non-heterosexual and/or non-cisgender identifications or practices are not a homogeneous group of people and may have different experiences of inequalities.

Important points for professionals

Intersectionality illustrates how different social identity categories such as ethnicity, class, gender, religion etc. interrelate and position individuals in unique and sometimes concurrent, multiple positions of oppression and/or privilege. When working with a person it is thus important not to make generalisations or assumptions based on one (marginalised) identity position, but to carefully explore with a client how divergent identities may interrelate and may offer multiple experiences of oppression and/or access to power and privilege, at times concurrently. Clinicians will need to engage in a process of reflexive practice to examine their own positioning pertaining to social identity norms and reflect how these may impact their therapeutic relationships and practices.

Important points for academics

Intersectionality is a very useful theoretical framework when designing research studies or trying to make sense of complex findings as it allows the researcher to address both, particularity and complexity. Hence, intersectionality is a particularly applicable approach for interdisciplinary research as it offers a converging theoretical framework which can encompass research from multiple, traditional and emerging disciplines in order to address, culturally embedded complex research enquiries .

Further reading (max 5 items)

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