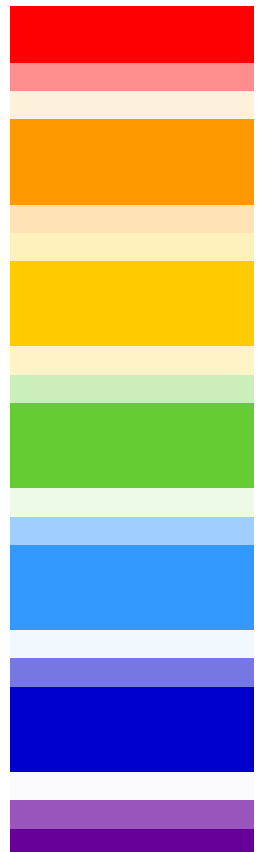




Gay-Affirmative Counselling Practice

Resource and Training Manual





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About the Manual...

Authors' comments

This manual is a result of my engagement with mental health concerns of sexual minorities for the last decade in the capacity of a counsellor as well as a researcher. As a practising counsellor, I struggled with heterosexist theoretical and practice models that seemed to be at times biased and at times merely silent on issues of gay people. As a researcher I sought to break this silence by doing my first research project on ‘Understanding mental health concerns of sexual minority youth’. This was followed by a study on ‘Medical Response to Male Same-Sex Sexuality – An exploration of conversion treatments for homosexuality’. The latter study focussed on harmful and biased practices of health care providers towards their homosexual clients/patients. While encountering extreme homo-negativity and ignorance among mainstream health care providers, voices that were gay-sensitive or gay-friendly were also encountered and recorded during this study. It is in these minority voices that the inspiration to work further on developing an understanding of gay affirmative counselling practice arose. The present manual thus is a direct result of an exploratory study titled – “Conceptualising gay affirmative counselling practice in India: Building on local experiences of counselling with sexual minority clients” - that I undertook in the last two years.

- Ketki Ranade

Contd...





I have been engaging with issues of gender and sexuality for the last 10 years in various capacities such as counsellor, researcher, trainer and activist. Starting in 2004, I worked at a human rights organisation based in Mumbai called India Centre for Human Rights and Law for the rights of lesbian, bisexual women, for three years. After that I have been part of the research team on two studies. The first one is titled 'Breaking The Binary- Understanding Concerns and Realities of Queer Persons Assigned Gender Female at Birth Across a Spectrum of Lived Gender Identities' and was conducted by a feminist collective called Lesbians and Bisexuals In Action¹. The other study, conceptualised by CREA² is titled 'Violence Against Marginalised Women In South Asia' and I worked in Mumbai at SNEHA³ for the India component of the study. I have addressed mental health concerns related to sexuality and gender as a phone line counsellor for several years and also as part of my private practice.

- Shruti Chakravarty

¹ Lesbians and Bisexuals in Action (LABIA), formerly known as Stree Sangam, is a Bombay-based autonomous, voluntary collective of lesbian and bisexual women and transpersons, with a focus on queer and feminist activism. www.labiacollective.org

² CREA empowers women and girls to articulate, demand and access their human rights by enhancing women's leadership, strengthening civil society organisations, influencing social movements and creating networks for social change. A global feminist organisation based in India, CREA works to make human rights an effective tool for social change, and to integrate human rights mechanisms, awareness, and principles into the fabric of the society. www.creaworld.org

³ A voluntary, secular, non-profit organization, SNEHA addresses the special needs of slum women and children in Mumbai by working to improve their health. www.snehamumbai.org





Note to the readers

The **term gay affirmative counselling** in this document is used as an inclusive term for all sexual minorities including gay, lesbian, bisexual individuals, men who have sex with men i.e. MSM persons as well as several local identities such as kothi, panthi identified persons that imply same-sex desires. The current manual does not centrally address counselling practice with trans-persons.

The **term gay** is used in the manual interchangeably to mean - Men who are attracted to other men and / or identify as 'gay'. It is also used as an umbrella term to describe any person (man or woman) who experiences sexual attraction to people of the same gender.

A **sexual minority** is a group whose sexual identity, orientation or practices differ from what is seen as normative sexuality within the society. Though this term need not necessarily apply to lesbian, gay and bisexual persons only, it is most commonly used for them. This term is often used in research/academic writing and often not used colloquially. For the purpose of this manual we have continued to use this term to signify non-heterosexual sexualities.

Process of writing of the manual

A study aimed at documenting gay affirmative counselling practices (GACP) in different parts of the country was carried out between February 2010 and August 2011. The study was carried out among professional counsellors, peer counsellors, counsellors specialising in HIV/AIDS counselling, psychiatrists and physicians working with sexual minorities. The respondents belonged to parts of Mumbai, Pune and Satara in western India, Kolkata in the east and Bangalore and Chennai in the south. Purposive sampling was used to include those respondents who had extensive experience of working with sexual minority communities. The current manual is based on learning and findings of this study. The authors being counselling practitioners themselves have brought in their own practice learning and experiences into the writing of this manual.

A project advisory group consisting of academics, practitioners, researchers and activists working in the areas of sexuality, queer issues and rights has been guiding the process of this study. Their invaluable inputs have been incorporated in the making of this manual. The first draft of the manual has undergone both internal and external expert review and the reviewer comments have been considered in making the final manuscript.





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Foreword

The GFATM (Global Fund to fight AIDS, Tuberculosis and Malaria)–round 7, Counselling Component grant was awarded to the Tata Institute of Social Sciences (TISS) in April 2008. The project is named *Saksham*, a Sanskrit word, which means, "Capable" or "Self- reliant".

The objective of *Saksham* is to strengthen human and institutional capacities of the national health system in the field of HIV counselling to achieve and better meet the long term goals of the National AIDS Control Programme for HIV prevention, care and treatment. The programme, led by TISS, is being implemented in partnership with 38 institutions of higher learning spread over 25 states.

As part of the programme mandate *Saksham* has developed a range of learning and teaching resources on different aspects of HIV counselling and training. Written and created by experts in the field of HIV and counselling, these resources are available as manuals, handbooks, films on DVDs, leaflets, posters and other self study material. Meant to supplement the training resources developed by NACO for HIV counselling professionals working in the public health system, these resources can be used within other learning contexts as well.

Developed under the aegis of the Tata Institute of Social Sciences these resources have been subjected to rigorous standards and have a strong practice base.

With the strong belief that knowledge is for sharing, all *Saksham* resources are made freely available for use to different stakeholders.

The manual on 'Gay Affirmative Counselling Practise' focuses on What is Gay Affirmative Counselling Practice (GACP) and why the need for it in HIV counselling? The manual gives the basic tenets of GACP and numerous interactive exercises to better understand and learn and teach, ways to incorporate GACP into HIV counselling sessions.

The trainers will find this resource manual useful in strengthening the quality of content in their sessions on HIV and gender, sexuality. The exercises and FAQs included will help in making the sessions interactive and participatory.

Shalini Bharat
National Programme Director
Saksham – TISS Mumbai
GFATM r-7





Chapter plan

The first section of the manual focuses on the ‘need’ and rationale for a manual on gay affirmative counselling practices. In doing so, it explores several concepts related to normative and non-normative sexuality and the possible impact of living as a gay person in a heterosexually constructed world. The next section introduces the concept of gay affirmative counselling and describes for the reader what gay affirmative counselling is and isn’t!

Followed by these introductory sections, the third chapter is dedicated to understanding unique stressors faced by gay individuals or couples and ways in which these impact their mental health. This section gives the reader a glimpse into the nature of problems and life events that gay individuals face on a day-to-day basis and for which they are likely to seek counselling interventions.

From the fourth chapter onwards, the manual dwells upon the different tenets of GACP and provides readers with several case scenarios and practice examples to understand each tenet.

Finally the manual concludes with a summary of the core values, principles and practices that GACP advocates. In the end, the readers find a fun exercise – ‘*an attitudinal scale*’ to measure the extent of GACP values that they have inculcated through reading this manual. The appendix lists a few resources for gay individuals that GACP counsellors may find useful in their practice.





Readership of the manual

The manual is primarily aimed at counselling practitioners who work with sexual minority communities. These could be mental health professionals i.e. psychiatrists, psychologists, psychiatric social workers, counsellors or these could be peer counsellors, physicians and doctors working with sexual minority communities. They may be working with NGOs or drop-in centers meant for gay clients or they could be practising in private clinics and set-ups, which may not specifically cater to sexual minorities but where gay clients are a part of a range of other clients that the professionals cater to.

The manual would also be a useful resource for health care providers including counsellors working within the National AIDS Control Program. These may include counsellors working within the Integrated Counselling and Testing Centres (ICTC) or those working within targeted intervention (TI) sites. In addition, the manual may be useful for program managers working with the sexual minority communities. For instance, program managers working on target intervention programs catering to Men who have Sex with Men and Transgender persons could benefit from some of the ideas in the manual relating to affirmative spaces, being informed about and making available resources for gay clients and so on.

Finally, the manual could be used to sensitise students of medicine, psychology, counselling, social work and other human service professions that may interface in the capacity of care providers to gay clients.





Chapter 1

Why Gay Affirmative Counselling Practice?

Two main reasons –

- ✓ Because we live in a world that is heterosexually constructed; i.e., we assume everyone to be heterosexual and there is no visibility to any other form of sexuality including same-sex sexual desires. As a result clients who are gay, lesbian or bisexual (GLB) may come into counselling sessions with a range of unique stressors and issues that may need to be addressed in a manner that affirms their sexuality. Affirming their sexuality becomes vital on the backdrop of a systemic culture of silence and shame about being gay and a lifetime of experiences of dealing with homonegativity, prejudice and ignorance.
- ✓ Because, traditionally ‘homosexuals’, gay, lesbian, bisexual individuals have been viewed as pathological among the mental health sciences (including counselling). Though this stance has changed world over, there are many mental health professionals, trained under these traditional paradigms, who continue to stigmatize these individuals. Hence there is a need to stop such discrimination in counselling practice and sensitise and train all providers to adopt an affirmative stance.

Let us consider the following concepts to understand the extent to which heterosexuality is entrenched into all of our social systems and ways in which this may marginalise people with same-sex sexual desires.

- a) Compulsory Heterosexuality- The assumption that everyone is heterosexual and is expected to have only a heterosexual orientation. This assumption leads to a complete silencing and invisibility of any form of non-heterosexual relating.
- b) Heterosexism – The social system that sustains compulsory heterosexuality by deeming that heterosexuality is superior and homosexuality is inferior. It is the assumption that all people are or should be heterosexual and that heterosexuality is superior and homosexuality is inferior
- c) Heterosexual privilege –Refers to rights and privileges granted to heterosexuals by the virtue of them being heterosexual and denied to gay individuals. For instance, right to marry, all partner benefits including insurance, tax breaks, availing loans, sharing of assets, adopting children, claiming child custody in case of divorce, visitation to





- hospitalised spouse, right to be employed and to housing without fear of termination or eviction because of sexual orientation are commonly known examples of heterosexual privilege. Other kinds of social freedoms include freedom to publicly express their love through grand wedding ceremonies or anniversaries as well as public display of affection without fear of harassment for their choices related to their sexuality.
- d) Homophobia – Feelings of fear, hatred, disgust about attraction or love for members of one’s own sex and therefore the hatred of such feelings in others (Lorde, 1984). However, homophobia does not fit into the classic description of phobia. i.e., an uncontrollable, irrational, persistent fear of a specific object, situation or activity. Instead it is a reflection of prejudice against homosexual people and results in many acts of exclusion and violence. Today the term homophobia has been often substituted by homonegative, homoprejudiced and homo-ignorant.
 - e) Homo-Avoidance - Refers to avoiding references to or discussions related to homosexuality and in doing so maintaining the shame and silence around the issue. Often counsellors or clients themselves avoid talking about sexual orientation. Many clients say that after they disclosed their sexuality to their counsellor, it was not followed by a discussion about the same. There was silence around it. There were no conversations on the client’s process of self-discovery, coming out to self or maybe even others, client’s sexual experiences, relationships and so on. The common fallacy that counsellors may report is that, they do not probe or discuss more about client’s homosexuality because, ‘people are people’ and they are ‘ok’ with homosexuality. The fact, however, is that gay people are not in all ways like straight people and their experiences and stressors maybe very different and often unique, though not necessarily all negative. Not talking about sexuality or under emphasising sexuality could be an indication of the counsellors’ own discomfort with the issue, which they need to address. This is even more significant given the fact that, for many clients it may not be easy to talk about their sexuality and they may still be struggling with coming out and then the disclosure in counselling sessions and the counsellors response becomes even more vital in the client’s journey of consolidating their sexual identity
 - f) Bisexuality – It is a valid form of sexuality, though often bisexual persons are seen as ‘confused’, ‘questioning’, ‘unable to make up their mind’, ‘promiscuous’. Often bisexuality in a person is seen as a passing phase and the person is eventually expected to make a choice between homosexuality and heterosexuality. Bisexual individuals often feel marginalised within the straight as well as the gay community. All the above stated





concepts relating to heterosexism, homophobia, homo-avoidance and so on apply to bisexual individuals and terms such as biphobia, bi-avoidance are used to refer to these.

Counsellors, especially those who are not gay and identify as heterosexual can try doing the following exercise to understand the notion of ‘homo-avoidance’ better.

Exercise: A day in the closet

Instructions:

Please follow the instructions given below for one whole day from morning to night. Please make notes at the end of the day about your reflections about the exercise, what you thought/felt about it? You can also make notes through the day. Repeat the same exercise on a *festival day* or *during a family function*.

Live this day just like any other regular day, doing all your daily chores, work, social, familial interactions, etc. Only thing different today is that, you will not make any reference to your sexuality/sexual/relational life. For instance, in your conversations (no talk about husband/wife, in-laws, children) or dress / grooming (no markers of marriage – wedding ring, mangalsutra, sindoor, bangles or any jewellery which marks marital status). This means that you don't initiate nor do you respond to other people if the conversation is about these topics. Also observe how many times other people make a reference to their sexuality and marriage while talking to you. Observe what kind of information they share about their relationships and note the same.

Reflections:

- Did you have to change your daily behaviour or thoughts to be able to do the exercise?
- How often and when?
- What are your thoughts / feelings about this exercise?

Points for discussion:

- The extent to which sexuality (heterosexuality) is a part of our daily life
- The extent of visibility of heterosexuality
- Gender differences in participant responses
- Empathy for experiences of gay individuals, who often live their relational and sexual lives in silence





- g) Internalised Homophobia – Refers to internalisation of negative social attitudes such as shame, disgust or guilt about being gay. Internalised homophobia may be often unconscious and even those gay clients who have been ‘out’ and open about their sexuality may have traces of internalised homophobia that may show up in different ways. Being able to identify manifestations of internalised homophobia or shame in gay clients is an important task of a gay affirmative counselling practitioner.

- h) Minority Stress – Refers to stress caused by prejudice, stigma and discrimination against a minority group. This kind of a stress is systemic in nature and stems from social structures that are beyond individual control. The stress is chronic in nature. i.e., cumulative and long standing and also unique. i.e., in addition to other general stressors of living (Meyer, 2003).

Let us consider the following scenario to better understand some of the terms stated above.

Imagine this...

Imagine a time 1000 years ago/in future. You live in a country of 10 million people. 95% people here are homosexual. Most of them marry people of the same sex and the average age of marriage is 22-28 and most families have 1 or 2 children. The state insurance covers use of medical technology for child bearing. Parents raise their children on story books of love between Cinderella and Snow white and bring them up to become normal, healthy homosexual adults. Religious leaders promote homosexuality and condemn any heterosexual behaviors as sinful. There are laws punishing any kind of heterosexual conduct. Medical foundations are putting in millions of dollars to promote research aimed at finding and eliminating of a ‘straight gene’ and to find cure for “heterosexuality”.

You are a 32-year-old woman/man, who has always been attracted to people of the opposite sex and despite several attempts at getting rid of these feelings, you have intense/incurable inclination towards persons of the opposite sex. You work in an educational institution that has a policy against hiring of such “perverts”. In this institution most people are married to people of the same-sex or some have steady relationships. The institution gives insurance cover and all partner benefits to homosexuals (married/partnerships)...

You have heard about reports on the internet that there are as many as 5% people in the country, who are straight, but you personally haven’t met anyone like you. You suspect that there would be others, but they all have to be in the closet due to the fear of being ‘found out’ just like you. The only place where you see heterosexuals is sometimes in movies, where they are used for comic relief...





Questions for reflection:

- In a country and a society like this,
 - Would you be at a disadvantage? If yes, in what areas of life?
 - What would be the challenges you face?
 - Which social institutions would perpetuate this disadvantaged position?
 - How would you see yourself (self image) and what would be your feelings?

The reverse of this scenario i.e. the majority/mainstream being heterosexuals and minority/peripheral being homosexuals is the current reality in India. Until recently, there was a section in the Indian Penal Code, Sec 377, which criminalised homosexuality. This section has been read down by the Delhi High Court in July 2009 to exclude adult consensual sex in private and is being still contested in the Supreme Court by several parties including right wing organisations and religious leaders. Thus there exists no legal recognition to same-sex relationships nor are there any anti-discrimination laws in place, which protect LGBT individuals from discriminatory acts such as loss of employment, housing, violence on the streets, in homes or at the hands of the medical and administrative, legal establishment.

Questions for reflection:

Based on the above scenario, can you now give examples for the following –

- a) Heterosexism
- b) Heterosexual privilege
- c) Homonegative/prejudiced
- d) Homo-ignorant
- e) Internalised homophobia





Chapter 2

What is GACP and What it is not?

Affirmative counselling with gay clients is not a new theoretical model of counselling or psychotherapy but instead can be applied to any of the models that counsellors may be working with. What makes a model of counselling an affirmative one is the use of modifications in practice to incorporate the issues and stressors inherent in living as a sexual minority in a heterosexually constructed world.

Basic principles and tenets of Gay Affirmative Counselling (GACP):

- a) Homosexuality per se is not pathological and is a normal developmental outcome for several individuals. Homosexuality is a valid form of human sexual experience and is a part of the vast diversity of sexualities
- b) Heterosexual privilege and heterosexism pervasive in society, negatively impacts lives of gay individuals
- c) Gay individuals face unique stressors related to being gay, which may impact their emotional worlds. It is important for a GAC Practitioner to be aware of the same
- d) Developmental trajectories of gay individuals from childhood to adulthood are often more difficult than their heterosexual counterparts, primarily due to silence and invisibility to homosexuality in most societies
- e) Isolation, invisibility and silence around homosexuality, often leads to most gay individuals internalising homonegativity of the larger society
- f) Language which is an important tool in counselling is often heterosexist in nature and therefore a GAC practitioner will have to develop and use non-offensive and gay affirmative language





- g) Counselling set-ups and clinics often carry only heterosexual messages, which may alienate gay clients. A GAC practitioner would ensure that spaces are more inclusive
- h) Heterosexual clients have several social and systemic supports outside of the counselling space that provide for their multiple needs relating to information, livelihood, shelter, relating, familial needs etc. There exist very few resources for gay clients in our society. A GAC practitioner should know about these and provide information on these to their gay clients
- i) Sexuality is a taboo subject in our society and hence there are several misconceptions related to sexuality and homosexuality in specific. GAC practitioners help to clarify such misconceptions that gay clients may bring into counselling
- j) GAC practitioner avoids assumptions about gender/s and sexualities of all their clients. In this sense, a GAC practitioner is 'gay-affirmative' with all her clients, thus opening a safe space for gay clients who may want to come out.
- k) Just as there is no homogenous community of heterosexuals, similarly there is no 'one gay community'. There exists a lot of diversity among the queer community that a GAC practitioner should be aware of
- l) Belonging to the same heterosexist society, a GAC practitioner, irrespective of their sexual orientation would share some of the larger social homonegativity and prejudice. A GAC practitioner strives to be self aware and reflexive about own biases and seeks knowledge about how one's own beliefs and feelings about sexual behaviours can influence the counselling process (Kort, 2008)

What GACP is not!

Historically, homosexuality has been viewed as a pathology within the mental health sciences, which includes counselling. There have been several homo-negative models of trauma and pathology that have been used to explain adult homosexuality. Research has shown several instances of biases in diagnostic as well as treatment practices with homosexual clients. As a result of this historical baggage, GAC practitioners with the principle of affirmation and





validation may be tempted to attribute all emotional disturbances or dysfunction in gay clients to heterosexism prevalent in society. It is however necessary that a GAC practitioner refrains from doing so.

One aspect of work of a GAC practitioner is to help clients work through internalised homophobia, make linkages between client's mental health condition and their experiences of stigma and discrimination and help clients to consolidate their sexuality and claim the same with a sense of pride. The other aspect of their clinical work is also to identify dysfunction and disorder where it exists. Clients may suffer from major emotional disorders, substance dependence, personality problems, self harm and so on. While homonegativity and heterosexism may play a role in these, the interventions necessary for these conditions would go beyond working through homonegativity, getting accurate information, being part of support groups and so on. *Thus a GAC practitioner will not try and explain every form of emotional disturbance or dysfunction only through the lens of homonegativity, nor will they prescribe affirmation, validation and working through homophobia as the only interventions to their gay clients.*

What is Gay-biased practice?

Gay-biased practice would include any counselling practice that discriminates against sexual minorities on the basis of their sexuality. Any practice that does not respect and accept diverse, adult, consensual sexualities of different kinds would be considered biased practice.

Why does biased practice exist?

All of us as practitioners live in a heterosexually constructed world and carry an inherent bias against homosexuality that stems from the society we live in. The training that counsellors or health care practitioners receive, the curriculum and often the supervision they seek tends to be silent on non-normative sexualities or worse, may label homosexuality as a perversion, pathology or a form of sexuality that is unnatural and uncommon and therefore associated with several difficulties. In addition to biased training, lack of exposure to non-normative lived realities results in assumptions and stereotypes about sexual minorities that colours the counselling process. Thus often counselling practice tends to be heterosexist and a negative bias towards sexual minorities is common.





How does bias get reflected in practice?

- ✓ Use of conversion or reparative treatments for cure of homosexuality or attempting conversion to heterosexuality is an example of biased and unethical practice. It is premised on the understanding that there is only one type of 'normal' sexuality i.e. heterosexuality and homosexual behaviours are abnormal behaviours that are learnt and therefore can be unlearned through use of several aversion treatments and reconditioning methods. Reparative treatments include use of mild electric shock as aversion stimuli, hormonal treatments, especially testosterone to homosexual males, which are based on the premise that homosexuality is a result of hormonal imbalance

- ✓ Counselling practice that looks for causes or encourages exploration of aetiology of homosexuality reflects biased practice

- ✓ Counselling practice that believes that people can choose their sexuality and homosexuals are people who made wrong choices due to early childhood experiences or sexual traumas is biased practice

- ✓ Counselling that is based on the premise that homosexuality is nothing but a passing phase reflects biased practice.

- ✓ Counselling people to give up their sexual orientation or advising clients to abstain from sex or choose only heterosexual sex (especially for bisexual individuals) are examples of biased practice

- ✓ Insisting that gay individuals or relationships meet the criteria of the heterosexual script such as marriage, monogamy, adopting children in order to be seen as 'normal' is also biased practice

[Please read APA position statement on homosexuality, 1973; Garnets et. al. 1991; Ranade, K., 2009; Schneider et. al. 2002; APA, 2009 for more details related to gay-biased practice]





Chapter 3

Unique Life Stressors

Key terms

Same-sex desire

Hetero-normativity

Internalized homophobia

Coming out

Being outed

Invisibility

Two foundational issues relating to mental health concerns of sexual minorities are stated at the outset:

- a. Same-sex desire or sexuality is not a problem in itself nor is it true that being homosexual in itself leads to disease or disorders
- b. Living one's life as a 'gay' person may get difficult due to the external environment that is hetero-normative, which views heterosexuality as the only natural, normal, universal, moral and pure form of sexuality. This context of social marginalisation forms the framework for understanding some of the common mental health concerns that are described here.

Presented below are some of the unique life stressors that sexual minorities encounter. These form the underlying basis for some of the mental health manifestations or problems that clients bring to sessions. It is unlikely that clients themselves may be able to pin-point these stressors in their lives. They will tell their counsellors about feeling depressed, ashamed or dirty, they may tell you that they are not being able to concentrate on their studies or being able to hold down a job. They may express that they get teased or beaten. Making the possible link of client problems and manifestations to the unique life stressors related to their sexuality, is the responsibility of the GAC practitioner.

Under the shadow of hetero-normativity, which assumes everybody to be heterosexual, same-sex sexualities may get eclipsed at best or even attacked in more extreme cases





Some of these life stressors that GAC practitioners should be familiar with are:

1. Difficulties with self acceptance

Sexual minorities grow up and live in a hetero-normative society, which stigmatises and rejects non-heterosexual sexualities. Therefore, having a healthy acceptance of one's sexual identity is often a tumultuous journey that they have to make.

Homosexuality and or bisexuality are perceived as perversion, pathology or a passing phase. This understanding and opinion of the outside world is often what sexual minorities also believe about themselves. This is called Internalized Homophobia/Bi-phobia. This would mean that clients experience guilt, hatred, shame, anger, denial, suicidal ideations, low self esteem, self doubt, confusion, neglect, repulsion, feelings of having done wrong, feeling different, feeling dirty and similar range of negative feelings about their own sexuality or sexual behaviour.

Client experience:

I am a lesbian. I try very hard to stop but I always seem to prefer girls. I have tried sleeping with men on many occasions in the hope that I will start liking it. But, since college days, I am like this. I have done my masters degree and for the last 4 years I am working in a very reputed company. I am scared that if they come to know about these feelings of mine, I will lose my job. I hate this addiction to girls.

GACP viewpoint:

Many narratives of sexual minorities will reflect internalised homophobia. It is the responsibility of the counsellor to be alert to feelings of non-acceptance in clients. In the first example above, believing that her sexuality is an addiction and wanting to stop her feelings is an indication of client's discomfort with her sexuality. When clients are unable to accept themselves, it becomes the priority of the practitioner to ferret out these negative feelings and address them in the counselling session. Self-acceptance can be enhanced by:

- Locating the locus of homonegativity outside the person, where it comes from in the first place
- Providing information or a new perspective
- Using one's expert position to validate and normalise same-sex desires
- Putting clients in touch with resources on sexuality
- Building a sense of community by connecting them to sexual minority groups, when the client feels ready for the same





Client experience:

I have always been attracted to boys. I have had 2-3 affairs with boys from my chawl. I started working in Sewri as a salesgirl in a clothes shop last year. I go by local train using the women's compartment. In the last 6 months, I have made a friend in the train. It started with her smiling at me everyday. Then we got talking. She lives in Sewri only. Our friendship became very strong. I started going to her house for tea after my work 2-3 times a week. I really enjoyed her company and we would laugh and talk endlessly. One evening, she sat very close to me and told me that she loves me. Then she kissed me. I was so shocked that I left immediately. But I realised later that I had actually liked it. So I went back the next day to meet her. That is how our affair started and I really want to be with her. The only problem is that I still like boys. I have many male friends and I like to explore sexually with them also. But I feel guilty. I feel I should have feelings only for my girlfriend. Sometimes I feel that I should have feelings for boys and I should find a good man and marry him. I don't know what to do. Can you help me choose?

GACP viewpoint:

It is possible that the client is bisexual and is emotionally and sexually attracted to men and women. GAC practitioners must beware from making the assumption that bisexuality is a passing phase or that people are bisexual till they make up their mind about whether to be with men or women. It is critical to understand bisexuality as a valid sexual orientation. It is yet another expression on the sexuality spectrum. Clients themselves may find it difficult to accept or understand their attractions. To start with everyone is expected to be heterosexual. Then they are expected to stick to the heterosexual script- marry and spend their lives with the same person. Given this heterosexual, married, monogamous set-up, to recognise and accept that one is bisexual can be a difficult journey and the pressure to fit oneself into either box can be tremendous. Such clients need to be reassured about their feelings as being normal and valid. Additionally, it is important to remember that often bisexual persons are marginalised by the gay community also and their support systems are further reduced.

Client experience:

I cannot bear it anymore. Please help me change. I want to be normal again. My religion, Christianity, does not allow men to have sex with other men. My parents are finding a girl for me. So I cannot go on like this. Please do something and change me. As a man, I want to have sex with women only.





GACP viewpoint:

Some clients may seek counselling support in order to ‘convert’ to heterosexuality. GACP advocates that ‘trying to cure homosexuality’ is inherently flawed and that Conversion Therapy is unethical practice. Such practice stems from the faulty belief that homosexuality can be treated to fit the heterosexual standard.

While some clients would benefit from more information, affirmative messages and building a sense of community by meeting more individuals like themselves, there would be many others who continue to remain conflicted and express a desire to change. Affirmative practice would include validating that conflict and the feelings that arise out of it. It would focus on exploring the source of the conflict and help clients work through the same. This would be done by providing a comfortable and non-critical space to the client such that the client is able to decide how to manage their sexual minority status and feel more integrated.

2. Coming out

Compulsory heterosexuality means that we assume that every single person is heterosexual and that no other sexuality is possible. Therefore, having a sexuality that is other than heterosexual becomes something that needs to be discovered and revealed. This process is called Coming Out. Coming out happens at two levels. Coming out to self means realizing ‘I am not heterosexual’. Coming out to others means revealing to them that my sexuality is different from heterosexuality. Because of living in a hetero-normative society, heterosexual people never have to come out and tell others about their sexuality. It is already a given. So, the process of coming out becomes unique to sexual minorities when they are forced to acknowledge their own difference in the face of a more mainstream, acceptable sexuality.

Client experience:

I was very scared to tell my mother but she was already suspicious and so I told her that I am homosexual. She locked herself in the bathroom and cried all night. Next day she told my father, who beat me up. One day, my mother caught me talking on the phone to my girlfriend. She went and insulted her in front of the teachers and other students. My girlfriend was asked to leave college after my mother outed her like that. My parents took me to a psychologist who started giving me medicines that made me feel drugged. I was only 18 but my parents started asking relatives for a prospective husband for me. Finally I ran away from home. This was 5 years back.





GACP viewpoint:

GACP takes the stand that with the client's consent and readiness, the counselling process should facilitate coming out to self and others. However, critical concerns to remember are:

- Every gay person has to constantly evaluate who they can come out to
- The final decision on how, when and whom to come out to must be made by the client
- Telling others about someone's sexuality without the person's explicit consent or knowledge is called Outing. Outing the client is unethical practice
- Coming out can sometimes have violent consequences because of the stigma associated with homosexuality. These often include, forced marriage, house arrest, stopping of education, separation from partner or emotional consequences of rejection, denial and being shamed
- Preparation and strategizing on how and whom to come out to can minimize the risks to some extent
- The process of Coming out may be different for different people. The counsellor can facilitate this process by helping the client to work on other issues such as guilt, shame associated with one's sexuality, which are known to be barriers to coming out to oneself as well as others. The final decision as mentioned earlier of whom, when and how to come out lies with client

3. Invisibility

Heterosexuality is visible, accepted and celebrated. On the other hand, homosexuality is invisible, unacceptable and stigmatized. Heterosexual privileges awarded to married heterosexuals include an affirmation of togetherness, never having to hide their relationship, being acknowledged as a husband-wife couple at all times, having extensive support system in the form of relatives and friends, having access to multiple material benefits and resources. On the other hand, sexual minorities may live a double life in order to hide their sexuality from significant others. Invisibility also means that they may have no knowledge of any spaces, resources or people to mirror their realities. Not having any resources that affirm one's existence results in a feeling of isolation and a deep sense of loss.

Client experience:

Every time I go home, my mother starts the same topic - "Beta, I found a wonderful girl for you. Why don't we go and meet her? You are now 28, how much longer will you delay your marriage?" And it is not just her but the relatives, neighbours, my colleagues, my friends, they all keep trying to fix me up with some girl. Sometimes I just want to tell everybody that I am gay and





now please find me a boyfriend! But that is not possible. That is a dream world. If I tell my parents, they will try and find me a girl even quicker. All this lying and hiding - it has begun to cause me a lot of stress.

GACP viewpoint:

This gay man's narrative reflects how sexual minorities may be forced into a dual existence, often having to lie actively or make up a pretend life. Not having enough information, not knowing other people like oneself and not having support for one's relationships are consequences of an invisibilised existence. Loss of primary supports like family, loss of heterosexual privileges, loss in terms of education and livelihoods also feature prominently in their lives. It is important to recognise that the GACP practitioner may be the first person to have knowledge about their client's sexuality. Therefore, acknowledging the invisibility, isolation and sense of loss and then affirming and validating the client's sexuality and life choices, is critical.

4. Discrimination and harassment

Various systems like education institutes, livelihood spaces, police and legal systems, hospitals and the medical system and even families can become sites of harassment if the non-heterosexual sexuality of a person becomes known. Discrimination is manifested in the form of withholding resources and privileges, violent responses, curtailing access and mobility or refusing equal rights.

Client experience:

I was sitting in the park with some others like me. A kothi friend of mine was showing us the gold bangles she had bought. Suddenly, we saw two policemen in the distance. Hurriedly, we put away the stuff and started to walk off quickly. But we are easy to spot because of our effeminate mannerisms. The policemen came to us and without asking a single question started hitting us with their sticks and using dirty words to abuse us. They snatched our bags from us and took all our money and the gold bangles. We were treated like this simply because we are kothi. We have no rights and we cannot even complain against such injustice.

GACP viewpoint:

It is important to recognise that not awarding a similar status to all sexualities is a systemic inequality. Thus, sexual minority clients are likely to have experienced some form of harassment and discrimination on account of their sexuality.





5. Relationship issues

Heterosexual marriages give sanction and legitimacy to a relationship between two people. Rarely do any other relationships ever get the same affirmation and validity as marriage. Therefore, sexual minorities have to wrestle with their romantic, sexual relationships not being considered serious enough and/or threat of separation from their partners. GACP takes into account the losses associated with that.

Marriage also promotes a long-term, single partner model of relationships. GACP recognizes that same-sex relationships [also several heterosexual relationships] do not necessarily follow the same trajectory. Relationships may be multi-partnered, open and non-monogamous. They may be short-term. The couple may not necessarily live together. There are no rigid definitions as to what a relationship means. A person may be in a relationship with a man as well as with a woman at the same time or at different points of time in their life. There are negotiations and boundaries that each person in the relationship decides with each other. GACP practitioners must guard against inadvertently pushing their clients towards building relationships along the lines of marriage. Instead, they must recognize that the counselling space may be the only place where the client's relationship is valued and validated.

Same-sex relationships, like any other, face interpersonal problems. Communication and compatibility issues, disagreements, fights and sometimes even physical violence are a part of intimate relationships. Fear of losing one's partner, jealousy, suspicion and abandonment are other emotions that clients bring to the session and need to be addressed. Additionally, the issue of how out to be as individuals and as a couple may cause discord between them.

Particularly for sexual minorities who are in heterosexual marriages, living a dual relationship is an additional stress. Their married spouses may not be aware of their other relationships. This may cause guilt. Health risks for the married spouse may also be an issue that GACP practitioners need to be alert to. Being married to heterosexual people brings its own set of problems between same-sex partners. Not being able to visit the partner where they live with their spouse or the unmarried partner being unable to deal with their partner's marriage has been reported as problems that clients express. Clients also find it harder to give up their married partners for fear of not finding another relationship.





Client experience:

M and I have been friends for a long time now. We did our post graduation together and after that she left for the USA to do her PhD. I started teaching in a college in Bombay and soon met A, who was also a faculty in the same institute. We got along well and soon started dating each other. It has been a happy 2 years with him. Last summer M came back from the USA and has been looking for work in India. She has had a lot of free time and we have been spending a lot of this time together. In the past few months we have discovered this intense attraction for each other. Neither of us has named it as anything, but we both know that it is emotional, intellectual and as much sexual. It is like being in love with your best friend perhaps. A has noticed this and has been quite upset. Last week I told him about M and I and is devastated by it. I have assured him that my relationship with M does not change how I feel about him, but he is very upset. On the other hand M too is asking me to make up my mind about A and where he stands in my life. I am feeling torn.

GACP viewpoint:

The situation that the client describes is indeed a complex one and can be emotionally taxing to all the three persons involved. Counsellors have to deal with similar issues with their bisexual clients as well as clients who want to be in open/multiple partner relationships. In these situations GAC practitioners do not pass moral judgements and empathise with the dilemma of the client. Assuring the client that being attracted to/in love with two persons, a man and a woman at the same time is normal. It may have emotional consequences for all involved which will have to be understood. GAC practitioner tries to create a safe and non-critical space for the client to work through her emotions as well as issues of transparency, communication with partners and taking responsibility for decisions about the relationship/s.

Client experience:

I was always afraid of rejection and exposing myself to more discrimination. So I was never able to propose to the girl I loved. I was never able to openly state my preference because if people will come to know about your sexuality, they will ridicule you, ostracize you. But I was lucky enough after a few years, to find a girl like me. We fell in love. Our friends did not know about us so we stopped hanging out with them. We became very involved. The relationship and each other was the only comfort space we had. No one else knew about us and we were afraid that they would find out if they saw us together.





But it did not work out. This is a big loss. I feel I am in a vacuum. I can't even go back to my friends. They don't know anything and they keep talking about their boyfriends. I can't share anything with them. I cannot go back to the dance class because I have not gone there for 2 years. They will all ask me where I had disappeared and I will have no answer. I cannot even go to the regular addas. They only talk about marriage or kids. I cannot relate to that at all.

Now I feel an immense emptiness. I have lost my world, I have lost my girlfriend. I will never find a girlfriend again. If I like some girl, how will I tell her? She may reject or ridicule me. I am feeling distressed, very distressed. I feel like committing suicide because I have nothing left now.

GACP viewpoint:

A loss of a relationship is a traumatic experience. However, for sexual minorities, the loss is experienced much more strongly. To start with there is disillusionment of not being able to sustain a relationship. Given that the over-arching structure for relationships is marriage, some people may wish to replicate this 'ideal'. They may look for single partner, long-term relationships and hope to live it out like a marriage. Then there is the panic of never finding anyone else or never being able to express their attraction. Thirdly, there is hardly any external support for the grieving client. Many same-sex relationships exist in invisible and silent spaces and end in silence too. Some of the consequences of relationships ending is that clients may turn to alcohol, attempt suicide or neglect their health. Mental health concerns appear as depression, grief or anxiety.

The mental health concerns that manifest in sessions with gay clients are common and similar to all populations. However, for sexual minorities, their mental health concerns cannot be examined on a blank slate but need to be contextualised on the basis of unique life stressors that exist.





Chapter 4

Basic Tenets of GACP⁴ - How To Make Counselling Gay Affirmative?

Tenet 1: Using Gay Affirmative language

Key terms

Heterosexist bias

Language is a primary tool through which counsellors reach out to their clients. To listen to clients, empathise with their issues, help them ventilate, get in touch with difficult feelings and experiences, working through these, looking for best possible options for the clients or even to provide information; language is central to all these processes. Unfortunately, language is not free of context. Therefore if the context assumes that heterosexuality is the ‘only’, ‘natural’, ‘normal’ form of sexuality that exists or that homosexuality is ‘abnormal’, then that gets reflected in language as well. It is then the task of the gay affirmative counsellor to identify such heterosexist biases in language where they exist and eliminate these in their use of language with their clients. In addition, the gay affirmative counsellor may want to think of new language that conveys inclusion, respect and trust to their clients.

What is Gay Affirmative language?

- ✓ Language that eliminates heterosexist biases, is non-stigmatizing, non-pathologising and non-derogatory towards gay individuals (includes verbal and non-verbal communication)
- ✓ Formulating new terms, new words, new language that is inclusive and respectful of experiences of gay individuals

⁴ All the tenets described in this chapter are derived from a study done by the same authors titled “*Conceptualising gay affirmative counselling practice in India: Building on local experiences of counselling with sexual minority clients*”.





Language reflecting heterosexism and compulsory heterosexuality:

Let us try to understand ways in which language maybe heterosexist.

Scenario 1:

This is an example of an Intake sheet at a private counselling centre, in which background details of all new clients are recorded. When we look at the sample on our left, at the first glance, it may seem like any regular intake proforma that collects basic background information of clients. But it would be important to ask the question - does this sheet reflect the experiences/realities of all my clients?

| | | |
|----------------------|-------------|---------------|
| <i>Name:</i> | | |
| <hr/> | | |
| First Name | Middle Name | Last Name |
| | | |
| Age: _____ | | |
| Gender: | | |
| Male () | | Female () |
| Relationship status: | | |
| Married () | | Unmarried () |

Questions to reflect on:

- a) A 42-year-old male client, who has been living with his male partner for the past 12 years.
Some questions to reflect on:
 - How would he answer the question on relationship status?
 - How would he feel saying ‘unmarried’ in response to that question?





- Would this question silence/invisibilise a part of his life?
 - Based on his answer of 'unmarried', would it be ok for the counsellor to assume that he is not in any romantic, sexual relationship?
 - Would that be a reflection of his lived reality?
- b) A 33-year-old transperson, who has been living in the body of a male. However, this person feels trapped and sees herself as a woman, while continuing to live in the male body.
- How would this person answer the above question on gender?
 - Does this question reflect the client's realities?
 - Would this question make the client feel excluded?
- c) A 22-year-old woman identifies as bisexual. She is the daughter of a well known journalist.
- How would this person feel writing her middle name and last name?
 - Would she feel safe coming out knowing that her full name will reveal her as well as her family's identity?

Scenario 2:

A 24-year-old woman has come for her first counselling session. As part of the initial assessment she reveals that she has finished her post graduate education in computer science and works in an IT firm. She seems very confident and is well articulate about her problems. She elaborates on her reason for seeking help and says that, she has been unable to concentrate and has frequent spells of crying, feelings of loneliness, inability to sleep, gets irritated easily for a while now. All this has been affecting her work and so her team leader has asked her to get help. She adds that all these problems have started since her break-up. On hearing this, the counsellor spontaneously says, 'so when did you break-up with your boy friend?'

Questions to reflect on:

- In the above mentioned information, did the client ever say that she was seeing / in a relationship with a man?
- Why does the counsellor assume that when the client says, 'break-up', it is with a 'man'?
- Does this have anything to do with the counsellor's assumption that all her clients are heterosexual?
- Would using neutral terms such as 'partner' be more inclusive, at least until the client has started to use some terms to describe that relationship?





Scenario 3:

Amit and Shamir met at a film screening organised by a gay rights NGO in the city over a year ago. Shamir had just come to the city from a small town nearby in search of a job and Amit was the first ‘out’ gay man he had met. ‘It was love at first sight’, says Shamir. Today they are at a fancy restaurant to celebrate their first anniversary of being together. After a romantic dinner, the waiter hands out a feedback form to them. The form asks among other things, date of wedding anniversary? ‘It’s ironic’ says, Amit ‘that while we are celebrating our love for each other today, we still leave out this question blank’.

Questions to reflect on:

- Do most of us, generally assume that all people around us are heterosexual?
- When we hear the word ‘marriage’ or ‘relationship’ do we always assume it to be between a man and a woman?
- How do these assumptions of ours alienate and invisibilise the reality of sexual minorities?

Language reflecting pathology:

Using terms such as ‘abnormal’ and ‘normal’ to refer to homosexuality and heterosexuality respectively is common. This is a reflection of a larger social attitude that considers homosexuality to be ‘unnatural’ or a form of ‘deviance’. It is also linked with the history of pathologisation of homosexuality within medical science.

History of pathologisation of homosexuality

The term ‘homosexual’ was first used by Richard Von Kraft Ebbing, a physician in his work ‘Psychopathia Sexualis’ (1894), which viewed homosexuality as a form of sexual deviance. Homosexuality continued to be seen as a form of mental disorder until 1973, when the American Psychiatric Association declassified homosexuality from its list of mental disorders. However, this legacy of medical pathologisation continues till date in medical practice as well as attitudes of both medical professionals and the general public.

A study with 40 health care providers in the cities of Mumbai and Pune (Ranade, 2009) indicates that, nearly half of the practitioners used different forms of treatments to cure their clients of homosexuality. An assumption implicit here is that, these practitioners viewed homosexuality to be abnormal or a condition that needs treatment.





Consider the following reflections of a counsellor:

Client: *“I realised I was gay in class 7th, when I saw that my other friends are ‘normal’”*

Counsellor’s thoughts about this statement: *This statement implies that the client sees heterosexuals as normal and in contrast to that being gay as ‘abnormal’. Also this may mean that the client uses the word ‘normal’ to refer to heterosexuals. He may not think it appropriate to refer to ‘them’ as ‘heterosexuals’ because they are people and so much more than just their sexuality, then how can one refer to them as merely heterosexual. However it maybe important to see, if the client thinks the same about referring to oneself or people like him as ‘homosexual’. This maybe linked to internalised homophobia that the client may suffer from.*

So the counsellor would want to explore both these areas with the client. The counsellor may start the exploration with a simple statement such as - “You mentioned that your friends were normal. What do you mean by that?” In this manner a counsellor can explore the client’s perceptions about normal and abnormal sexuality and reframe it by providing an affirmative framework.

Stigmatizing and derogatory language:

Derogatory terms and words to describe deviations from normative sexual and gender expressions are plenty in the English language as well as all local languages in India. This is not to say that there are no celebratory or affirming words. These exist as well but may not be as accessible in memory or usage as the words that are used to taunt, poke fun at or humiliate individuals with different gender and sexual desires and expressions.

Some examples of these are –

| <u>Hindi:</u> | <u>English:</u> |
|---------------|-----------------|
| Gud | Lesbo |
| Mamu | Homo |
| Chakka | Faggot |
| Chameli | |
| Baylya | |

Most of these terms are used to describe gender transgressions, especially for men. Some terms such as ‘*ganda kaam*’ (doing bad things) in Hindi or ‘*vait vichar*’ (bad thoughts) in Marathi are used to refer to sex in general as a ‘bad thing’ as well as specifically used to refer to sexual attraction or sexual acts with a same-sex partner.





It is important for a gay affirmative counsellor to be aware of these terms and the meanings that they carry. Many clients grow up being teased and taunted with one or several of these terms in their families, homes, school, among peers, in public spaces and so on. Sometimes clients may use some of these terms such as ‘homo’ to describe themselves or their desires. This maybe a reflection of the client internalising the negative connotations attached to same-sex sexuality in their context or it may simply be a result of not knowing any other words or terms for same-sex sexuality. The only words available are the ones with a negative or derogatory tone. Thus being attentive to and knowing about such terms used in the local culture is important for counsellors.

Consider the following quote

“Many times people use derogatory language towards LGBT when they themselves are gay. First, I try to see the intention behind the use of that word. Is he intending it in a derogatory way or is he short of vocabulary? Maybe he doesn’t know the word homosexual but knows the word ‘homo’, which is a derogatory word. He is meaning simply homosexual by that when he says, “I am a homo.” Intention needs to be studied first. The first idea is not to change the vocabulary but it is to change the intention. To make him understand that it is normal; otherwise the vocabulary will never change. If the intention was positive from the beginning you simply say, can you replace this word? “Many people consider this word to be derogatory you know? You can say this or that, is a better word.” It is somewhat educative.

*If the word is intended to be derogatory then first remove the intention and counsel about that rather than focus on the language. And if he is impressed that ‘I am normal’, automatically language would change...” **27 year old practising psychiatrist and counsellor***

Stigma, disapproval, disgust and several such intensely negative responses maybe conveyed non-verbally as well. So while the language used may not necessarily be derogatory, non-verbal cues may convey similar messages. Sexual minority clients often describe such experiences with their health care providers. These may range from simply ignoring, avoiding eye contact while talking, avoiding touching the patient during physical exam, asking the client to talk from a distance and so on. All of these convey indignity to the client and are indicative of the counsellor’s discomfort with sexual minorities. Also these point to the need for the health care providers to be self reflexive about their own prejudices.





Coining New Gay Affirmative Language:

Given the dearth of terms to positively or affirmatively address same-sex sexuality, desires, relationships in everyday usage, it may be significant to create and popularise new terms that are local, familiar and respectful to address same-sex sexualities.

For instance, consider the following quotations by counsellors who have been working with LGBT persons.

“Lesbian is so western that women may not understand it. Using words like Humjinsi and explaining it. Like hum means similar and jinsiyat means sexuality. So two women who love and desire each other can call themselves ‘humjinsi aurate’ (humjinsi women). I think it is essential to deconstruct the invisibility. Because you are living in such invisibility, just hearing these words is very important and also giving knowledge because clients may not have heard these words...” (30-year-old practising counsellor)

“We need to have a word that is comfortable for us. That is what is very important. And I think each State has to come up with their own words. If Hindi (national language in India) is a language that is, well, widely spoken, then you also need to have some words in Hindi. But you also need to have very affirmative words in our local language. We make our own, you know? In Tamil, we have very nice words. ‘Nangai’ is a person who is a male who has transformed into a female. A very positive way of calling that person. ‘Tiru’ is like how you say ‘shri’ (used to address someone with respect like ‘sir’). So we have ‘tirunangai’. So you respect, you call the person with respect. And for female to male, we have ‘tirunambi’. It sounds good. Everybody will immediately say ‘wow! I’ve never heard of this word; what does it mean? And it’s easy to say. So then when they start calling themselves tirunangai and tirunambi automatically that affirmation that ‘we need to be respected’ comes...” (39-year-old practising counsellor)

Some affirmative terms that are used to refer to same-sex sexual identities / relationships / desires / sex are: Sakhi Dogana Svairini Kothi Queer Partner-Dyke MSM Panthi





Tenet 2: Gay inclusive counselling set-up

Key terms

Gay-inclusive

Heterosexual messaging

Marginalization

A significant part of the counselling process is the physical environment that the counsellor is able to provide their clients. The physical space in which counselling takes place as well as the attitudes counsellors carry within those four walls, both impact the client. In GACP, emphasis is placed on the counselling setup in order to make a space gay-friendly or gay-inclusive for sexual minorities.

By default, counselling spaces tend to be heterosexually leading. Images and messages found in counselling rooms and clinics are usually directed towards heterosexual couples and lifestyles. Even when spaces are neutral with no explicit heterosexual messaging; books, magazines and even the newspaper lying around in the reception area reflects to clients a heterosexual reality of the world we live in. This counselling space can then feel as alienating to a gay client as the world outside. As a result, the client may expect an equally harsh judgment about their sexuality even in this space, just as in any other space.

The significant question then is whether separate counselling spaces should be drawn up for gay clients or can these issues be integrated within any space that is inclusive for every client? It is important to realize that separate counselling spaces for gay clients have been tried out and some of the distinct advantages of these spaces are:

- Clients get to meet with others like themselves and this reduces isolation
- There are predominantly same-sex messages and images, which are affirming to clients
- Counsellors who are highly skilled in working with gay clients
- Such spaces can become '*comfort zones*' for clients

However, setting up separate spaces can also mean further marginalization and exclusion of sexual minorities. Any counselling space should be able to provide gay affirming counselling services. Therefore, GACP advocates that counselling spaces should exhibit a gay-inclusive





environment. This means creating an affirming atmosphere for the client at the outset and stating clearly that gay clients are welcome and safe in this counselling setup.

Tips on how to make your physical space gay-inclusive

- ✓ Put up posters that indicate that people with all sexual orientations are welcome here
- ✓ Make sure your visiting card mentions that you address issues of sexuality
- ✓ In a brochure, you can show a homosexual couple, alongside a heterosexual client when you advertise couple therapy at your clinic
- ✓ Keep a few gay friendly magazines along with other magazines in the reception area
- ✓ Make sure your intake form is open-ended and does not ask heterosexually leading questions like marital status or gender (F/M only)

One of the psychiatrists said following about gay affirmative spaces:

“I think the best thing to do is to set up a space that is for all people but indicate that it is gay friendly. Instead of setting up isolated spaces for gay people it is better to include them because it does away with discrimination. At the same time it indicates that it is gay friendly. There are many subtle ways of doing that. For example when you are doing publicity for your clinic and in your leaflet you are giving pictorial representations of doctor speaking to his clients and the word bubbles indicating dialog? Two, three can be heterosexual and one representation can be gay or lesbian”. (27 years, male, psychiatrist)

Another counsellor practicing in a private set-up said

“We had put up this poster in all our offices where two women are holding hands. This gives a message that there is approval in this set up to talk about such things. This would be a positive sign.”





The other aspect of a gay-inclusive space is reflected in the attitudes of the people within that counselling setup. GACP practitioners should ensure that the staff they employ have received some basic understanding on these issues. Staff should be trained not to stare at clients who may transgress gender norms or to ask inquisitive questions to them. They should be trained to not gossip about clients or insist on complete and full details such as name and address while preparing records. Remember that gay clients are often faced with very real, negative consequences if they are outed and such precautions are necessary to ensure their safety [Please refer to tenet on Confidentiality for more details].





Tenet 3: Avoiding assumptions

Key terms

Stereotypes

Heterosexual script

This tenet is true for counselling in general. Good practice would automatically mean that we do not make assumptions about our clients. To be able to do that, we must become aware of the biases or stereotypes we may have about sexual minorities.

Exercise

The aim of this exercise is to help us become familiar with some of the common assumptions that society has about sexual minorities. If you are the counsellor, choose how you will respond to the different issues that a client brings to a session.

A 21-year-old girl tells you that she is attracted to a girl in her tailoring class. Her parents are looking out for prospective proposals for her marriage. She does not know what to do. You will tell her that...

1. She should think about what her family will go through if she allows her feelings to continue
2. Such feelings are wrong and she should look at boys instead
3. Her feelings will go away in some time and she should concentrate on learning tailoring.
4. Being sexually attracted towards a person of the same sex is normal and she can use this session space to work through her options.

GACP option: 4

Do not pathologize same-sex attractions or behaviours. They are a normal and equally valid expression of sexuality. Option 4 would be the appropriate response. Believing that homosexual feelings are a passing phase or that the client can control and stop such feelings stems from the belief that only heterosexuality is the norm.





Javed tells you in his 4th session that he wants to stop being gay and wants you to help him change his sexual orientation. You will...

1. Tell him that you cannot help him change and he should stop coming for further
2. Show him pictures of nude women and ask him to masturbate looking at them
3. Explore the reasons behind such a request and help him accept his sexual orientation
4. Try to find the causes of his homosexuality so that you can assist him in changing

GACP option: 3

Very often clients are unable to accept their own sexuality and may request a change. GACP advocates that the use or supporting the use of any method that attempts to 'change', 'cure' sexual attractions or orientation is unethical. However, sending clients away without addressing their need to change may also damage the client. Option 3 would be an appropriate response. Trying to find causes for sexual orientation is again upholding the belief that there is something that went wrong and the person deviated from the standard norm of heterosexuality. Asking sexual minorities why they are homosexual is like asking straight people what caused their heterosexuality.

Your client is a 19-year-old girl who tells you one day that her hostel roommate is lesbian and this makes her uncomfortable. You tell her that...

1. Anybody would feel uncomfortable as her roommate must be hitting on her all the time
2. If she is uncomfortable she must change her room at once
3. She is feeling uncomfortable because we all have a very negative image towards gay people and perhaps getting more information or understanding that lesbianism is also a valid sexuality may help her deal with her discomfort
4. She does not deserve to feel uncomfortable because of certain people who choose this lifestyle and she must report the matter to the authorities at once

GACP option: 3

Homophobia exists in all of us due to the negative stigma attached the homosexuality and the belief that heterosexuality is the only normal and natural expression of sexuality. The other options stem from a stereotype that lesbians are hypersexual or that they can choose this sexuality at will. Neither is true. The fact is that homosexuality is as innate as heterosexuality and like heterosexuals, sexual minorities also have choices about who they find attractive or not. Option no. 2 is also one that GACP would not advocate because it does not help the client deal with her discomfort about homosexuality.





A woman with short hair, wearing full sleeved shirts and pants, closed shoes and carrying a helmet and sports jacket, walks into your room. She is accompanied by another girl who has longer hair and is wearing trousers with a sleeveless t-shirt. In an attempt to establish rapport after they tell you that they are a couple, you...

1. Ask the person with short hair if she is the husband and the woman with her is the wife?
2. Address one person in the couple as 'he' and the other as 'she' based on their looks
3. Ask them to tell you more about butch-femme dynamics
4. Mirror the language and terms they are using to address themselves and each other

GACP option: 4

Do not assume that all relationships have a 'man' and a 'woman' and will follow the prescribed script for gender roles. Nor do lesbian couples necessarily use the terms husband-wife to define their relationship. Do not assume even if there is an apparent difference in gender expression that one person identifies butch and the other femme. Because sexual minorities do not have a heterosexual script nor a model of relationships to follow, it allows for much diversity in their lives. This diversity can be seen in identities they use for themselves, gender expression, relationships and sexual behaviour. Making assumptions or trying to fit all sexual minorities into a stereotypical box is a fatal flaw that GACP counsellors must avoid. Option 4 shows that counsellor is keeping an open mind and allowing clients to inform them about their lives. Good practice includes giving room for voluntary disclosure or simply seeking clarification from clients about their genders, orientations, behaviours and lifestyles.

Your client is a 45-year-old gay man who has been in a relationship for 8 years with his male partner. He tells you that he has met a much younger man and is having sex with him. It makes him alive and young again and he wants to rent an apartment for his current lover so that he can visit him regularly. He asks you your opinion and you tell him that...

1. He should be more sensitive towards his partner of 8 years and stop the fling with the younger man at once.
2. He should reflect on the boundaries and negotiations he has with his partner and then take the decision accordingly.
3. He should not risk his long term relationship especially taking into consideration that he is now 45.
4. The younger man would not be able to give him the love and companionship that he receives from his partner and so he should not spend so much time away from his partner.





GACP option: 2

Relationships per se are not black and white and this is more so with sexual minorities. They do not necessarily follow the socially prescribed script of marriage and monogamy or lifelong relationships. The couple may not necessarily live together. Each person involved in the relationship negotiates with each other about boundaries and definitions of that relationship. Relationships may be long term or short term. They may be monogamous or non-monogamous. Given that the values advocated by marriage are long term and monogamy, counsellors should beware against inadvertently steering their clients in that direction as seen in option no. 3. Nor should any moral judgements be made about the sexual choices of the clients as seen in option 1. Nor should counsellors place value on permanence and companionship and minimize the sexual lives of their clients as seen in option 4.

Your client is well-built and muscular, keeping himself fit by working out at the gym everyday. He enjoys watching and playing football and refers to himself as alpha male. He makes it obvious that he prides himself in his masculinity. In the 2nd session, he tells you he is versatile but he doesn't know how to communicate that to potential sexual partners. You are not completely sure what versatile means and so you...

1. Clarify to your client that you are unsure and can he help you understand what versatile means.
2. Take into account that he is talking about sexual behaviour and wait a while for more cues that will help you understand.
3. Tell him to use an easier word like 'top' or 'active' instead of 'versatile' because you conclude that being so masculine he must be not be allowing penetration.
4. Ask him if versatile is a dressing style?

GACP option: 1

Given the range of diversity that exists within sexual minorities it would be best to politely ask the client what a particular term would mean. This would help maintain authenticity with your client. Option 2 is also a possible response, however, the use of words and terms is varied and extensive, depending on class and language backgrounds of the client, it is perhaps a better strategy to clarify right away rather than misunderstand what the client is saying. Option 3 is based on an assumption that masculine men do not penetrate and should be completely avoided. Option 4 would indicate to the client that you have little or poor knowledge about his life and would impede rapport building.





Your client who is aged 23 years tells you that she feels she is attracted to women but she is not sure. What should she do? You tell her to...

1. Have sex with a woman to be completely sure if she is attracted to them
2. Try to concentrate on boys while she is still unsure so that her feelings towards women can be controlled
3. Tell her many women her age go through such a phase and to wait for it to pass
4. Tell her that discovering one's sexual identity is a process and she should keep an open mind, read up more and maybe meet some people from the sexual minority community in order to understand herself better.

GACP option: 4

Just as heterosexual people can know they are straight without ever having sex, lesbian/ bisexual women too can know they are attracted to women without ever having to sleep with one. Coming out is a process and there is no quick way to figure out if you are indeed a lesbian or not. Trying to ensure that someone does not become lesbian while she is still unsure is an indication of one's homophobia. Option 4 would reflect that we genuinely believe that any sexuality is possible and all sexualities are natural.





Tenet 4: Challenging misinformation

This tenet amplifies the need for GACP counsellors to take an educative stance in counselling sessions. Very often sexual minorities grow up with a silence about their lives. They have little information, limited access to resources and distorted representations of themselves in media. This results in many clients having no knowledge, being confused or even having incorrect information about their lives. Misinformation can be related to sexual acts and behaviour, health related, sexuality related or about societal attitudes.

Exercise: Try to identify what misinformation these clients have?

1. Rehmaan, age 28, tells his counsellor, “I am not having sex. Why should I wear a condom? I only do *masti* with men. I penetrate them anally.”
2. Shobha, age 16, tells her counsellor, “My family doctor told me that I am lesbian because of hormonal imbalance. He gave me some pills to take every night.”
3. Victor, age 41, tells his counsellor, “Why did God make me like this? Only I am like this. There is no one like me in this world. I am a freak because I am attracted to men.”

GACP Viewpoint

1. Rehmaan is misinformed when he says that he is not having sex. This maybe so because Rehmaan believes that having sex means peno-vaginal penetration only. He may view any sexual activity in the absence of vaginal penetration as ‘*masti*’ and not ‘real sex’. In an atmosphere where limited knowledge about sex and sexual acts is available, many people believe that the ‘correct’ way to have sex is when the penis enters the vagina. This is a myth and there is no one correct way of having sex. Campaigns around safe sex tend to focus only on man-woman sexual relationships and promote the use of condoms for peno-vaginal penetration. Given this backdrop, it is possible that Rehmaan genuinely believes penetrating men anally is not sex and he is not at risk for STIs and HIV. As a GACP practitioner, not only will you have to tell the client about various sexual acts but also the health risks of unprotected sex – whether vaginal or anal. Some clients while engaging in other forms of sexual expression (other than peno-vaginal sex) may believe that these are inferior, invalid or not as significant as sex with a woman. This may be a reflection of internalized homophobia





and the client would need a fresh insight in order to appreciate experiences like ‘masti’ as valid and pleasurable sexual acts.

2. Shobha has been misinformed by her doctor that her sexual orientation is a result of hormonal imbalance. Furthermore, he has prescribed medication to her to correct her hormonal imbalance and thereby her sexual orientation. Looking for a cause for a non-heterosexual orientation and trying to change it through intervention is itself a reflection of prejudiced practice and is a result of misinformation on the part of practitioners. Often, many health care practitioners believe that there must be a reason for why people have deviated from the standard of heterosexuality and hence try and look for the cause in hormones, early childhood experiences and so on. Such a belief reiterates the idea that heterosexuality is the only natural and valid form of sexuality.

Please answer the following questionnaire if you are a heterosexual practitioner.

What is the cause of my heterosexuality?

1. Hormonal Imbalance
2. Genetic Defect
3. Very strict family atmosphere in childhood
4. Child sexual abuse
5. Sins of last birth
6. Lifestyle choice

Questions for reflection

Have you ever looked for a cause for your own heterosexuality? If not, why?

Did you find the cause after attempting this exercise?

How did you feel while trying to find the cause of your heterosexuality?

This exercise was to better understand how the notion of finding a cause for any sexual orientation is a meaningless endeavour. Asking sexual minorities for a cause for their sexual orientation is like asking straight people why they are heterosexual. As GAC practitioners we





must understand that any expression of sexuality is equally natural and homosexuality or bisexuality is a part of the diversity that exists in human sexuality. In this case, the counsellor would have to clarify Shobha's belief by offering her new knowledge and resources and reiterating that being lesbian is normal and these feelings cannot be changed.

3. Victor is misinformed when he feels that he is the only one who is attracted to men. He does not know that there are many more like him and that these feelings are normal and valid. He feels that God has created him as a freak. This reflects the isolation and loneliness that many clients are subjected to in a heterosexually constructed world. A GACP counsellor must inform the client about support groups, websites and resources which visibilises and normalizes the presence of other sexual minorities. They should also take into account the stigma that religion attaches to homosexuality and help Victor through his feelings of guilt and repulsion towards himself.

Through this exercise we can now identify some ways to address misinformation

- ✓ GAC practitioners should avoid confirming or validating the misinformation.
- ✓ They should explore the source of the misinformation and then supply the client with new knowledge and information.
- ✓ They should increase the client's access to gay-friendly materials like books and films, resources such as websites, organisations, support groups, gay friendly doctors such as general physicians or specialists such as gynaecologists, psychiatrists, dermatologists and so on.
- ✓ They should build a data-bank of locally available resources to hand over to their clients. Please refer to the Resource Kit we have provided with this manual as a sample.





Tenet 5: Self-acceptance

Key terms

Heterosexually constructed world

Mirroring

This is perhaps the most important tenet of GACP and an overall goal of counselling. It perhaps becomes more crucial with sexual minorities given the historical prejudice and culture of shame and silence they are subjected to that impedes self acceptance.

The Story Of Internalised Homophobia: An illustration

Rahul, age 10: Mom, I kissed a boy today. It was so much fun.

Mom: That is not good, beta. Don't do it again.

Rahul, age 13: Dad, I love my best friend Kishor. He is so handsome, isn't he?

Dad: What's wrong with you? Boys don't love boys. They love girls.

Rahul, age 16: But teacher, I was only holding his hand and hugging him.

Teacher: You better not do something like this. I will report it to the Principal and you will be expelled.

Rahul, age 18: Come on dude, just because I don't have a girlfriend yet doesn't mean I am gay.

Friend: Get laid, faggot. Let's set you up with Maya. What say?

Rahul, age 20: I am not gay. I don't want to be gay. I want to be normal. Help me change.

Counsellor: ?

This illustration demonstrates how every interaction with a significant person is a negative one when it comes to homosexuality. Every successive interaction succeeds in making Rahul more and more ashamed of himself and his same-sex desires until he reaches a point where he does not even believe that it is possible to be gay and normal at the same time. Many clients would come



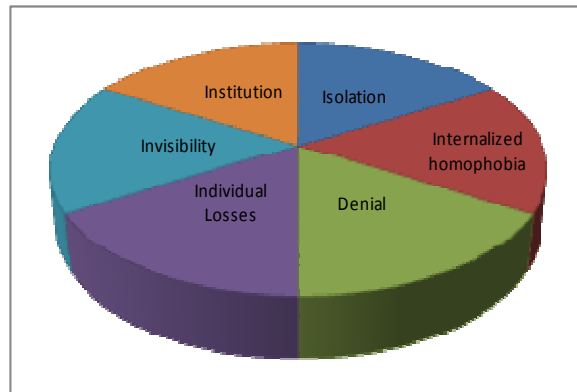


with varying shades of self-hate, denial, shame and guilt around their sexuality. The counsellor is perhaps the first person who can break that chain of negativity and affirm the client's sexuality in a positive manner. This would be one small step towards self acceptance.

To be able to successfully facilitate self acceptance in clients, GACP practitioners must be aware of the various processes that act as impediments in the journey towards self acceptance.

Impediments

- **Isolation:** Growing up in a heterosexually constructed world would mean that clients often grow up feeling that they are the 'only one like this.' They may not know that same sex-desires are normal and that there are others like them who feel the same way.



- **Invisibility:** The silence and invisibility around homosexuality means that clients may not see their lived reality reflected anywhere around them. People like them, resources for them, images that celebrate their reality, benefits of any sort or even language to address themselves is often missing from their lives.
- **Internalised homophobia:** Negative messages, stigma and rejection by society are often internalised by clients themselves.
- **Denial:** Many clients may not be able to recognise or articulate deep-seated feelings of homophobia and rejection.
- **Institutions:** Many religions and religious leaders 'ban' homosexuality deeming it unnatural. Marriage is another institution that puts huge amounts of pressure on sexual minorities. The pressure to marry and produce children to continue the name and family lineage or to continue appearing 'normal' in the eyes of society is rather high.
- **Individual losses:** Clients may have to give up many benefits that come from being heterosexual. The loss of heterosexual privilege or not being able to live the heterosexual script may result in many individual losses big and small.





Growing up with distorted images of oneself or in silence and shame can make the task of developing an integrated, ‘whole’ self extremely difficult. Accepting oneself as one is in the face of opposing social and cultural imagery, finding oneself worthy and feeling proud of oneself seems even more of an arduous task. Yet it is one of the core goals that every GAC practitioner must strive for.

Research has documented several stages as well as a range of responses that gay individuals go through in the process of self acceptance. Often there exists denial of feelings of attraction to people of the same sex, individuals may avoid such feelings, wish them away, try to distract oneself and so on. Usually however, one may learn to live with and tolerate these feelings though acting on the same maybe associated with a lot of shame and guilt. There maybe a lot of comparison with experiences of others including friends, reading materials on same-sex sexuality, if any is available. All this is an attempt to make sense of these feelings and desires that do not seem to ‘fit’ with the heterosexual script that is assumed to be universal. Feelings of being the ‘only one with such desires, doubts about ‘being abnormal’ may plague the individual. Most people may try to look for more information, may find prejudiced information and struggle with some of the feelings mentioned earlier until they find some safe spaces that seem to normalise them and provide them with affirmative information. Getting in touch with community, real or virtual is often a milestone. Meeting with others like oneself as well as exploring one’s sexual attractions and desires enables to develop some comfort in one’s own skin.

A 32-year-old gay man living in a city in South India talks of his journey of self acceptance,

“When friends start talking about sex while you are growing up, you realize, you can’t identify with it. First you make an effort and try to identify, you repress your thoughts and desires and try to think about girls. It’s like an internal aversion therapy. You don’t see any point and so then you give up the effort, but keep the pretence on, on the outside. So you first give up the pretence internally and continue with your fantasies, but keep the outward pretence going and continue to talk about being interested in girls. Later you stop saying anything and keep mum. Finally, you give up the whole game and assert... you stop interchanging the pronoun and stop saying ‘she’ instead of ‘he’...”

Source: (Ranade, K, 2003, MPhil
Dissertation, NIMHANS, Unpublished)





It may not be necessary that every individual experiences all stages or all kinds of responses mentioned above and each individual's process need not follow the same particular order. There are many who have said that, when they heard the word 'gay', they instantaneously knew that it fit them best. There is thus a lot of diversity and fluidity in how sexuality is experienced. Similarly, self acceptance is not a single point and maybe a process that can be ongoing for most people. So, there would be clients who have come out to themselves and their family members and yet may struggle with self acceptance in the context of their spiritual or religious beliefs. Some may find it difficult to come out to their peers or co-workers, even if the circumstances are conducive. Thus, they may struggle with internalised shame and silencing and may expect discrimination or stigma even in situations that seem safe.

Role of the Counsellor in facilitating Self-Acceptance in their gay clients:

Consider the following views of counsellors regarding importance of self acceptance in clients.

'I think that a lot of one's life is based on feeling that I'm not wrong or that I love myself, that I deserve this respect'

'If we grow up believing that heterosexuality is normal and you discover that you are not that, then there is this internalized homophobia. So it is essential to normalize and facilitate self acceptance'

'...What happens is that a lot of time and energy is wasted in accepting one's sexuality... I think if they get the right amount of counselling which does not push them anyway but helps them deal with their confusion and gives them some insight and helps them to accept themselves, it is very useful'

Some points to be considered while working with clients on self acceptance:

- 1) Counselling spaces are often one of the first few spaces where the client is talking about his/her same sex desires. Hence the responses that the client receives here are extremely vital in the future journey of the client. If the client experiences prejudice, discomfort, stigma then it is likely that the client's process of self acceptance will receive a severe set-back and the client may feel further driven into the closet. On the other hand if the first experience is validating, where the client feels accepted is assured that he/she is not alone, is not pathological, is given information on resources for gay people, then the client's process of self acceptance is likely to be accelerated





Consider the following case example:

David, a third-year degree student does not take part in much of social activities. He is good in academics and gets good results always. He prefers to sit alone and study rather than mixing with other students. He has often been a target of a gang of boys in his college. This gang regularly teases and taunts him about being a 'wierdo', who does not have a girlfriend and never talks to girls. Within the family as well, David usually avoids family functions or meeting relatives. His parents are concerned about his behaviour and bring him to a counsellor for help

The counsellor first builds trust with David and helps him articulate some of his problems. David confides in her about what he considers to be 'shameful' and 'embarrassing' events in his life. When David was 15 years old, he was attracted to a neighbourhood boy. When he tried expressing his emotions to this boy, the boy insulted and humiliated him badly. He called him a "*Chakka*" and stopped talking to him

Since then David started avoiding boys out of fear that if he develops similar feelings towards another boy then he will be humiliated again. The counsellor then helped David to deal with his feelings of shame and embarrassment associated with his first sexual experience and this was the beginning of dealing with homophobia that David had internalised due to his first negative experience.

2) Mirroring is an important process in development of the 'self'. All of us need to see positive images of us being reflected back to us by significant people in our lives such as our families, our friends, neighbours, communities and so on. However, most gay individuals may have missed this in their growing up years, especially with regard to areas where they may not be conforming to the norm. This can cause a lot of insult and trauma to the developing 'self'. Thus providing affirming, validating mirroring experiences to gay clients in counselling spaces with respect to their sexual and gender expressions is very important. This can provide the clients with an emotionally corrective experience that maybe vital in self acceptance.

3) Helping client's to place the onus of their problems outside themselves onto the homoprejudiced society is useful. As a senior psychiatrist working with gay clients for several years said, "*...when the person feels extremely in conflict with himself or herself, then part of the therapy is to clarify the situation... in a sense putting the source of guilt not inside you but outside you. That you are homosexual is not your fault, but you are having trouble being a homosexual because of the situation you are in. So the locus of the problem is outside you. And that relieves the person that I am not the problem*".





4) Therapeutic group is another effective strategy to enhance self acceptance in clients who have high degree of internalised homophobia. Group sessions help to reduce isolation that many clients may have faced while growing up. They also provide safe ventilation spaces. Listening to each other's stories of struggle and resilience can be cathartic as well as healing. Such group sessions, if conducted by a skilled counsellor can provide for spaces for emotionally corrective experiences, cohesion and a feeling of community and support among it's members.

5) Counsellors just like doctors are seen as being in a position of authority. There is a lot of power that the clients and their families ascribe to the counsellor. Hence when counsellors provide basic information about homosexuality, which is non-pathological, normalising, affirmative and informative about resources for gay people; all this information coming from an 'expert' helps both clients and their families to better accept the non-normative sexuality of one of the family members.

6) Homoprejudice, stigma, discrimination, internalised homophobia and difficulties with self acceptance is a vicious cycle. The more the number of negative life events and experiences of violence and discrimination related to one's sexuality, the more the individual is likely to be isolated, feel ashamed, inadequate and unsupported and the more the number of difficulties with self acceptance. It is important that counsellors recognise this cycle and help their client's make the linkages between stigma and their mental health status in counselling sessions. Making these linkages explicit to gay clients is an important component of GACP.

Following quotes from counsellors elaborate this further:

Because you are living with discrimination and stigma plus there is no support it can increase stress and one can feel why should I live this life? It is because of my sexuality that all this is happening. Why am I like this? So the feeling gets increased and they may take the extreme step [committing suicide]..." (28 years, gender queer, peer counsellor for LBT persons)

Discrimination takes away your self-esteem and it takes away your hope. Then installing that lost hope becomes challenging in counselling sessions. This is the wellbeing part...And so as in other counselling, even LGBT counselling is not just problem focussed, it is also strength focussed. It is also about generating the strength from the resources that they have....you have to work on their strengths, their resources and their supports.(45 years, Female, Counsellor)





Case Example of working on client self acceptance:

“There was this case of a young college going boy, who suffered from acute social phobia due to being gay and being effeminate. He thought that, if he were to go up in front of the class and speak, they would all know that he was gay... We started our conversations by exploring the implications of people knowing about his sexuality, how would they react?, what does he expect?, how would he respond to that? We then went on to look at this ‘fear of being found out’ ... what does it mean to the client? We also did some cognitive work to understand, whether people would just know or guess without he telling them or coming out... Do people really guess his identity, what are the ways he thinks he is giving away his identity?

So we did a lot of brainstorming on that, we did a few role plays, some of it he did at home by practicing in front of the mirror. We actually worked on it for a long time and eventually, he did very well in his exams and actually gave the oral assignments. In fact, he later on went on to learn salsa!” (42 years, Female, Psychiatrist)





Tenet 6: Diversity

Another important tenet is knowing about the diversity that exists amongst sexual minorities. There is no such thing as a 'homosexual community' just as there is nothing like a 'heterosexual community'. We cannot even begin to think of heterosexuals as forming one large community. That is because we see heterosexual individuals as 'whole people', who have multiple identities, roles and affiliations in the society. We do not think of them merely in terms of who they have sex with. We think of them as Tamilians, Maharashtrians, Hindu, Christian, old, young, educated, unemployed, upper caste, poor, rich, women, children, artists, engineers, dark, dusky, fair and so on. In the same way, it would be impossible to think of one sexuality minority community with same interests, affiliations, belonging to the same class, caste, region, faith etc.

Most sexual minorities living in India may have some commonalities of experiences. For instance, most may experience some form of homophobia, stigma, discrimination based on their sexuality. Some of these have been highlighted in the section on 'unique stressors' and in several other places in this manual. However this is not to say that any two gay individuals have the same experience and have the same resources and mechanisms of coping with this experience.

Similarly, sexuality need not be thought of as singular. There are many forms of sexualities that exist all around us, though the most accepted, valued and therefore socially valid form is that of a heterosexual, within marriage kind of sexuality that is associated with procreation. The '*hum do, humare do*' is the most visible form of sexuality. Yet we all would know of the many other forms of sexual relating that exist all around us.

Sexuality may also be thought of as fluid and not as something that is divided into two compartments i.e. 'homosexual' and 'heterosexual' or for that matter, 'married' and 'unmarried i.e. asexual'!

Some of the specific aspects related to sexual diversity among gay individuals that counsellors need to be aware of and that we address here are:

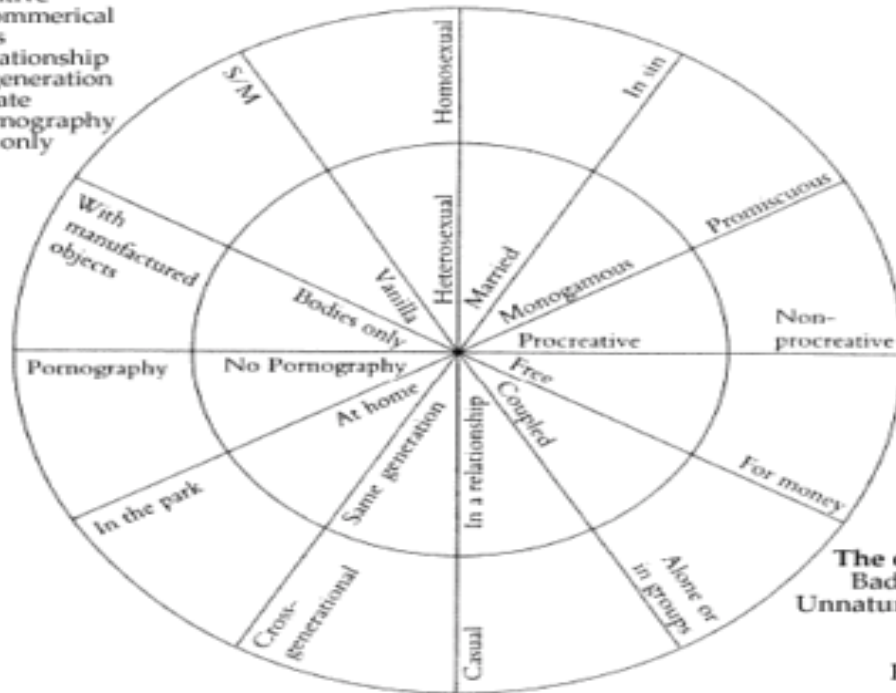
- a) Sexual identities and behaviours
- b) Relationship models – going beyond the monogamous, marital relationships





The charmed circle:
Good, Normal, Natural, Blessed Sexuality

Heterosexual
Married
Monogamous
Procreative
Non-commercial
In pairs
In a relationship
Same generation
In private
No pornography
Bodies only
Vanilla



The outer limits:
Bad, Abnormal,
Unnatural, Damned
Sexuality

Homosexual
Unmarried
Promiscuous
Non-procreative
Commercial
Alone or in groups
Casual
Cross-generational
In public
Pornography
With manufactured objects
Sadomasochistic

Figure 1. The sex hierarchy: the charmed circle vs. the outer limits

Figure 1⁵: Charmed Circle – Rubin, G.S. Accessed at <http://www.feminish.com/wp-content/uploads/2012/08/Rubin1984.pdf>

As can be seen in the figure above, the inner circle or the ‘charmed circle’ represents normative, socially acceptable, pure and normal forms of sexuality; this includes heterosexual sex between man and woman, within marriage, for procreation and so on. A

⁵ Rubin, G.S. (1984). Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality





range of other sexualities which are non-procreative, for pleasure, sex outside of marriage, sex within inter-religious marriages or in the Indian context, inter-caste marriages, being single, homosexual sex, sex in public spaces, commercial sex; all of these lie outside the charmed circle and are seen as non-normative, unacceptable, sinful and often abnormal.

Sexual identities and behaviours:

Sexual behaviours refer to sexual acts that individuals may engage in, but sexual identity is a broader term that includes not just sexual behaviours but ways in which people self identify with regard to their sexuality i.e. the way people see themselves and describe themselves as sexual beings, their relationships, their sexual partners...

Sexual behaviours and identities may not always be congruent and one cannot be inferred from the other. For instance, there are many women, who see themselves as lesbian but who are married to men and are living within these heterosexual marriages. Thus they maybe bisexual in terms of sexual behaviours i.e., engaging in sex with their husbands as well as lesbian lover/s but in terms of their sexual identity they define themselves as lesbian. Similarly there are many MSM, who may identify as heterosexual even though they engage in sex with other men.

There exist several identity labels in India around gender and sexuality that individuals who identify as non-heterosexual take on such as gay, lesbian, bisexual, trans persons, transgender, transsexual, queer, kothi, panthi, hijra, jogta and so on. It is important that counsellors know about the different sexual identities because when clients use particular identity labels for themselves or their partners, they need to understand what the client means. Knowledge about these identities is not meant to be used to classify clients into different boxes or categories or label clients, instead to understand their lived realities in a better way.

It is also important to remember that there is diversity in gender expressions within sexual experiences. The popular assumption is that men are the initiators of sexual activity and women are passive participants. Based on the clients' gender expressions it is important not to assume that the more 'masculine' looking partner may be playing a 'dominant role' during sex. Sexual expressions and roles played may be diverse, exploratory and may not necessarily be bound by the more stereotypical understandings of sex.





Relationship models – going beyond the monogamous, marital relationships

The heterosexual norm for gender roles and relationships tends to be defined and visible. Marriage is the marker for relationships, sexual relationships are expected to be monogamous and gender roles for husbands and wives are set out. On the other hand, the invisibility or lack of models for sexual minorities lends itself to much diversity. It is critical that counsellors work hard at not having any pre-conceived notions about gender identities, sexual acts and relationship models. Keeping an open mind and creating an affirming environment where clients feel safe to share their lived realities is crucial.

1. A 38-year-old lesbian woman tells her counsellor in her 3rd session that a few weeks ago a new colleague had joined her team and they had struck up a friendship. The client had felt sexually attracted towards that woman and the colleague too had responded. They had now planned on an overnight stay at the colleague's house and she knew that it would become sexual between them that night. This was making her a bit anxious. The counsellor was already aware that her client has a girlfriend and that they had been in a relationship for the last 5 years. Therefore, in an attempt to understand her client better, she asks, "Can you tell me more about what is making you anxious about this extra-marital affair?" The client looked at her and said, "Nothing really. I will manage it."

What really happened?

The counsellor tried to fit her client's relationship into the already existing mould and assumed that a sexual relationship outside of the 5-year relationship with her girlfriend would be 'extra-marital.' Using that term and defining non-monogamy from a heterosexist perspective resulted in the client clamming up and refusing to share more about her life.

Marriage promotes a long-term, single partner model of relationships. GACP recognizes that queer relationships do not necessarily follow the same trajectory. Relationships may be multiple partner, open and non-monogamous. They may be short-term. The couple may not necessarily live together. There are no rigid definitions as to what a relationship means. There are negotiations and boundaries that each person in the relationship decides with each other. GACP practitioners must guard against inadvertently pushing their clients towards building relationships along the lines of marriage. Instead, they must recognize that the counselling space may be the only place where the client's relationship is valued and validated.





2. A lesbian couple was in therapy to sort out interpersonal issues between them. As part of the therapy, the counsellor was also helping them structure their daily routine and helping them divide up roles and household responsibilities as a couple. When she learnt that neither woman could cook, she suggested to only one of them that she could attend cooking classes in order to learn how to prepare meals. Her explanation while giving this suggestion was, “Your partner will be working all day in office and would appreciate a nice home cooked meal at the end of the day.” The couple never came back to her after that session.

What really happened?

When this counsellor went for supervision, it came to light that she had assumed on the basis of gender expression that there would be one woman who would do the man’s roles and the other woman would do the woman’s roles in the relationship. Her suggestion about learning to cook had been directed at the woman who seemed more feminine as she had long hair. The counsellor then assumed that the other woman would therefore be the one who would step out of the house to earn money. These assumptions had been based on a concept of traditional gender roles between husband and wife which the counsellor had then applied without questioning to this setup as well.

3. A gay man who has been in a relationship for ten years tells his counsellor that sex is no longer exciting with his partner. The counsellor asks, “Help me understand. Can you tell me more about your sex life?” The client goes on to describe how he used to enjoy being naked with his partner, how they enjoyed caressing each other, kissing a lot and mutually masturbating. The counsellor asked again, “But how did you have sex?” The client abruptly left the session after this question.

What really happened?

Sex is primarily understood as only peno-vaginal penetration. The penis entering the vagina is actually just one single sexual act between heterosexual people. However, it is seen as the only valid way of having sex. Operating from this mainstream understanding of sex, the counsellor was unable to understand that his client was actually describing how he has sex with his partner. The counsellor assumed that penetration of some form was necessary for sex and dismissed the client’s descriptions. There is no ‘correct’ or ‘one’ way of having sex and penetration is not a compulsory sexual act for all people.





Tenet 7: Knowledge About and Engaging with Resources for Sexual Minorities

Knowing about and engaging with resources for gay individuals:

Resources for gay individuals refers to –

- ✓ Books, magazines, films with gay themes
- ✓ Websites with information on gay issues including health, mental health, HIV
- ✓ Websites with information on social events for gay people including parties, film festivals, public events
- ✓ NGOs, support groups, forums that work on gay issues and may have drop-in spaces, sharing meetings
- ✓ Phone lines that provide crisis services for gay people
- ✓ Help lines that are known to be gay friendly and provide information on sexuality, safe sex, HIV and other concerns around sexuality

In addition to the above mentioned resources, knowing and interacting with gay people outside of the clinical context has been known to help counsellors better understand and appreciate the layered realities of their lives.

Three main reasons why counsellors need to know about resources for gay individuals –

1. By knowing about engaging with these different resources, counsellors will be better educated about their clients' problems as well as about other services available for gay individuals
Counsellors (who are straight) knowing about and engaging with these resources, for instance, reading books/watching films with gay themes or meeting with gay individuals at NGOs or drop-in centres is useful. This helps counsellors to be more educated and informed about gay lives. This is important because straight counsellors are also only exposed to the heterosexual model of living and hence may not know enough about gay lives, relationships, social scene or political positions. By interacting with gay individuals outside of the clinic/counselling space, counsellors get a chance to learn more nuances about some of the issues that their clients bring up in sessions. Thus in order to be a GACP practitioner, it is important that counsellors do not rely merely on their clients to educate them but meet with other gay individuals outside of their clinics and engage with other resources available for gay individuals.

For instance, consider the following quote of a counsellor working with MSM clients





*“When I came here [refers to NGO working on MSM issues] for the first time, I came to know that gay men have sex in public toilets. Not just anal sex but oral sex as well. I was shocked to know this. But slowly I learned to be okay about it and not to be/show shock about it.”
35 years, F. Counsellor*

2. If clients know about these resources for gay people from their counsellors, it would reduce the clients’ isolation

Many gay clients often come into counselling spaces thinking that they are alone, there is no one like them out there and this intensifies their sense of isolation as well as internalised homophobia. One of the first steps towards self acceptance is knowing that there are others like me, who live happy lives, who are proud of their sexuality, who negotiate with similar issues as oneself such as how to tell family, friends, employers, how and where to find a partner/s etc.

“I think it would be useful if counsellors have a data bank of people who are queer or queer groups, or NGOs or queer material. Please give your queer clients this information. Please tell them about support groups. There is so much isolation and because of that they feel there is nothing really that exists for queer people. So getting in touch, affirming that you are not the only one...I think that would be a good practice.”(30 years, F, counsellor)

3. Knowing about resources and services for gay individuals would help counsellors to make better referrals and provide more effective services to their clients

Finally, clients seeking help in counselling centres often do not have singular needs i.e. they are not merely looking for resolution to emotional conflicts. Alongside dealing with emotional distress, they may also be looking for spaces to meet other people like themselves, may want to leave their parents homes and maybe looking for a self sustaining job or shelter, maybe looking for information to pass on to their parents or friends, which will help with their coming out process, maybe looking for gay friendly doctors for other health issues or information on sex reassignment surgeries and so on. A GACP counsellor recognises that, most heterosexual people have several services as well as social spaces that cater to their multiple needs and hence these may not come up in counselling. Even if some of these come up in counselling, the counsellor may know about ‘standard’ support systems for heterosexual people such as family, peer group, colleagues, school/college/office, legal mechanisms and so on. However this may not be the case with gay clients. Hence the GACP practitioner will make an effort to find out about resources and services for gay people within their cities as well as outside to be able to make appropriate referrals, give information and provide holistic services.





Tenet 8: Confidentiality

Confidentiality is an inherent part of counselling ethics. However, it becomes an additional concern for sexual minorities. There are 2 main reasons for this-

1. The societal stigma towards sexual minorities heightens the possibility of violent consequences towards them if confidentiality is breached and clients are ‘outed’
2. Sexual minority communities just like most marginalized and minority communities can often be closely-linked. Hence information tends to circulate quickly and breach of confidentiality can put the client in jeopardy.

Let us consider examples of both these scenarios.

Case Scenario 1

A 15- year-old girl, Tahira, was meeting her school counsellor weekly after her teachers noticed that she was missing school often, doing poorly in studies and being sullen and bad-tempered. After about 4 weeks (after taking the client’s consent) the counsellor even had a session with her parents to enlist their support in helping their daughter follow a routine. 3 weeks after that, the client began to trust her counsellor and revealed that she was in love with Neha from the same class. They had been best friends for 2 years but now Neha had found a new best friend and had stopped eating lunch with her and also meeting her after school to take a walk in the park. Earlier Tahira and Neha would take walks in the park just by themselves. They would hide in the trees and hold hands and sometimes even kiss. She said she had seen Neha and that other girl hugging in an empty classroom at break-time. She was really sad and did not like to see Neha having so much fun with her new friend and that is why she hated coming to school.

The counsellor addressed Tahira’s hurt and continued to work with her after this revelation. She began to encourage Tahira to tell her parents about this friendship. When Tahira refused, she told Tahira that as her counsellor it was her duty to inform her parents. She added that she would also inform the teachers so that they could support Tahira in dealing with these feelings better.

The next thing Tahira knew was that her parents had been summoned and they had taken her out of school. No one knew what happened to Tahira and it was rumoured that her parents had sent her to live with her grandparents





. Questions for reflection

Had the school counsellor breached client confidentiality? If yes, in what way?

Is the counsellor responsible for what Tahira's parents did after she told them about their daughter?

GACP Viewpoint

Parents and teachers are often considered authority figures in children's lives and therefore it may seem appropriate that they are told about their child's sexuality. However, what the counsellor did not take on board was that- *given the stigma and lack of acceptance about sexual minorities, revealing such information to significant adults without the consent or readiness of the client herself, is dangerous.* Families, schools and persons in positions of authority hold considerable power and can withhold basic rights and freedoms of their wards in order to 'correct' or 'punish' what they consider deviant behaviour. When sexual minorities are outed, they face severe negative responses like physical violence, house arrest, forced marriage, stopping of education, sexual assault, hospitalization to list a few. The client must feel ready and the counsellor needs to feel confident about working with significant others, over a period of time and create that space and prepare the client for it, before this knowledge is shared. At all times, however, the client must make that final decision about whom and when to tell and the counsellor should not influence it in any way.

Case Scenario 2

An 18-year-old boy, Raja, identifies as a man who has sex with men (MSM). The counsellor had built a good rapport with him and the client had shared with him that he was in love with a 38 year-old guy. He told him details about how he would wait every evening at 7pm for this man to leave the restaurant where he worked as a waiter and follow him home. Then he would again be up at 6am and follow this guy to the restaurant. He said he did not have the guts to approach this guy and for the time being was quite content just watching him for 20 minutes everyday.

Now the same counsellor has another client who also identifies as a MSM and was working with the counsellor to work up the courage to propose to someone. The counsellor in this context,





without giving Raja's name, shared with this client Raja's story of following the man he loved who worked in a restaurant.

In the next session, Raja was very angry and upset with the counsellor, accusing him of ruining his life and revealing everything about him to the community. The counsellor tried to assure him that he had never revealed his name and only parts of his story. He had kept Raja anonymous. Raja told the counsellor that he had broken his trust and that he was never coming back here or going to any other counsellor ever again because they always gossiped about people like him.

Questions for reflection

Did the counsellor break Raja's confidentiality? If yes, in what way do you think so?

If no, how do you think the information went out and reached Raja?

GACP Viewpoint

The counsellor did not reveal the client's name or any other identifying details in order to protect his client. So the counsellor did think about confidentiality and made his client anonymous while sharing the story with another client. But he did not take into consideration an additional aspect- *that sexual minority communities are often closely-knit making it easier to identify people despite the obvious lack of details.*

In this case, what really happened is that the 2nd client knew of the man who worked as a waiter at a restaurant. When the counsellor told him that a client was in love with a waiter he remembered his friends telling him that a waiter in a restaurant in that area 'was just like us.' Knowing about the waiter made it easy to identify the person who was following him and that is how Raja's identity was revealed.

Confidentiality in Community Settings

In case of community based organizations and peer counsellors working there, the need to maintain confidentiality is heightened. This is because the counsellors are part of the same community as their clients and may often meet their clients on social occasions. Also the counsellors and clients may have friends and other social contacts in common. Here





confidentiality of information shared during counselling sessions and maintaining professional boundaries becomes very crucial as well as challenging.

I am both a counsellor and a member of a support group for LBT persons. I share a relationship with other members outside of the clinic or the counselling room. So I am friends as well as a counsellor. So sometimes what happens is that there are some addas or certain chit-chats and I know some things and I am not able to participate in that very healthy discussion. I have to draw boundaries for myself. And that is where confidentiality is important. (42 years, F, psychiatrist)





Tenet 9: Self-Awareness

Self Awareness on the part of the counsellor is vital in all counselling processes. Knowing about one's own biases, inadequacies, seeing oneself as fallible and therefore open to correction, change and growth lies at the heart of this tenet of counsellor self awareness. Just as knowing about one's limitation is significant, knowing about feelings and thoughts that clients generate within the counsellor is also a significant part of self awareness. Traditional literature in psychotherapy refers to this phenomenon as counter transference, which refers to the counsellor's sense of emotional entanglement with their clients. This may include positive or negative feelings and may have to do with issues that are unresolved for the counsellor. For instance, the counsellor may experience too much identification with client/s or an inability to maintain objectivity in the counselling relationship. It is recommended that counsellors identify issues of counter transference and ways in which these come up in the counselling sessions and work through these with the help of their supervisor.

It is also important that counsellors are aware of conscious and unconscious thoughts and feelings that their client might experience towards them. This phenomenon has been referred to as transference in literature of psychotherapy. Transference refers to an unconscious redirection of client's feelings or desires for a significant person in their lives towards the counsellor. For instance, feelings towards one's parent, partner, lover, sibling etc. can be projected onto the counsellor. These feelings may be positive as well as negative. In any case these are often inevitable in a counselling relationship and it is the role of the counsellor to identify transference feelings and bring these up for discussion in sessions.

More specific to sexual minorities, homophobic attitudes among counsellors can evoke negative feelings within themselves towards their sexual minority clients. Practitioners may have a moral opinion against homosexuality. When this is overtly stated to the client, then it is part of discrimination and harmful practice with gay clients. However often counsellors may not state it openly, but it may exist covertly and may keep coming up as negative judgments, inability to build rapport or other forms of resistance to gay clients. Counsellors may experience shock or repulsion when sexual acts are described by their gay clients. On the other hand, there may be excessive curiosity about the client's life, especially sexual life because it so different from one's own. All these would be examples of negative counter transference that has been described above.





“Counter-transference is the counsellor’s thing. It is sometimes positive and also negative. Negative counter-transference is your prejudice, your judgment – you may wonder, ‘how they can live like this with multiple partners’, even sexually it can feel disgusting, how they will narrate the sexual activities, they are bindaas to talk about sexual life and descriptions. And also sometimes you are more interested about it. Your own life is not like that so you want to know more. I think supervision is very important. Supervision is essential to address transference and counter-transference”. (45 years, F, counsellor)

Erotic transference towards same sex counsellors i.e. client/s having feelings of sexual attraction towards the counsellor has been seen to be a common issue. If counselling space has been one of the first places where the client has felt accepted and has received a lot of positive regard, then often feelings of gratitude and fulfilment evoked within the clients tend to slip into romantic attraction for the counsellor. This may be difficult for counsellors to deal with, especially if the counsellor has not worked through their own homophobia. While the same is possible between client and counsellor of the opposite sex, the fact that it is a heterosexual attraction may make it easier for the counsellor to address it. Whereas in the case of erotic transference of a gay client, not having the same sexual orientation as the client may act as a stumbling block for straight counsellors. Counsellors, who have not dealt with their homophobia may experience extreme discomfort and even disgust on knowing about their clients attraction for them. Therefore, GACP advocates that heterosexual practitioners must be aware of the possibility of same sex attractions, explore their feelings, particularly discomfort about it within supervision.

Consider some of the following responses of counsellors and doctors to the issue of transference:

“All doctors should be aware of this phenomenon. Not just in psychiatric practice but in all practice, transference comes in. To some extent transference is important. It builds a relationship of faith and rapport, which is significant for healing. If it goes to a pathological level where the client is blindly treating the doctor as God or his brother, lover or father... that dependence is pathological because it is beyond the professional relationship”. (27yrs, male, physician)





“My lesbian clients have said openly to me that, I wish you were my partner. They think that, I listen to them, understand them so well, so it would be nice, if I would have been their partner... So I say, ‘How nice but I don’t have sexual feelings towards you, I have these feeling towards you’. So using some amount of self-disclosure, immediacy i.e. by telling the person in the session itself that you are sensing that something else is going on, addressing what happens there and then, here and now and between me and you, gentle confrontation about how or what the client is feeling... There is no point pushing it under the carpet, if these feelings exist, they need to be worked on”.

In some cases, termination of sessions and a referral to another counsellor may be necessary, if the counselling relationship is not able to work through or get past the erotic transference.

“I tell them because of this thing it may be hard for you to continue, or it may be hard for me to continue so can I refer you to someone else? It is important to have a reflective space for yourself too. So I have a supervisor, who I visit regularly...” (45 years, F, counsellor)

Self awareness about one’s own attitudes, feelings and thoughts; positive and negative evoked by clients as well as awareness of clients’ feelings and emotions towards oneself is an important aspect of good practice according to GACP.

Being aware that bias and prejudice can colour counselling interaction as well as realizing that, in a counselling relationship two or more ‘real’ people with ‘real’ feelings are involved and hence transference and counter transference feelings are inevitable. Being able to recognize it and having the space to address and process it is essential according to GACP. All GACP counsellors are therefore encouraged to seek supervision and create this space for reflection and self growth.

“People who are counsellors, over a period of time begin to think that they are not biased at all. But I feel that every single one of us is biased. So understanding that we are biased is a lesson that we’ve got to learn. And where those biases are? ... After 16 years of work I will say that every single counsellor has to go into supervision. Be in a system where you meet your supervisor regularly. I always say even to my other counsellors, ‘You have to talk to someone. Because only then, you’re grounded – you’re grounded totally’” (39 years, female, senior counsellor, who runs a counselling centre)





Chapter 5

Conclusion

BEING GAY-INFORMED IS THE CRUX OF GACP

The Unique Life Stressors that counsellor practicing GACP should be familiar with

| | |
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| Difficulties With Self Acceptance | Sexual minorities grow up and live in a hetero-normative society, which stigmatises and rejects non-heterosexual sexualities. Therefore, having a healthy acceptance of one's sexual identity is often a tumultuous journey that they have to make. |
| Coming Out | Because of living in a hetero-normative society, heterosexual people never have to come out and tell others about their sexuality. It is already a given. So, the process of coming out becomes unique to sexual minorities when they are forced to acknowledge their own difference in the face of a more mainstream, acceptable sexuality. |
| Invisibility | Sexual minorities may live a double life in order to hide their sexuality from significant others. Invisibility also means that they may have no knowledge of any spaces, resources or people to mirror their realities. Not having any resources that affirm one's existence results in a feeling of isolation and a deep sense of loss. |
| Discrimination And Harassment | Various systems like education institutes, work spaces, police and legal systems, hospitals and the medical system and even families can become sites of harassment if the non-heterosexual sexuality of a person becomes known. |
| Relationship Issues | Heterosexual marriages give sanction and legitimacy to a relationship between two people. Rarely do any other relationships ever get the same affirmation and validity as marriage. |
| Mental Health Manifestations | In sessions, clients are unlikely to present their problems in the form of unique life stressors. What is visible will be feelings and problems that the gay client is going through. Making the possible link of client problems and manifestations to the unique life stressors of their sexuality, is the responsibility of the GACP practitioner. |





The 9 crucial tenets to becoming gay-informed are summarized here

| | |
|--|--|
| Knowledge Of And Using Gay Affirmative Language | Using respectful language to affirm all sexualities, using sexuality-neutral language, building vocabulary and coining new words that reflect realities of sexual minorities |
| Gay-inclusive Counselling Setup | Creating spaces that are welcoming to sexual minorities by using more explicit homosexual messaging and ensuring that the staff employed are educated on these issues |
| Avoiding Assumptions | Creating a safe space for voluntary disclosure or respectfully asking clients about their genders, sexual orientations, sexual behaviours and lifestyles is preferred rather than making assumptions about them. |
| Challenging Misinformation In Clients | Misinformation in clients may be about sexual behavior and health risks, about their sexual orientation and gender identities. It is important that GACP practitioners do not confirm or validate this misinformation. |
| Facilitating Self Acceptance | GACP counsellors must recognize that growing up and living in a society that is rejecting of same sex desires contributes to internalized homophobia that impedes self acceptance of clients. |
| Knowing Of And Respecting Diversity | Heterosexual individuals are seen as ‘whole people’, who have multiple identities, roles and affiliations in the society and we do not think of them merely in terms of who they have sex with. The same is true about sexual minorities whose realities are varied and diverse and not restricted to sex. |
| Knowledge About And Engaging With Resources | By knowing about these different resources and engaging with these, counsellors will be better educated about their clients’ problems as well as about other services available for gay individuals. This will help the counsellors to make better referrals and provide more |





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| | effective services to their clients as well as assist in reducing their isolation |
| Confidentiality | This is an additional concern for sexual minorities given the societal stigma towards them. GACP counsellors must also be aware that sexual minorities may belong to close-knit groups where information is quickly circulated. |
| Self Awareness | In the context of sexual minorities, GACP counsellors need to recognize and address prejudice they may experience towards non-heterosexual sexualities. Being able to recognize and address same sex attractions is another important aspect. |





Annexure I

How Gay Affirmative Are You?

Take this attitudinal test to find out⁶!

Do you agree or disagree with the following statements? Please mark each statement according to the point-scale given below. After completing the table, please total your points and compare it to the scale given at the end to know how gay affirmative you are.

1= strongly disagree

2= disagree

3= neither agree nor disagree

4= agree

5= strongly agree

| Statements | Points |
|--|--------|
| You will reassure your client by agreeing with him that his homosexual feelings will go away in a while. | |
| A bare room with no explicit heterosexual messaging will indicate to sexual minorities that this space is open to all sexualities. | |
| Gay relationships cannot last as long as marriage because they often have multiple partners and open relationships. | |
| You will inform the parents of a 14-year-old girl when she tells you that she kissed a girl because around puberty her sexuality is still in the making and can be influenced. | |
| If your gay client is depressed, you will treat his depression in the same way as | |

⁶ This scale has not been validated and is prepared by the authors only for the purpose of this manual. This exercise, which has been made in the form of a scale comes at the end of the manual and is meant as a self reflexive exercise for the readers after reading the whole manual.





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| that of any other client. | |
| There is no need to validate a relationship between a kothi and panthi. | |
| If your client is attracted to you, you must immediately terminate sessions and refer her to someone else. | |
| Being gay is a lifestyle choice. | |
| A married heterosexual couple facing interpersonal problems can benefit from marital therapy but this is not the case with lesbian relationships since these relationships lack the basic commitment of marriage. | |
| It is good practice to avoid referring to your client's homosexuality during sessions. | |
| As a counsellor you are obliged to inform the wife of a person who has sex with other men about her husband's sexuality. | |
| All lesbian women are masculine or man-like. | |
| Homosexuality is a product of the Western world and is not inherent to the culture and tradition of India. | |
| If you give a client, who is unsure of her sexuality, the information of a support group for lesbian women, it means that you are influencing her to become homosexual. | |
| Most clients will know the cause of their homosexuality and as a counsellor you should not contradict them. | |
| Meditation can help soothe nerves and reduce arousal feelings towards the same sex. | |
| To protect the sanctity of heterosexual marriages, sexual minorities should not be given the same rights. | |
| It is okay if your client does not know about any other gay person in his life. | |





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| Condoms are required only during peno-vaginal intercourse so your Panthi client does not need them. | |
| If your client seeks your advice you would tell her honestly that it would be easier for her to stay in her heterosexual marriage rather than express her desire for another woman. | |

Score reader

A score of 20 would mean that you are a gay affirmative counsellor.

Between 20 and 40 would mean that you are still fairly gay affirmative in your practice.

Between 40 and 60 would mean that you need to brush up on some of the gay affirmative counselling techniques and tenets.

60 and above would mean that much more work is required to break out of the heteronormative mould and develop a n affirming perspective to work with gay people.

A score of 100 would indicate a high range of homophobic responses.





Annexure II

Glossary

Some terms used in the manual are defined here.

- Bisexual: An individual who is sexually attracted to people of the same gender and also to people of a gender other than their own. (TARSHI 2006, pg: 82)
- Gay: A man who is sexually attracted to other men and/or identifies as gay. The term can also be used to describe any person (man or woman) who experiences sexual attraction to people of the same gender. (TARSHI 2006, pg: 82)
- Heterosexism: The viewpoint that all people should be heterosexual and the assumption that this is the 'normal' or 'natural' sexual identity people should have. This viewpoint results in bias against other sexual identities. (TARSHI 2006, pg: 82)
- Homophobia: An intolerance or irrational fear of homosexual people that can manifest itself in discrimination, prejudice, disgust or contempt of homosexual people. (Basics And Beyond: A Manual For Trainers, Integrating Sexuality, Sexual and Reproductive Health and Rights, TARSHI 2006, pg: 82)
- Homosexual: An individual who is sexually attracted to people of the same gender as their own and/or identifies as being homosexual. (Basics And Beyond: A Manual For Trainers, Integrating Sexuality, Sexual and Reproductive Health and Rights, TARSHI 2006, pg: 82)
- Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors. (World Health Organisation, Working Definition, 2002 Cited in TARSHI 2006, pg: 65)
- Sexual Identity: A concept that refers to how people view themselves sexually in terms of whom they are attracted to. This refers specifically to whether an individual is attracted to people of the same gender, a different gender, more than one gender and which category of these identities they want to adopt for themselves. (TARSHI 2006, pg: 64)





- Queer: A person who questions the heterosexual framework and the gender binary system. This can include homosexuals, lesbians, gays, transgender persons and persons with intersex variations. To some, this term is offensive, while other groups and communities have used it as a form of empowerment to assert that they are not heterosexual, are non-conformist, against a dominant heterosexual framework, and dissatisfied with the 'labels' used on people who do not identify as heterosexual. (TARSHI 2006, pg: 83)
- Transgender person: An individual whose own sense of gender does not match with the gender assigned to them at birth. It means having dissonance between one's body and sense of gender identity. They may or may not consider themselves a third sex. (Adapted from TARSHI 2006, pg: 83)

Source: TARSHI, (2006). Basics and Beyond: A Manual For Trainers, Integrating Sexuality, Sexual and reproductive Health and Rights

- Coming out: Coming out is the popular term used to describe disclosure to others that one is gay, lesbian, or bisexual. Coming out is not a one-time occasion. Coming out is often described as a life-long process that involves a widening circle of friends, family, and acquaintances. [Source: *American Psychological Association, (2004). Assisting students with disclosure - The "Coming Out" process, Washington DC*]
- Gay-friendly: An attitude of acceptance towards gay people or people with non-heterosexual sexual orientations.
- Gay-inclusive: An environment that demonstrates openness and acceptance towards gay people or people with non-heterosexual sexual orientations.
- Gender binary: The gender binary is the classification of sex and gender into two distinct and disconnected forms of masculine and feminine. It can describe a social boundary that discourages people from crossing or mixing gender roles, or from creating other third (or more) forms of gender expression altogether. It can also represent some of the prejudices which stigmatize transgender persons and people with intersex variation. The term describes the system in which a society splits people into male and female gender roles, gender identities and attributes [Source: http://en.wikipedia.org/wiki/Gender_binary]





- Heteronormativity: It is a term coined by Michael Warner in 1991 to describe any of a set of lifestyle norms that hold that people fall into distinct and complementary genders (man and woman) with natural roles in life. It also holds that heterosexuality is the normal sexual orientation, and states that sexual and marital relations are most (or only) fitting between a man and a woman. Consequently, a "heteronormative" view is one that involves alignment of biological sex, sexuality, gender identity, and gender roles [*Source: Lovaas, Karen, and Mercilee M. Jenkins (2006). "Charting a Path through the Desert of Nothing" Sexualities and Communication in Everyday Life: A Reader. Sage Publications Inc.*]
- Heterosexist bias: A heterosexist viewpoint that results in discrimination and bias against people with non-heterosexual sexualities.
- Heterosexual privilege: The advantages and benefits that a heteronormative existence offers to heterosexual people.
- Heterosexual script: A normative existence that follows the rules laid down by a heteronormative society.
- Homo-avoidance: Refraining from or resisting referring to anything to do with homosexuality.
- In the closet: A term used to describe a homosexual person who has not told anyone of his or her sexual orientation.
- Invisibilization: To make invisible the lives of people who are not heterosexual especially in a heteronormative society.
- LGBT: This acronym stands for Lesbian, Gay, Bisexual, Transgender and is another term for sexual minorities.
- Mainstream: An existence that mirrors the normative reality of people.
- Marginalization: The social process of becoming or being relegated to the fringe of society.





- Minority stress: Minority stress describes chronically high levels of stress faced by members of stigmatized minority groups [*Source: Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Psychological Bulletin, 129, pp. 674-697*]
- Non-heterosexual sexualities: Any person having a sexual orientation or identity that is not heterosexual.
- Outing: Disclosing or revealing to other people, a person's sexual orientation without that person's consent.
- Peno-vaginal penetration: A sexual act in which the penis enters the vagina.
- Sexuality: Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.
- Sexual Orientation: The innate, main focus of one's sexuality, often with the understanding that a sexual "orientation" is also affectionate, spiritual, emotional, relational, and psychological. It is enduring, lasting and unchanging [*Source: Kort, J., 2008, Gay Affirmative Therapy for the Straight Clinician – The Essential Guide, W.W. Norton & Co. Inc, NY, pg: 267*]





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