

AT THE EDGE:  
EXPLORING
GENDER AND
SEXUALITY IN
COUPLES AND
FAMILIES. 

AFTA
Monograph Series

American Family Therapy Academy



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AFTA

Founded in 1977, the American Family Therapy Academy is a nonprofit organization of leading family therapy teachers, clinicians, program directors, policy makers, researchers, and social scientists dedicated to advancing systemic thinking and practices for families in their social context.

Through diversity in its membership, continuous dialogue, collaborative interchange, and commitment to social justice, AFTA flourishes as a learning organization that offers value to its members and to those whom they serve.

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At the Edge: Exploring Gender and Sexuality in Couples and Families

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INTRODUCTION

Exploring Gender and Sexuality in Couples and Families

Arlene (Ari) Istar Lev, LCSW-R, CASAC and Jean Malpas, LMFT, LMHC

“[No] ... bill of sexual rights ... [can] begin to hold its own against the lawless, untamable landscape of the erotic imagination.”

—Daphne Merkin
(New York Times, 2000)

This issue of the American Family Therapy Academy’s Monograph, *At the Edge: Exploring Gender and Sexuality in Couples and Families*, co-edited by Jean Malpas and Arlene Lev, has been an experiment on many levels. It has been a joy for us to work together; a loving and honest gay marriage of ideas. It has also represented a stepping outside of the safe parameters of family therapy, and venturing into previously uncharted waters. Our process of working together, under the guidance of Editor-in-Chief Melissa Elliott, mirrors the difficulty of addressing sexuality issues in family therapy, and of moving them from the edge to the center. You would not be surprised to know that this monograph has been an exciting process, paved with titillating questions and fascinating explorations.

This monograph is organized in three sections: featured articles; clinical commentaries; and book and movie reviews. The themes covered in the Featured Articles – the role of fantasy in couples’ sexuality, “kinky” sexuality, open relationships, and the adjustment of families to the coming out of a transgender adolescent – are issues that are easily avoided socially, as well as clinically. With eyes averted, people hide knowing or uncomfortable smiles when one mentions these topics. The featured articles give a voice to these often invisible and sometimes hidden aspects of human gender and sexuality. They question our concept of normalcy and offer applied knowledge to support our therapeutic journeys with diverse couples and families.

In the opening article, Esther Perel invites

us to consider sexual fantasies as a pathway to our soul and a tool for meaningful connection in couples. Based on her clinical experience, Perel posits that fantasies function as a form of erotic blueprint, revealing our relational maps. “Tell me how you *were loved*, and I’ll tell you how you *make love*,” she claims. Her therapeutic stance takes a step back from the act of sex to enter the realm of its connection to our past, self-perception, and fundamental beliefs about intimacy. She proposes to transcend the idea of sexual fantasies as “secret intentions,” potentially threatening for couples. Sexual fantasies, she says instead, “state the problem and offer the solution.” They are creative ways for individuals to overcome conflicts about desire. Once shared and translated, they offer couples the possibility of a deeper, and hopefully healing, sexual connection.

In the second featured article, Shruti Singh Poulsen and Deanna Fierman offer a culturally and clinically sensitive approach to open relationships. They bring forth the underestimated demographic prevalence of open couples and invite us to (re) consider our ideas about monogamy, boundaries, and love.

Recently on a clinical email list that Ari follows, a seasoned therapist posted that she was working with a man whose wife was having an affair with another man. The man wanted to bring his wife to therapy with him. The therapist was hesitant and sought advice from colleagues. To a family therapist, it might be obvious that the

couple should be working together on these sensitive and intimate issues. Ari was shocked to discover she was the only person who thought inviting the wife into session was important; indeed, most clinicians thought it was “dangerous.” The discussion revolved around issues of infidelity and betrayal, and the absolute need to sever the affair if the marriage were to be saved. When Ari suggested that it might be worth exploring the couple’s values about monogamy, and asked whether they had ever considered a more open (less exclusive) relationship, there was silence on the (very active and opinionated) listserv. Her questions were apparently so absurd that no response was required. Clearly, even the idea of working with a couple when an individual seeks therapy is still considered unusual by many psychotherapists; introducing sexuality into individual or family therapy seemed daunting. Both the fields of sex therapy and family therapy seem like islands, “alternative” to mainstream psychology, with no bridge between them.

The very idea of discussing non-monogamy with a man whose wife is having an affair might seem like we are directing the therapy, perhaps introducing “odd” suggestions into the clinical conversation. However, are we not prescribing the narrative when we discuss “affairs,” and presume sexual exclusivity? Isn’t the assumption of monogamy introducing a value-laden therapy, one that determines the direction of the therapy?

We have found that even the most outrageous questions have already been entertained by clients. But if the therapist doesn’t give voice to them, how do clients know they are permitted to discuss them? The simplicity of asking, “So before your wife began engaging in this affair, did you have an agreement of an exclusive relationship,” could reveal alternative stories about the marriage. For example, “We had an open relationship before we were married,” might be one response. Another might be, “Oddly enough, I was the one who wanted an open relationship and she didn’t.” Or

even the clarity of, “Oh, I am very monogamous and that was an agreement we made early on in our marriage ... she knew how much this would hurt me,” reveals important information about the direction of therapy, and the potential unfolding narratives.

In a training video made in the 1980s for marriage and family therapists, called *A Different Kind of Caring*, Carl Whitaker talks with a female client about her previous negative relationships with men. He asks her, in front of her siblings and parents: “Have you ever considered becoming a lesbian?” It is an absurd moment and completely outrageous given the context of the therapy. Lesbianism is not a topic therapists casually introduce into a presumably heterosexual family discussing normative heterosexual dating. Not now, and certainly not twenty-five years ago. However, the young woman was not appalled or offended. She responded thoughtfully, “Well, actually I have.” Indeed, how many things have our clients thought about, but do not give voice to within the hallowed walls of therapy, especially regarding sex and sexuality?

Do we ask clients if they use online dating sites, or watch pornography? Do we routinely ask people as part of a psychosocial history-taking if they are comfortable with their assigned gender? Do we assume that the couple sitting in our office is monogamous, or heterosexual? Can we not become derailed when the couple mentions off-handedly their “other girlfriend?” As gay and lesbian couples and families become less “alternative” and more commonly perceived as having issues mirroring those of heterosexual couples, what other topics remain underground, veiled in judgment?

So we wonder: what exactly prevents us from bringing up sexuality? Are we concerned about making our clients feel uncomfortable? Do we think we are being intrusive if we do not purely follow their agenda and introduce sexuality? Are we less likely to believe we are overstepping boundaries when we ask them to reveal their most

painful memories, the details of their inner lives or the minutia of their relationship schedule? Do therapists sometimes participate in the social condoning of emotional pornography, expecting clients to expose the deepest details of their personal history, while sanctioning sexuality as private and taboo?

An important question concerns what exactly triggers our discomfort. Can we as therapists identify the material we are most likely to avoid, the socio-cultural contexts in which we are most hesitant to explore gender and sexuality? Are we more intimidated by clients of an older age, a higher class status, a different ethnic background, or a different sexual orientation? Do we stop ourselves from asking sexual questions because we fear we might not “know” what they do in bed or the words they call it? And most importantly, if clients bring this rich material into the consulting rooms, how well prepared are we to address these issues?

These questions are highlighted in bold relief in the third featured article, “Couples and Kinky Sexuality: the Need for a New Therapeutic Approach.” Margie Nichols’ manuscript offers non-pathologizing guidelines for working with couples in the kink/BDSM (Bondage, Discipline, Sado-Masochism) communities. The Internet has created an online sexual cornucopia and is rife with sexually explicit material. Typing the letters “BDSM” into a search engine reveals about 50,000,000 results. The website www.FetLife.com, an online community for people who practice BDSM and kinky sex, has over 700,000 members and adds hundreds more people weekly. Clearly, people are exploring aspects of sexuality online that they may not be sharing with their therapist! At the time of this writing, there are over 3,000 kinky sex gatherings advertised. These are places where people go to meet others like them, and often to engage in sexual activity. If our clients attended, would they tell us? If they did, how would we respond?

Ari recently worked with a client through her transition from male to female. Two years after her

successful transition, she confessed she was “into kinky sex” but was afraid to tell “exactly what” she was into. As they established more trust, the client revealed, “I like daddy/girl sex.” How does Ari, as a feminist who has worked with sexual abuse survivors, hear these words? What are the issues that surface for us as therapists hearing “daddy/girl” sex? What *is* the client “doing” sexually, and, of course, the most important question: is it healthy? Who is even to decide what is healthy or not? “When I am sexual with a man, who loves me as a girl-child, I get to be the girl I never was allowed to be,” she explained. *The girl I was never allowed to be*. How do we hold a safe space for this exploration that allows for adult sexuality that evokes childhood eroticism? How do we contain our own counter-transference? How do we allow this client to discuss her fantasies, shame, and joy in “finally” being the girl-child she had protected within a growing boy’s body?

In that context, we would be remiss to publish Margie Nichol’s article without sharing the process surrounding its labor and birthing. One of our deepest appreciations goes to the respectful dialogue that unfolded between the three of us as editors, each from different sexual, religious, geographic, age, and cultural backgrounds, as we were editing the article. Faced with the dual responsibilities of gauging the level of sexual content optimal for our readership and of respecting the professional objective of the manuscript, we had to make explicit to one another our values around sexuality. We needed to find, check, and expose our respective personal and cultural thresholds, for example, could we talk about rape fantasies or pain in the context of consensual adult pleasures? At what point, with what images, might we lose some readers? And, Melissa was concerned, how could we talk honestly about this together without hurting or losing each other? As the only one of us who has never been marginalized because of her sexuality, she was aware of both the benefits of her privilege and of the limitations of her

imagination, but Ari and Jean encouraged her to use this privilege in the service of preparing a monograph that would be accessible and useful to all our readers. With the strong support of Jean and Ari, Melissa wrote Margie, “I believe I’m just the kind of reader you want to reach and I want to be reached. I wanted to read this not just to be more informed, but also to be less reactive and more reflective when I am with people whose experiences are so different from my own. To that end, I want to discuss three sentences in your manuscript that interrupted my intent. They moved me from a mode of reflection to one of alarm and caution.”

Margie immediately responded and reassured Melissa, “I never get upset by people who are open with their reactions and looking to learn. This stuff looks scary because sometimes it IS pretty edgy.” She appreciated the suggestions and adjusted the alarming sentences. Margie was happy to collaborate to help her voice be heard by all our readership.

Gender and sexuality are social constructions of our biological, social, cultural, and emotional differences.

Different dilemmas with other manuscripts called us again to socially locate ourselves and to learn from one another. Editing is a political process, especially editing these manuscripts, determining what we would publish about people who are marginalized. We were aware of the perils of our power and were fortunate in having the ideal balance, a trusting team of three in which the majority person was the minority. We, in turn, were aided and informed by a group of dedicated manuscript reviewers from the AFTA membership, many of whom brought not only their academic knowledge but also the expertise of their own lived experience, as people who had endured marginalization on the basis of their sexuality.

Confronting our own differences, our cultural frames of reference and resonances with

sexual matters, manifested the very point of the monograph: Gender and sexuality are social constructions of our biological, social, cultural, and emotional differences. Aware of this, our discussion unfolded, deeper. We made room for each other’s editorial limits and sensitivities, striving to hold respectfully in mind the diverse voices of the AFTA readership. We hope that the reading will trigger as rich a dialogue as its editing did.

The last featured article moves us from sexuality to gender and from couples to families. Melissa MacNish and Marissa Gold-Peifer describe how families adjust to the coming out of gender non-conforming and transgender adolescents. We live in a world with an assumption of a sex and gender binary. One is either a male or a female, a man or a woman, a boy or a girl. One is either masculine or feminine, and the traits considered to belong to one sex should not be displayed by the other sex. This impacts all people, of all sexes and gender. Certainly as family therapists, concerned about gender in the consulting room, we see the effects on women’s and men’s lives as they live in limited spheres, with assumptions about their roles and expectations. For those who do not easily fit into the binary, whose lives are on the margin of sex and gender – cross-dressing males, transsexuals, and those born with intersex conditions – their lives become easily invisible, unrecognized and marginalized.

Couple and family therapists have a crucial role to play in highlighting transgender issues from a systemic perspective. The mental health field is finally attending to the needs of trans individuals, but has neglected the needs of their family members. Parents of transgender teenagers must navigate the complex tension between acceptance and protection. While more communities and friends express support, families often suffer the same hardship that their child is exposed to. In a group that Jean facilitates for parents of gender-variant children, a mother speaks out, “The hardest part is not my relationship with my daughter and her fluidity, but it is having everyone, my family, the

outside world, school, everyone scrutinize my parenting. I feel watched and always on the fault line. I feel bullied as a parent who loves my child for who she is. But I know she is going to grow up and I will be in her life. She will want to be with us because we have believed in her.” Family and larger systems interventions are critical to empower family members and create social change. “We are pioneers, and the world needs to know about raising a fluid child,” another mother of a transgender child says in the group. A father in the same group wisely concludes, “Talking about gender and sexuality will not only help families like us, families with a gay or gender-variant child. It will free everyone from having to think in such narrow ways. It will free us all from fear.”

Indeed, clinical change is sometimes made possible by the social advocacy and transformations to which therapists indirectly contribute. In the midst of editing the monograph, Jean left for India to study emergency humanitarian assistance. On the first day of training, he sought counsel from the course director about whether he should come out as a gay man with the multicultural and multi-faith international training group, the group with whom he would be living and working for the next five weeks. Larry, a former British military man, openly heterosexual, and long-time humanitarian executive, responded: “Be yourself, fiercely. If they have a problem with it, it’s their problem. If their reactions become a problem for you, we will be there to help!” Emboldened by this wonderful show of support, Jean introduced himself to a group of humanitarian professionals from India, Asia, Africa, Europe, and the U.S. Shortly after his personal introduction, he asked who in the group knew the difference between ‘gay’ and ‘transgender.’ Five hands rose out of the group of eighteen members and a long conversation about sexual orientation and gender identity unfolded. Jean was blown away. For five full weeks colleagues from all cultures and walks of life came together around this conversation, sharing their own gender fluidity and

bisexual experiences. A couple of times throughout the course, the needs of sexual minorities in contexts of humanitarian emergencies were brought up by several members of the group, showing the growing awareness for this population’s specific issues among the group of newly trained humanitarian specialists. Jean left with the hope that his instructor’s model of unconditional support and his own coming out might have facilitated the needs of LGBT humanitarian victims to be recognized and taken into account.

Opening the section on Clinical Commentaries, Mary Sue Green and Margaret Reed challenge therapists to think about the legacy that families pass along to children regarding sexuality. They urge family therapists to pay more attention to the family’s history regarding sexual issues. Every family, they suggest, has legacies about sexuality: the legacy that each parent has inherited and refined and the one they impart to their own children, in both subtle and overt ways. The authors especially ask therapists to reflect on ways that their own family legacies impact what is discussed in the consulting room. They encourage us to consider how fostering parents’ intentionality about the messages they share with their children can be part of our best practices.

In the second clinical commentary, Lisa Mau-rel outlines some of the family issues when a loved one comes out as transgender. She highlights the power of heteronormativity, as well as the grief and sadness experienced when families explore gender transitions. Within the frame of family systems theory, she utilizes tools like the genogram to explore the way gender has been enacted within the family, and assists them in uncovering hidden stories and developing alternative narratives.

As Jean and Ari were editing this monograph, Ari began working with a nine-year-old child named Jaydan, who was born to a rural, working class family. Within hours of his birth, his parents were notified that he had a medical condition causing

the genitals to not form completely. The medical team performed surgery within days of his birth because they determined that raising him as a girl would be “a better outcome” since they believed he did not have a “large enough penis.” They never revealed to the parents that Jaydan actually had XY chromosomes. These decisions were made by physicians and surgeons, with no mental health experts involved. Jaydan was raised as a girl named Jada who knew nothing about the diagnosis or the surgery. However, he began insisting that he was boy as soon as he could speak. At the age of 7, his parents allowed a gender transition, negotiating on their own with the school in their rural community. Jada became Jayden, and only as he neared puberty did the family seek out therapy.

Ari couldn't help but reflect on the Clinical Commentaries in this issue of the monograph, weaving together these threads of the legacy of sexuality within families, and the impact of gender-variance on the entire family system. What was Jaydan's family's legacy regarding sexuality? How did that impact how they perceived their child's developing identity? Jaydan's parents had been divorced many years ago, and his mother assured Ari that Jaydan's father would never agree to come into therapy. However, when Ari called the father, a gruff man with an 8th grade education, he cried on the phone. “How do I raise a son without a penis?” he whimpered. He readily came into therapy and shared an experience he'd had at a construction site with “a woman ... a person ... a girl who looked like a guy.” He watched his friends make jokes about her, and he said with anger in his voice, “That could be my child they are making fun of. Until this happened to us, I never would've understood. I would've laughed too ... but now I understand when I see people on the street, who are, you know, queer in some way, I am the first person to defend them. No one chooses this; we have to protect people. This has changed me.”

The last section, Book and Movie Reviews, presents critical and multiple perspectives on

issues such as fidelity, families of lesbian and gay youth, and heteronormativity. Michele Scheinkman comments on Pamela Druckerman's *Lust in Translation: The Rules of Infidelity from Tokyo to Tennessee* and invites us to a multi-cultural reading of affairs. Deidre Ashton reviews Michael Lasala's new book, *Coming Out, Coming Home: Helping Families Adjust to a Gay or Lesbian Child*, highlighting the adjustment process of families of gay and lesbian youth and discussing the intersection of race and sexual orientation. Finally, Jackie Hudak unveils the heteronormative assumptions hiding behind one of the most recent and popular depictions of lesbian life in the motion picture *The Kids are All Right*.

Shortly before finishing the editing of this issue, Jean was in Paris and had the chance to watch the latest French social commentary comedy movie. In “Les Petits Mouchoirs” (translated into “Little White Lies”), Vincent, a heterosexually-identified and married 35 year-old man declares his sentiments to Max, his best male friend. “I don't know what's going on with me. I think I fell in love with you. I am not gay. I just... I don't know. I can't stop thinking of you.” Vincent, incarnating fluidity, does not want to leave his wife, but needs to confide to his best friend that he has crossed the fine line between friendship and love, even among men. Unfortunately, Max, representing our common fear of the unknown, panics and, overwhelmed with homophobic reactions, makes his best friend's life miserable. Vincent and Isabelle, his wife, have not had sex for months. Isabelle turns to an old habit of hers, interactive animation porn web sites, where she can be tied up and made love to by many desirous men, all hungry for her. Later in the movie Isabelle painfully figures out her husband's feelings. In a poignant scene, where she tenderly leans on Vincent's shoulder, she expresses her understanding for her husband's heartbreak and bisexual feelings. While the scenario does not bring the couple to therapy, Jean imagined how this issue of the monograph would help the clinician treating Vincent and Isabelle.

How the therapist would comfortably explore each individual's sexual history, the fluidity of his sexual orientation and the meaning of her fantasies. How she would inquire about the couple's desire for a monogamous or open marriage, leaving room for Vincent's bisexuality and Vanessa's longing to be loved by many men. How much complexity the clinician could hold and how expansive the couple's journey could be, open to their inner and relational aspirations.

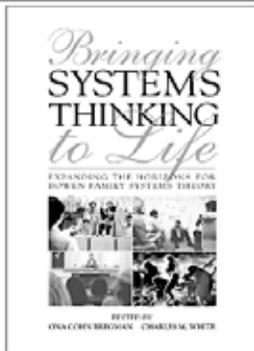
Gender and sexuality are multifarious matters, challenging to grasp and hard to contain. They denounce our fluidity and stain our normalcy. They give us a name and define our lives. Gender is who we are; sexuality is where we go, meaningfully. The thread each author has carefully crafted will surely add to the captivating tapestry of our gendered and sexual lives. As you weave them together in your

practice and relationships, we hope you will enjoy reflecting on the questions that have guided us: Are we exploring the edges of gender and sexuality? Or are we instead acknowledging the diversity and complexity that has always been the essence of human erotic and identity? Are we surfacing new forms of sexuality and gender embodiments? Or are we, more accurately, making visible and challenging the social constructions that prevent gender and sexual fluidity from being embraced?

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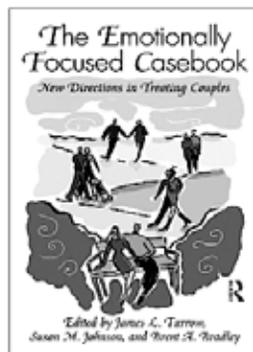
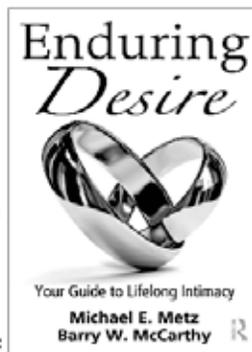
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Erotic Fantasy Reconsidered: From Tragedy to Triumph

Esther Perel, M.A., LMFT

Abstract

Many people approach the inner workings of their erotic mind with great trepidation, believing that the content of their fantasy life is inappropriate in the context of a loving relationship. Our cultural taboos about erotic fantasy are so strong that the very idea of discussing sexual fantasy leads some of us to anxiety and shame. Fantasy, however, can be an ingenious way for the creative mind to overcome relational and intrapsychic conflicts around desire and intimacy. Therapists can help couples develop a view of fantasy as a narrative that creates a safe space to experience the pleasure that can invigorate their loving relationship. They decipher the meaning of sexual fantasies approaching them more as dreams or complex symbolic structures than as literal narratives of secret intentions. Once the depth, complexity, and healing qualities of the erotic imagination are realized, sexual fantasy can be viewed as a staging ground for action and escape that turns the tables on those responsible for earlier experiences of demoralization, defeat, and even trauma. In the following case presentation, the therapist, drawing from systemic couple therapy, psychodynamic, and body-oriented practices, describes the use of sexual fantasy in working with couples.

“A fantasy is a map of desire, mastery, escape, and obscuration; the navigational path we invent to steer ourselves between the reefs and shoals of anxiety, guilt, and inhibition. It is a work of consciousness, but in reaction to unconscious pressures. What is fascinating is not only how bizarre fantasies are, but how comprehensible; each one gives us a coherent and consistent picture of personality—the unconscious—of the person who invented it, even though he may think it the random whim of the moment.” Nancy Friday (*Men in Love* 1992, p. 14).

Sexual fantasies are a wellspring of information about the individual’s internal life and the relational dynamics of the couple. They remind us that sex isn’t something we do, but a place we go, inside ourselves and with another. Too often, couples focus almost exclusively on the act and the statistics of sex, especially if they are caught in a sexual stalemate. “Three times a week is too much, but twice, is too little.” “We both have orgasms, but sex is always the same . . . the whole thing lasts 10 minutes from beginning to end.” “Conditions are never

right, I can’t remember the last time we had sex.” The therapeutic approach described herein helps couples exit the “doing” story of sex, and enter their subjective and inter-subjective experience.

The erotic landscape is vastly larger, richer, and more intricate than any repertoire of sexual techniques. Sex is a receptacle for our longings, hopes, fears and struggles, and we invest our erotic encounters with a complex set of needs and expectations. We seek love, pleasure, escape, validation, ecstasy, to be seen, and even spiritual union.

In therapy, the role of sex in the couple’s life is explored: *What does sex mean for you? What do you seek in sex? What do you want to experience in your encounters?* A wide range of feelings and desires can be heard in answers such as: “A longing for communion and transcendence;” “An expression of pure love;” “The delightful feeling of being wanted, taken, ravished;” “The wish to be taken care off without having to earn it;” “The exuberance of release;” “A safe place to experience aggression, power, and control or the pleasure of losing control and surrender;” “The

melting of bodies which unleashes a unique kind of vulnerability and intimacy;” “The permission to relinquish responsibility and to step out of one’s familiar roles;” “An act of rebellion against social conventions and the excitement of toppling the rules of good citizenship;” “The experience of freedom, playfulness, naughtiness and transgression;” “The trespassing of taboos;” “A temporary merging being simultaneously in and out of one’s body, inside oneself and inside another.” Or simply as one partner said: “To feel good.”

Our emotional history shapes our erotic blueprint and is expressed in the physicality of sex. Accordingly, there is a strong connection between our attachment map—defined as our expectations, conflicts, hopes and disillusionment with intimate connections—and our sexual feelings and behaviors: Tell me how you were loved, and I’ll tell you how you make love. Were our parents or caregivers responsive to our needs or were we expected to monitor theirs? Did we turn to them for protection or did we flee to protect ourselves? Was pleasure celebrated, suspiciously tolerated or simply dismissed? Did we feel safe to trust? Were we rejected? Humiliated? Abandoned? Were we held? Rocked? Soothed? Did we learn to receive or to be denied; to dare or to be afraid? Did we figure out not to expect too much and to hide when we were upset? In our family, we sense when it’s okay to thrive and when others might be hurt by our zest. We learn how to feel about our body, our gender and our sexuality. And we learn a multitude of other lessons about whom to be and how to act that seep straight into our erotic life. All these experiences shape our beliefs about ourselves and our expectations from others. They are part of the dowry each man and woman brings to the unknown continent of adult love. Part of this emotional scorecard is obvious, but much of it is unspoken, concealed even from ourselves.

Upon careful listening to clients’ erotic revelations, it becomes clear that fantasies are an imaginary transposition of their emotional needs into the

creation of a paradigmatic erotic schema. A valuable creative resource, fantasies transform our emotional and existential quests into sources of pleasure. They offer us an imaginary pathway to repair, compensate, and transform. A couple is a gathering place where we bring these imaginary elaborations to bear. There is a dialectical relation between the power and dominance, the surrender, the dependency, and the care that we toy with in our sexual fantasies and the reality of a couple’s life. The same power imbalance we fight about in the kitchen, may incite our sexual excitement after dinner. It is, however, beyond the scope of this article to delve into the tensions and inconsistencies of power dynamics in couples and the intersections with sex.

One patient Joanna, a 51 year-old lab technician, has always approached the inner workings of her erotic mind with great trepidation. “Something would creep in and it would be dismissed before it could ever develop,” she says. “You know, my fairy tale fantasy has always been ‘Oh, why don’t we just cuddle? Wouldn’t it be nice to just, like, rub my back?’ But I realized my fantasy was very different.”

Tell me how you were loved, and I’ll tell you how you make love.

She describes herself as a child living in the background of her family, often feeling invisible. She tells the story of how one night she woke up vomiting in her bed, afraid to call her parents for fear that it would disturb them and that they wouldn’t take her seriously. She left a crumb on the side of her mouth, hoping that someone would notice her distress in the morning. They didn’t.

The theme of invisibility looms large in the making of her erotic blueprint. It is dominated by the words: “I have enough, I don’t need any more.” The intricacies of our desire often lie buried in the details of our childhood. Our sexual proclivities, arise from the thrills, challenges and

conflicts of our early life.

Joanna tells me that she has a deep wish for people to see her. “I want them to notice me, to watch me, to admire me, to *know* me.” “Is this wish realized in your fantasies?” I ask. She tells me that she likes to be blindfolded and tied up. “In my fantasies, it’s all about me. I don’t have to do anything.” I try to decipher the meaning of sexual fantasies by approaching them more as dreams or complex symbolic structures than as literal narratives of secret intentions. What happens in the fantasy of “tie me up” that meets that need?

Joanna explains: “When I am tied up, I don’t have to think, I don’t have to give or be nice. I cannot *not* let you give to me and I can’t give anything because I’m tied up.”

Understanding what fantasies do for our clients helps therapists to understand the emotional needs they bring to their sexual encounters. A good fantasy states the problem and offers the solution.

Recognizing the depth, complexity and healing qualities of the erotic imagination, we explore sexual fantasy as a staging ground for action and escape that turns the tables on those responsible for earlier experiences of demoralization, defeat and even trauma.

For Joanna, the restraint is not about force or being over powered. Rather it bypasses the ways that she stops herself from receiving pleasure, a lifelong habit of self-abnegation and disappearing in the background. When she is tied up she can only be given to, she needs not worry and feel guilty that she’s taking too much, and she feels no pressure to instantly return the favor. In her fantasy, she is put in a situation where she has no other choice but to

receive, legitimately and abundantly.

Understanding what fantasies do for our clients helps therapists to understand the emotional needs they bring to their sexual encounters. A good fantasy states the problem and offers the solution. It is an ingenious way for our creative mind to overcome all sorts of relational and intrapsychic conflicts around desire and intimacy. Psychoanalyst Michael Bader (2002), whose brilliant book *Arousal* offers an in-depth discussion of the undercurrents of fantasy, explains that in the sanctuary of the erotic mind we find a psychological safe space to undo the fears, inhibitions and prohibitions that roil within us. Joanna frees herself from her psychological constraints and the limits put upon her by her conscience and her self-image. The ability to go anywhere in our imagination is a pure expression of individual freedom. It is a creative force that can help us momentarily transcend reality. In the playful twist of her erotic imagination, being entrapped unleashes her freedom.

Sex therapist Jack Morin (1995) explains that the erotic imagination is inventive in undoing, transforming, and redressing the traumas of the past. The very experiences that caused us the most pain in childhood sometimes become the greatest sources of pleasure and excitement later on.

Joanna’s husband, Carl, recounts one of his formative memories: One evening as he sat next to his mother on the sofa watching TV, he unexpectedly brushed his leg against her skin and instantly recoiled in fear, a powerful blend of terror and longing. The tenderness he craved was a transgression into dangerous territory. This incident became a seminal experience in the shaping of his erotic blueprint. Carl’s mother spent much time on the sofa smoking cigarettes and watching soap operas on television and he learned to hide his vulnerabilities and need for tender connection.

During the day, Carl was an engineer in charge of an entire division. After hours, his libidinal pursuits went in overdrive with on-line

porn, or off-line revelries, all depicting older women and young men/boys. In his imaginary world, the adult Carl could experience the needs the little boy had to repress – tenderness, softness, vulnerability, and dependency. All these repudiated emotions fueled his erotic scripts. There, Carl the man can play the little boy without suffering the pain of the little boy who was refused the soothing, loving touch of mother. In his fantasies he is not needy: the women always want him, they never say no, they know exactly what he needs and are happy to give it to him. Reliving the little boy is frightening; to play him is enchanting. Fantasies express truths about ourselves that are hard to get at otherwise. They reveal us at our most bare, and in their own mysterious way they convey our deepest wishes.

Unfortunately, Carl's metaphors got confused. Need and desire got mixed up. Joanna is clear about that. "I don't mind nurturing the little boy, but I don't want to have sex with the little boy." She sees him as demanding; he sees her as withholding. She wishes he would desire her, he says why don't you want me? And both are saying: "See me, hear me, touch me, feel me."

Delving into narratives of fantasies, de-pathologizing them, translating the metaphors and the power of the turn-ons, connecting them to the person's emotional history, and then creating a bridge between past and present, self and other, are important steps in the therapeutic process. While for some, sharing fantasies is intimate (the exposure of a unique nudity to one's partner) others would rather maintain an intimacy with themselves and prefer to host their revelries privately. This paper does not do justice to the intricacies and dilemmas of fantasy disclosure: Whether to tell? When? How? What for? Whether to enact them, and if so, how far? This paper discusses how we can use fantasies in therapy as a metaphoric language to address sexual impasses in the individuals and in the couple. Narrating our fantasies is an exercise in self-description, which

in turn promotes differentiation between partners. It elicits separateness and curiosity, which is at once alluring and threatening. To turn the spotlight on oneself, and to invite the other into a vulnerable territory puts responsibility on each person to own whom they are. It is the other side of blame. It involves not only trusting the other, but also the belief that one is worth being known, loved and desired.

When clients open the door to their imaginary musings, offering literal translations can be tempting. Yet, any element of a fantasy—any object, toy, type of light, time of day, smell or smile—has a subjective meaning that only the author of the plot stands to interpret.

One day, Joanna planned a sexual encounter. She put a note on the door that read "Help me!" and then she tied herself to the bed. When Carl arrived she sensed his hesitation, but she stayed focused on herself, and did not worry about him. Her desire wasn't contingent on him; it was about her.

As a child, Joanna would leave minor marks on her body, like the crumb mentioned previously, hoping to be noticed. She was accustomed to receiving little response from her parents, and had learned to protect herself from disappointment by leaving signs that were so subtle that, if nobody noticed them, she could easily pretend they never existed. We named this the "crumb approach." For many years she would initiate sex with Carl using the same subterfuge. She would come on to him in a vague and non-committal manner so that when he refused her advances, it was barely evident she had ever taken initiative.

That day, she didn't just leave a crumb on her lip, she put herself in full view. There was nothing sheepish or tentative about her seduction. Not surprisingly, Joanna reveals that this was the first time in decades that she had an orgasm with Carl. She describes how she felt alive. We agree that the energy comes from her sense of

self-worth, and healthy entitlement that drive her action. Joanna was in the realm of desire, of owning the wanting. The script is sexual, but the risks she takes and the healing she experiences are quintessentially emotional. The pleasure is commensurate with the meaning, far beyond its specific theatricality.

Reflecting on her boldness, Joanna tells me that in the past she would immediately whisk away any sexual thought she had. As she has become more comfortable with her thoughts, more open and connected to her sexuality, she meets herself anew. “I realized that I wanted to be dominated. I wanted him to be rough, which was so far away from where I ever thought or even dreamed that I would be. I didn’t want to be hurt, though. I was very aggressive, very forthcoming with my wants. ‘I would like you to tie me up. I would like you to blindfold me. I don’t want to know what you’re going to do until you do it.’ Like that. And it was good. She said, “Oh my God, this is what it feels like to be alive.”

When I inquired if she had feared Carl’s reaction, she smiled and showed me with her hand how she had blindfolded herself. Some people may be very scared to place themselves in such an explicitly helpless state, but for Joanna, being unable to see freed her from self-consciousness, inhibition, and worry about Carl’s reaction. Her disempowerment was a staged, assertive, and playful way to get Carl’s attention, and he could, in turn, sidestep the allusions to the depressed mother on the couch. This time, he was able to respond to his wife with erotic fervor and desire. It was clear that he didn’t need her. He wanted her.

Clearly, fantasies are not experiences we necessarily want to live in reality. When we act them out, we are playing, and when we play, we are in pretend mode, we are in control, especially if we decide not to be. To play we need to be free; to be free we need to feel safe. We don’t play jail when we live in one. Fantasies are subversive,

creative acts. Perhaps sex is never just sex?

Early childhood experiences of touch, play, or trauma become the cornerstone of our adult erotic life. In fact, one facet of the erotic blueprint that highlights the irrationality of our desire is that what excites us most will often arise from our childhood hurts and frustrations. Carl knew what he liked, but he had no idea what was so powerful about it. He had always sexualized his needs but he hadn’t connected the dots. Growing up, he learned to live on a diet of quick pecks on the cheek from his mother to satisfy his emotional needs. Sex was the place where he lodged his need for security, for caring and communion. It was a perfect storage place for his suppressed emotional needs. When he would feel rejected, his reactions could be extreme. For people like Carl, sexual frustration is physical and the emotional price they pay can feel unbearable. For them, sex is a lifeline through which they nurture their need for giving and receiving affection, love, care, tenderness, and for attunement. It is also a venue where they can be assertive, demanding, greedy, needful, where they express themselves authentically and communicate in their most intimate voice. After all, it isn’t only sex Carl is being denied, it’s an entire emotional landscape that becomes sealed off.

I ask him if he ever puts his hands on Joanna’s face. He doesn’t. On her arm, yes, so too on her shoulder and her leg, but never the face. The face is the most vulnerable place to receive touch. When we hold someone’s face in our hands, or vice versa, it creates an inescapable focus between two people, a reminder of the primal parent–child gaze. Till now, Carl has only known motherly care and tender touch visually on a computer monitor screen. So I created an enactment in which he could experience some of his emotional needs in a non-sexual way, and with a real live woman, his wife. The therapeutic intervention was to have Joanna hold his face so he could have a safe embodied encounter being

gently held. At the start, Carl felt nauseated; he said he had a knot in his stomach. Once again his proclivity to physicalize feelings is at work here. It is palpable in his body. As the exercise progresses, slowly and carefully, Carl the adult will receive what the boy never did, clearing the way for the boy to grow into a man.

Similar to hypnotic induction, Carl is guided to take in the experience. I tell him, “As this new relatedness grafts itself under your skin, let it travel through you, through your nose and into the extremities of your fingers. As you take in her contact, you will breathe through the knot in your stomach, and at some point you will surrender to the embrace. From there you will reach for her face, but not by hunting for her – rather you will reach her from within yourself.”

This enactment took a quite some time. While Carl soaked up the connection, I gently pressed him to nestle on Joanna, a sign of how far back he had to go and start from infancy onward. From a place of receiving, he slowly began to give. He held Joanna, her body, her face, his hands caressing. When he finally disentangled himself he seemed to have come back from afar. He said, “I don’t feel sick anymore. When I started, I felt really small, scared. Then I saw myself getting younger. I felt like a baby. I never experienced anything like that. I didn’t know what to expect. I felt small, safe, loved, and then I started feeling myself getting a little older and bigger. And it still felt good, but in different way. And then it felt like wanting to give. Like an expression. It felt like it was just a part of me. It felt legitimate. And I wasn’t punished. Nothing bad happened. It’s a good feeling, to get this in real life, in real flesh.”

In the past, Carl would often approach Joanna pretending to say: “I want you,” but really saying: “Do you want me?” even, demanding: “Want me!” His focus was on receiving. But he needed to add the dimension of giving. This is not something strange and new for him. Their relationship

is infused with generosity, but not their sex life. It is the sexualizing of these obfuscated needs that makes all this so blurry. In sex, he has to shift from needing the mother to wanting a woman, that is, to differentiate the motherly touch from the woman’s sexual response. Then, Joanna can feel wanted instead of needed, and they will mark the first step out of their erotic ambush. The point is not at all to eradicate need or dependency. Carl and Joanna depend on each other for so much. Their relationship offers them a sense of grounding and anchoring, a feeling of belonging, and continuity. This mutuality and reciprocity has made their 26 year-long marriage remarkably resilient. They have relied on each other to build a home, raise children, bury parents, acquire an education, change careers, discuss their personal challenges, wipe their tears, and lately, travel and discover other coasts. But in the realm of sex, the confusion between need and desire had become an erotic death sentence.

Later, Carl reported a few mini breakthroughs in which he connected with his manly desires. He felt in charge; he “knew” he wanted Joanna, and their lovemaking felt full. One day he came home with nail polish to give Joanna a pedicure. The color was dark, not a mommy color. Another day he brought a silk scarf to add texture to the softness and to blindfold her. One evening when she refused his advances, he took the scarf and used it to masturbate in front of her. The little boy who had a tantrum of despair and rejection, now discovers that he can self sooth in the presence of his wife. His imagination is flowing and play has replaced shame. Having found the pleasures of the “real,” we were able to go back and examine Carl’s historical quests for this exact encounter on-line.

Upon listening and probing the intricacies of the erotic imagination therapists can uncover the shrewdness of fantasy – its energy, its artful efficiency, its healing qualities and its psychological

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tour de force. Our fantasies combine the uniqueness of our personal history with the broad sweep of the collective cultural imagination – the incentives and the prohibitions, the ideals and the repressions, what we are told is sexy and what we are told is forbidden. They bridge the gap between the possible and the permissible.

Fantasy is the alchemy that turns this jumbled mishmash mixture of psychic ingredients into the pure gold of erotic arousal – a powerful antidote to libidinal demise in the relationship.

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Open Relationships: A Culturally and Clinically Sensitive Approach

Deanna M. Fierman, M.A. and Shruti Singh Poulsen, Ph.D.

Abstract

Romantic and sexual relationships that challenge the notion of monogamy are becoming much more common and visible in American society, yet there is very little published literature focusing on therapy with clients in open relationships. Concepts from the literature on open relationships that could be used in couple and family therapy are discussed, in addition to specific ethical considerations for therapists who work with this population. The authors provide a case description to illustrate a clinical approach that draws upon constructionist and narrative elements, discuss how therapists can assist with the negotiation of non-monogamy, and suggest ways to create a secure therapeutic space for clients in open relationships.

Consensual romantic and sexual relationships that are open and non-monogamous challenge the norms of exclusive relationships and have largely been overlooked by the scholarly literature (Ellis, 1970; Otto, 1970; LaSala, 2004; Rubin, 2001; Weitzman, 2007), including the couple and family therapy literature. An integration of current theories of couple and family counseling must be adapted to include open relationships as these relationships are becoming more prevalent and visible (Taormino, 2008; Nelson, 2010; Weitzman, 2007). People in open relationships may be discouraged at the difficulty of finding culturally sensitive therapists (Keener, 2004; Shernoff, 2006) and are concerned both about being judged by the therapist and with the need to educate the therapist about open relationships.

There has been scant research on both the prevalence of open relationships and on the ways monogamous values affect therapists' work with consensually non-monogamous clients. This is complicated by the difficulty of conducting research on sexual minority populations (Shernoff, 2006). Informal surveys about non-monogamy suggest it may be more common than most people assume (Cook, 2004). For example, the Janus Report, a 1993 survey of human sexual and erotic behavior, analyzed 2,765 questionnaires and

follow-up interviews nationwide and found that 21 percent of adults reported participating in an open marriage (Taormino, 2008). Another study examining bisexually-identified men and women showed that out of 217 bisexual people, 33 percent reported that they were in open relationships, and 54 percent considered polyamory an ideal relationship model (Taormino, 2008). In addition, an on-line survey of over 14,000 people conducted by Oprah.com revealed that 14% of men and 7% of women surveyed were in an open marriage (The Oprah Winfrey Show, 2006). Although these surveys lack rigorous scientific methodology, they reveal an increasing interest in, or at least visibility of, open relationships.

Open relationship structures may take many forms. These include, but are not limited to, *partnered non-monogamy*, *swinging*, *polyamory*, and *monogamous/non-monogamous combinations* (Easton & Liszt, 1997; Shernoff, 2006; Taormino, 2008). These relationship structures are all *consensual*, which is a distinction integral to understanding how alternative relationships differ from infidelity or cheating (LaSala, 2004). Cheating can certainly occur in open relationships as it can in any relationship, for example a partner may maintain a secret relationship or give misleading information about the nature of that relationship despite

agreeing to disclose all romantic or sexual interactions. People in open relationships sometimes identify one partner as their *primary partner*. *Partnered non-monogamy* generally emphasizes a non-monogamous sexual relationship, while the emotional intimacy remains with the primary partner. *Swinging*, in contrast, is considered more of a lifestyle with distinct social etiquette and formal events rather than a purely sexual practice, though it is similar to partnered non-monogamy in that participants are generally emotionally monogamous and sexually non-monogamous. *Polyamory* refers to having multiple emotionally intimate relationships simultaneously. Often, though not always, these relationships are sexual in nature; the emphasis in polyamory is generally on the presence of multiple romantic partners. *Polyfidelity* refers to a group of three or more people in a closed relationship. As Taormino (2008) points out, the aforementioned categories contain false dichotomies; clients can belong to several of the categories. For example, a polyamorous couple may also choose to participate in the swinging community (Cook, 2004), or an initially polyfidelitous triad might later choose to have an emotionally closed but sexually open relationship. However, these labels are useful for the purposes of discussion.

Culturally and Contextually Sensitive Practice

Contextually and culturally sensitive practices can be implemented in practical yet meaningful ways. Intake forms and assessments can be changed to reflect diversity of relationships; for example, rather than ask clients to specify “Marital Status,” the more inclusive “Relationship Status” could be used, including options other than two-person relationship formats. Similarly, it may be possible to raise awareness of open relationships by using inclusive language in the therapy literature.

A number of concepts exist in the literature on open relationships that are useful for therapists.

Although the concepts of compersion, starvation economies, the myth of equality, institutional and social prejudices, and jealousy are certainly not unique to clients in open relationships, they may be especially likely to arise when working with these clients. Therefore, a discussion of these concepts may be particularly useful for therapists working with this population.

Compersion

Those who are in open relationships often have nontraditional feelings toward their partners’ other romantic or sexual relationships. One of these is *compersion*, a term coined by the Kerista commune in San Francisco, which occurs when one partner has positive feelings about a partner’s other intimate relationships (Cook, 2004; Taormino, 2008). Compersion can be similar to being happy because one’s partner develops a new friendship, a hobby, or other outside interest. Although the idea of finding joy by observing your partner’s joy may be a familiar concept, helping a client find joy in her partner’s other relationships is something clinicians may overlook. Therapists need to spend time exploring and engaging their own relationship with the concept of compersion in order to successfully work with clients in open relationships, and this process will look different for each individual. It is essential that therapists who work with these clients develop an understanding of compersion as a mentally and emotionally sound way to respond to one’s partner. Naturally, compersion isn’t always possible or desirable. However, it could be a useful part of reframing the partners’ bond and strengthening the connection of a primary relationship (Cook, 2004).

Starvation Economy

Another somewhat distinctive concern to those in alternative relationships is that of the *starvation economy* (Easton & Liszt, 1997), or the worry that there is indeed a limited amount of a substance. This is indeed the case for many things, including time with a partner and their sexual or emotional energy.

In addition, many intimate relationships are rooted in the idea that there can only be so much love available, thereby conceptualizing love as a starvation economy. However, love for one person doesn't mean there must be any less love for another. Easton and Listz (1997) cite the example of a parent having plenty of love for multiple children, even when sufficient time or energy may be lacking. Thus, when counseling clients in an open relationship, it is important to identify and address the nature of a client's fear. Deconstructing this fear, placing it into a framework that helps the partners identify their specific concerns and see different perspectives, renders the fear more manageable.

For example, a client may be unhappy because her husband spends a great deal of time with another partner. The therapist might inquire whether she feels as though she is losing her husband's affection, his time, or both. Depending on the client's response, the therapist might encourage her to discuss her concerns of loss of affection, mediate a conversation about time management, explore their narratives about the relationship between time and love, and inquire how experiences have shaped the clients' ability to handle multiple demands on their attention.

Myth of Equality

Many clients in open relationships unwittingly fall into believing the *myth of equality* (Taormino, 2008), which assumes that each partner has the same needs and desires. Taormino discusses how the concept of equality has become a central part of relationships, and explains that equality has become synonymous with symmetry in modern parlance. In reality, partners in an open relationship are likely to have different needs in terms of style of open relationship, amount of information they want to be told, sexual behavior, and so forth. Partners may incorrectly assume that their needs are the same and conclude that they necessarily must share the same set of behavioral rules. Unnecessary conflict could arise when, for example, partners differ

in the degree to which they want to hear about the other's sexual encounters.

In the above example, it may make sense for one party to give information about sexual behavior or emotional intimacy and for the other to refrain from giving any. There is nothing wrong with asymmetric information sharing as long as both partners agree to the arrangement. Clients will thus be working within the reality of their own particular relationship, rather than within a prescribed framework.

Jealousy

Jealousy is a complex force in relationships consisting of conflicting emotions, thoughts, and actions (Sheinkman & Werneck, 2010), and is experienced in both monogamous and open relationships. It is important to note, however, that those who choose open relationships are not predisposed to feel jealousy any more or less than those who choose monogamy (Easton & Listz, 1997). Within the literature on alternative relationships, jealousy is not perceived as inherently negative or positive; rather, it is viewed as an emotion that needs to be acknowledged and worked through in the context of a relationship (Easton & Listz, 1997, Taormino, 2008). People in open relationships often acknowledge early on that jealousy is likely to arise and choose to actively explore this concern, rather than deciding to end a relationship because of the presence of jealousy (Cook, 2004).

Therapists may be of great assistance in exploring the issue of jealousy as long as they understand that the goal is *not* to encourage clients to be monogamous. Rather, the goal might be to help communicate and manage jealousy effectively. Facing the emotions surrounding jealousy is just as crucial for healing as addressing the behavior that provoked the jealousy, especially if the behavior had been mutually agreed upon and if the partners wish to remain open. Therapists should be cautioned not to assume that a behavior causing jealousy should necessarily be stopped.

Institutional and Social Prejudice

Like many minorities, people in open relationships face a number of visible and invisible external challenges (Shernoff, 2006). We, as therapists, must not dismiss the ways that monogamy forms the implicit normative assumptions for all relationships in western cultures. Legal and medical authorities in the US assume families form a dyadic relationship structure. For example, three individuals in a committed triadic relationship are unable to establish legal parental rights for each adult. Social discrimination is widespread as well: it is found in the media, which almost exclusively depicts couples in closed relationships, and in everyday social assumptions, such as in the expectation that a person will have a single date at a social gathering. Keener (2004) explains that open relationships can be socially isolating due to their invisibility, and identifies six common fears: loss of friendships, potential for others “freaking out,” prejudice against and confusion with polygamy, the use of polyamory as a scapegoat, a lack of understanding, and the fear that others simply do not want to hear about non-monogamous behavior.

The therapeutic environment is not immune from these underlying social assumptions (Shernoff, 2006). Therapy will only be effective when ideas of normality and pathology are critically explored and deconstructed and when the therapist has examined her own biases (Nichols & Shernoff, 2007). A constructionist viewpoint considers relational norms in the context of the social group in which they exist, enables acceptance of a client’s story at face value, and also allows for challenging and restructuring realities and narratives that have the potential to harm the client or others (Nichols & Schwartz, 2008; Pare, 1995). For someone unfamiliar with the non-monogamous community, many of the aforementioned challenges clients face due to institutional and social prejudice may, at first, be difficult to see. In addition to becoming educated about the social and legal concerns that

people in open relationships encounter, therapists may choose to make explicitly clear to clients that they are familiar with open relationships and are comfortable exploring the topic during therapy.

Therapy will only be effective when ideas of normality and pathology are critically explored and deconstructed and when the therapist has examined her own biases.

Ethical Considerations

A number of ethical issues may arise for therapists who are approached by non-monogamous clients. In some ways non-monogamy is not particularly different from any other multicultural issue. However, the perspective that it is appropriate to have multiple sexual and romantic partners may be an especially difficult one for some therapists, given how prevalent monogamy is in our society. One primary concern is how to approach therapy when clients’ sexual or romantic proclivities do not align with the therapist’s values. The legal and ethical implications of working with gay and lesbian clients when a therapist is not comfortable with homosexuality has been discussed in the therapeutic literature (Hermann & Herlihy, 2006), and the concerns related to therapy with non-monogamous clients are similar. It may be difficult for a therapist to discern how to broach the topic with clients or whether and when it is ethical to refer clients to another therapist due to discomfort or lack of experience with this population. Simply being aware of the possibility of seeing clients who are in open relationships and having referrals available to therapists who are comfortable with non-monogamy can be an extremely important measure of support. Doing so demonstrates respect for a population who might otherwise easily be scared away from therapy due to past exposure to institutional prejudice (Keener, 2004).

If a therapist is comfortable working with non-monogamous clients, it may be helpful to give forethought as to how to broach the topic during therapy. There are small ways a therapist can explicitly demonstrate respect for this population, such as reformatting wording and questions on intake forms to be inclusive of open relationships, or adding a question that asks about the topic directly. It may also be useful to have a book on open relationships visible to provide clients with a way to bring up the topic of non-monogamy. A therapist may also address the topic of open relationships while addressing general multicultural differences at the beginning of therapy, either directly or indirectly. A respectful statement about differences in worldview during a first session could help clients disclose their open relationship. For example, a therapist could encourage a client by saying “I believe it is important to discuss

If a therapist is comfortable working with non-monogamous clients, it may be helpful to give forethought as to how to broach the topic during therapy.

how the lenses through which we see the world may differ. Our different experiences impact the way we view the world, and factors such as our gender, race, sexual orientation, and so forth can shape our perspective. I hope to honor your worldview in our work together. If I do or say something that feels as though it doesn't fit for you, I invite you to let me know so that we can address it.”

Clinical Application

Exploring non-monogamy

When they came to therapy, Kay and Jim, both in their late twenties, reported they had been living together in a monogamous relationship for two years. They each identified as “primarily heterosexual” in their orientation and identified as

White for their ethnic identity. Kay and Jim were in the process of exploring the option of an open relationship. Kay and Jim presented a recent incident in which they had mutually agreed to include a third individual in their sexual activities while still considering their own relationship as primary. Other than the occasional mutual fantasizing of including another individual in their sexual activity, neither had engaged in an intimate relationship with someone outside their relationship. Kay and Jim attributed their frequent arguments, lessening of positive interactions, and increasing tensions to the fact that they had not adequately addressed their goals and desires for a non-monogamous relationship and had moved too quickly into an open sexual relationship. Their agreed on purpose for attending therapy was to understand what had happened to their relationship and to stabilize their relationship so that they might work toward their original goal of having a sexually and emotionally open relationship. Kay and Jim's tension had rapidly deteriorated into much anger, hurt and vilification of each other. They were concerned that just as they started considering an open relationship difficulties began to emerge. They feared they would never be able to successfully engage in open relationships in the future, and that they might be unable to stay together.

Over the next few weeks, the therapist worked to make sessions productive for Kay and Jim by interrupting their personal attacks, offering process comments (e.g. in-the-moment comments that highlighted their verbal and non-verbal communication patterns, noting their patterns of interacting and pointing out when they were able to risk new behaviors, etc.), setting ground rules, and coaching them on speaking and listening skills. The therapist continued to explore the messages that each partner had received from their family of origin and from their cultural contexts. These messages were that monogamy was the only right way to engage in an intimate relationship, that having additional partners in

a relationship constituted infidelity, and that relationships that veered from the norm were destined to fail. While exploring these messages, each partner was able to recognize that they had no relationship role models for what they desired in their own relationship. They also had few resources in their familial and social contexts for support, approval or validation. As the partners' awareness of these challenges expanded, they were able to consider other ways of viewing the difficulties in their relationship. For example, they acknowledged that their relationship had been experiencing more stress because they were not automatically (as they might in other situations) turning to even a close friend or family member for advice or support due to the fear that they would be misunderstood, rejected or vilified for their decision to have an open relationship. Gaining this additional awareness and understanding helped each partner develop a little more empathy and kindness for themselves and each other. No one specific model of therapy was used to work with this couple; the therapist used practices of therapy that would be considered structural (Dickerson, 2010) but were applied in a manner that reflected post-modern and constructionist elements and that attended to the clients' meaning and experiences. For example, the use of the genogram helped explore their family backgrounds, patterns and messages, cultural narratives and experiences, and also their sexual, relational and emotional experiences. In the process of constructing the genogram, the therapist asked each partner to identify their family-of-origin and cultural messages about the value of monogamy as a prerequisite for a successful intimate relationship, and about the meaning of love and commitment. In acknowledging the pressure of messages that challenged the credibility of open relationships, and exploring them in more depth, the couple reported feeling less "wrong" in their decision to move toward an open relationship because they were able to see that they held very

different values and beliefs than their families of origin and their cultural contexts. Seeing these differences starkly portrayed in the visual of their genogram also helped them recognize that their desire for an open relationship had no precedence or support in their families of origin. Thus, as a couple they were trying to accomplish something in their relationship for which they had no role models. With this realization, each partner could take a stance that was less reactive and blaming towards the other. In creating the genogram, the therapist took a narrative and constructionist approach to create a therapeutic environment that felt safer and allowed each partner's experiences, meanings, and voices to be heard. While Kay and Jim sought therapy after a critical event and were highly escalated initially, the narratives that emerged through the genogram helped them de-escalate and be more open to each other's emotional experience and needs.

The therapist also fostered the couple's sense of safety and trust in their primary relationship by exploring the principles of the starvation economy, the myth of equality, the management of jealousy, and the ways in which these experiences could become sources of strength. Constructionist (Pare, 1995) and narrative processes (Freedman & Combs, 1996) such as contextualizing the clients' reactions to the precipitating event within the framework of their relationship experiences and their familial and cultural backgrounds helped the partners access their emotions, clearly express their emotional experiences and their needs, and develop a sense of empathy and understanding for each other even while dealing with the fact that their fear did not completely abate over the course of therapy (Johnson, 2004).

While each partner wanted to move forward with the prospect of engaging in an open relationship, exploring their individual and conjoint narratives was a key part of the therapeutic process. Exploration of their family and cultural narratives enabled the couple to examine their conflict in a

way that reduced blame towards each other. Their efforts shifted toward working together to create a new kind of relationship they both desired. A culturally and contextually sensitive approach using the genogram (McGoldrick, Gerson & Petry, 2008), narrative therapy (Freedman & Combs, 1996), and some Emotionally Focused Therapy processes (Johnson, 2004) provided an initial opportunity to develop a new narrative that included understanding both the couple's initial reactivity and their reasons for wanting an open relationship. This, in turn, facilitated the development of new solutions and problem-solving skills.

Negotiating Non-Monogamy

In addition to the exploration of clients' cultural and familial expectations, their histories, and what an open relationship means to them, it is also important to examine the practicalities of an open relationship. By exploring their families of origin, the couple saw that they had neither support nor role models for the different kind of relationship they were trying to establish. This scenario is likely the case for many clients attempting an open relationship. Therapists have several options in working with clients to find resources and develop support systems. Therapists can suggest that clients actively seek out others in open relationships for support and friendship, and can promote the use of online resources in finding information and communities. Clients may be encouraged to seek out self-growth opportunities that support the option of open relationships. In addition, therapists can act as a role model for the clients by encouraging communication and introducing questions that help the partners define their relationship.

Although clients must discuss and set their own boundaries within their relationship, a therapist can guide this conversation by asking culturally sensitive questions that include both behavioral and emotional components (Shernoff, 2006). Behavioral components could include a discussion of when flirtation with others is appropriate, when and how

frequently date nights could happen, with whom it is acceptable to have sexual encounters, which sexual behaviors are permissible, what type of fluid barriers will be used, sleeping arrangements, and so forth. Kay and Jim discussed these concerns in their attempt to create a sense of trust and safety for each other in the relationship. The topic of a starvation economy may be particularly relevant when exploring behavior with clients because discussion about what behaviors are and are not acceptable may relate to a perception that a given substance is limited. During therapy, Kay and Jim realized they had been taught that sexual attraction is finite and that their jealousy was partially rooted in the fear of loss of the other's sexual desire.

Exploring clients' emotions in conjunction with their behaviors is clearly important. The topics of jealousy, insecurity, attachment, and compersion may arise when clients are discussing their open relationship. During the construction of the genogram, the messages that Kay and Jim learned from their families of origin began to emerge. Placing these messages and emotions in the context of a present-day situation can draw attention to specific issues that are likely to arise. For example, a therapist could ask a client to imagine his emotions when his primary partner is out on a date, and could explore these feelings with the clients while both are present. The therapist might inquire how the client expects he would feel as his primary partner is leaving on the date, may choose to explore whether a client desires reassurance during the time that a partner is on the date, and could discuss how the couple might choose to reconnect after a partner arrives home. Clients may also struggle with strong emotions relating to discrimination or a feeling of invisibility because of their open relationship.

In addition, it could be useful for a therapist to mediate a discussion on how to have a conversation with one's primary partner about the development of another intimate relationship and to explore what details will be shared. Clearly, it is impossible to plan for every eventuality, but general guidelines

can certainly be developed. Reminding clients that misunderstandings will happen, and encouraging them to view misunderstandings as a chance to clarify expectations will help to strengthen their relationship in whatever form it takes. (Cook, 2004).

Conclusion

To create a successful and fulfilling therapeutic experience for clients in open relationships, it is important to foster a safe and secure therapeutic environment that is rooted in the clients' reality. Therapists may join more easily with clients and become more effective in their clinical role by becoming knowledgeable about constructs intrinsic to open relationships, by assessing how prepared they feel to work with clients from this population, and by examining their own comfort with the topic. Therapists should strive to create a space where clients' worldviews are readily accepted and where disclosure of open relationships is encouraged, as this practice will allow for the therapist to assess if referral is needed early in the therapeutic relationship. When working with non-monogamous clients, therapists should encourage an explicit discussion of open relationships and the concepts of compersion, starvation economies, the myth of equality, institutional and social prejudices, and jealousy. Future work in this area should explore in greater detail which therapeutic approaches work most effectively with clients in open relationships, and whether the effectiveness of the therapeutic approach depends upon the structure of the open relationship.

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In Tribute to Murray Bowen

AFTA's First President 1977-1981

For:

- Psychotherapeutic Theory *based on science*
 - *Respect* for the presence of *reactivity*
 - *Respect* for the impact of *anxiety* on all living matter
- Defining the *difference* between *change*, and a *shift* in behavior
- *Theory* allowing: predictability, preparation, prevention or minimization
 - *Theory* describing the *automatic nature* of emotional patterns
 - Encouraging *curious* observation
- *Theoretical Structure* for: observation, *hypothesis development*, definition of where change is required for increase in level of differentiation
 - *Theory* describing *The Triangular Process*
 - *Theory* describing *The Process of Differentiation: The Solid Self*

With Gratitude

Patricia Hanes Meyer, LCSW

Couples and Kinky Sexuality: The Need for a New Therapeutic Approach

Margaret Nichols, Ph.D.

Abstract

Recent decades have seen changes in the way gays, lesbians, bisexuals, and transgender people are viewed by mental health professionals, but this comparative enlightenment has not extended to the so-called “paraphilias.” The mainstream view in the mental health field is still that non-standard sexual practices are pathologies which should be included in the diagnostic manual. This paper presents an alternative view, first defining BDSM or “kink” and then summarizing the data about practitioners of BDSM. Some clinical issues are delineated, such as countertransference, differentiation of problem behaviors from those that are merely unusual, and provision of resources to isolated clients. A few case vignettes are presented for illustration.

From the very start of psychiatric nomenclature, non-procreative sexual behaviors have tended to be viewed a priori as pathological: guilty until proven innocent. Today we look back on some of the diagnoses and harsh treatments used to “cure” people of what were considered deviant sexual behaviors and we shake our heads in wonder that our field could once have been so primitive. It is embarrassing to remember that our colleagues once endorsed cliterodectomies and forced sterilization, condemned masturbation and oral sex, and subjected people to electroshock therapy and lobotomies for sexual behaviors we now consider normal.

From a historical perspective, we should be deeply skeptical of psychiatric diagnoses involving sexuality, because the designation of “sick” and “healthy” seem to mirror rapidly changing social mores which calls into question the scientific basis for classification (Bayer, 1981; Szasz, 1961). Nymphomania, a diagnosis that applied only to women, was included in the first DSM in 1951 (APA, 1951), during a time when our culture did not expect women to enjoy sex and deemed them defective if they did. As sexual standards for women (and everyone) became more liberal, so did diagnoses: the 1980’s saw the DSM discard

nymphomania but introduce HSDD (Hypoactive Sexual Desire Disorder) as the culture shifted from condemning women for being too sexual to pathologizing not being sexual enough (APA, 1980). Homosexuality is another prototypical example: before 1973, all manner of invasive and punitive treatment methods were acceptable to “cure” homosexuality; at this writing, most mental health professional organizations condemn reparative therapy as a cure for what is no longer considered an illness; actually, some even support gay marriage (Bayer, 1981; Drescher & Zucker, 2006). Recent decades have seen changes in the way gays, lesbians, bisexuals, and transgender people are viewed by mental health professionals, but this comparative enlightenment has not extended to the so-called “paraphilias.” People whose sexual practices are outside the accepted norm have become increasingly visible in our culture and, to a lesser extent, in the offices of psychotherapists. The traditional psychiatric view of sexual minorities, however, has not changed. The mainstream view in the mental health field is still that non-standard sexual practices are pathologies which should be included in the diagnostic manual. This view is being challenged by a vocal minority of sexologists (Kleinplatz & Moser, 2006; Moser, 2001; Nichols, 2006; Weinberg, 2006).

Defining BDSM and Kinky Sex

BDSM is a modern acronym to denote certain sexual activities broadly described as bondage (B), dominance (D), submission (S) and sado-masochism (SM). Many would include fetishism as properly belonging to this group of sexual activities, and fetishists are considered part of the BDSM community. Collectively, these practices and attractions are sometimes referred to as “kinky.” In general, kinky sexual activities include one or more of the following characteristics:

- A hierarchical power structure, i.e., by *mutual agreement*, one person dominates and the other(s) submits. It is important to note that these roles are negotiated for sexual play in much the same way that kids agree on the roles of cops and robbers for the duration of the game;
- Intense stimulation usually associated with physical or emotional discomfort or pain, e.g., slapping, humiliation;
- Forms of sexual stimulation involving mild sensory deprivation or sensory confusion (similar to that experienced on some amusement park rides) and/or the use of restraints, e.g., bondage, use of blindfolds;
- Role-playing of fantasy sexual scenarios, e.g., doctor-patient roles, abduction fantasies. The roles usually incorporate a dominant/subordinate theme, often mirroring roles commonly found in life such as teacher-student and boss-worker;
- Use of certain preferred objects and materials as sexual enhancers, e.g., leather, latex, stiletto heels;
- Other unusual sexual objects or practices often classified as a fetish, e.g., fixation with feet.

BDSM sexual activities share certain characteristics. First, they are statistically non-normative,

that is, they seem unusual to those who do not share BDSM proclivities. Second, during a sexual experience, called a scene, the roles appear very polarized (top/bottom, dominant/submissive). Third, BDSM players experiment with physical stimuli and emotions- like fear, humiliation, or pain- that have a paradoxical relationship to the pleasure of sex. BDSM activities are the extreme sports of sexuality. These sexual activities share much in common with activities like Iron Man competitions, a penchant for sky-diving, and a love of horror movies. The combination of pleasure with negative sensations is the hallmark of BDSM. It is the source of what is often called a “peak experience,” which many believe are an essential quest of humans once basic needs have been met. Peak experiences can be experienced as spiritual, revelatory and healing. A woman with a sexual abuse history, who role plays a little girl with a partner who is sensitive and attentive to her history, may enact a BDSM scene and may achieve intense sexual satisfaction, a sense of spiritual connection, and a healing of childhood wounds all at the same time. In fact, Kleinplatz (2006) has called BDSM practitioners “extraordinary lovers” who can teach the rest of us a great deal about romance, creativity, sexual bonding and healing, as well as about keeping sex vibrant and authentic in long term relationships.

The “kink community” is a loose network of advocacy and support groups, spaces and events. The internet has allowed people interested in BDSM to find each other and, over time, to create a network of real-world social organizations, to sponsor events and to organize political and advocacy groups. The social networking site Fetlife.com, similar to Facebook as a social networking site, began in 2008 and as of this writing two years later boasts half a million members. Leaders within the community have promulgated guidelines for what is considered acceptable BDSM practices. The motto of the community is “Safe, Sane, Consensual” (Wiseman, 1996). Kinky activities quite

specifically do not include, for example, rape or sexual contact with children. The intent is for all participants to be consenting adults who are fully informed and to avoid activities that might pose a medical or mental danger. Most community leaders frown upon the use of alcohol or recreational drugs by participants in BDSM activities.

Imposing unwanted danger, trauma or injury is as unrelated to BDSM as rape is to intercourse. Nevertheless, the current Diagnostic and Statisti-

The motto of the BDSM community is “Safe, Sane, Consensual.”

cal Manual, the DSM IV APA, 2000), classifies Fetishism, Fetishistic Transvestitism, and Sado-masochism as mental illnesses with such loose criterion for inclusion that people can be, and are, deemed mentally ill because their behavior upsets a spouse. And this has consequences. People who practice BDSM have lost jobs, housing, and custody of their children based on the testimony of psychiatric experts pathologizing their sexual practices (Klein & Moser, 2006; Wright, 2006). BDSM clients report feeling abused at the hands of mental health professionals (Hoff & Sprott, 2009), and some are arrested for BDSM behaviors despite the clear consensual nature of their decision to participate in BDSM behaviors (White, 2006). Classifying behaviors as psychiatric diseases provides a psychological justification for oppressive discrimination. Thus professional views of BDSM are deeply important not only to our clients but to society as a whole.

Both Moser and Kleinplatz (2005) and the National Coalition for Sexual Freedom (NCSF) White Paper on the DSM Revision (2010) provide comprehensive reviews of the scientific literature on BDSM. This literature clearly refutes most of the DSM-IV statements about paraphilias by exposing the lack of evidence for the APA's

assertions. It is beyond the scope of this paper to expand on these arguments; interested readers are urged to read the above sources for a full perspective of the controversy. The proposed DSM-V revisions of the paraphilia section, which can be found at www.dsm5.org, reflect a major shift in the diagnosis, a shift that has been praised, as well as condemned for not going far enough (Moser, 2010). The DSM-5 proposal clearly distinguishes between a paraphilic interest and a paraphilic disorder. It stipulates that BDSM activities are not pathological unless they cause distress or harm to self or others. Critics of this revision, like Moser and Kleinplatz (2005), point out the similarity between the “distress” criteria and the old category of ego-dystonic homosexuality that was removed from the DSM. Both ignore the likelihood that the “distress” of the paraphilia is socially caused, like the “distress” of homosexuality. According to these authors, the diagnoses still reflect socially negative attitudes toward an oppressed minority, and reinforce that oppression.

What the Data Tell Us

The image of a person diagnosed with a paraphilic disorder as portrayed by the DSM and most psychiatry texts is that of a socially isolated person at a low functioning job, with an impaired ability to sustain intimate relationships and a high likelihood of depression, anxiety and personality disorder. This person is usually assumed to be male. His sexuality is supposedly narrowly focused on a particular fetish or behavior; he is compelled to engage in this behavior, and he is driven to escalate his sexual activity to more intense levels. He ultimately progresses from consensual to nonconsensual acts (APA, 2000). Paradoxically, although his sexual focus is narrow, he is also more likely to engage in multiple paraphilic behaviors including pedophilia. His impulse control is impaired and he is likely to engage in “frequent, unprotected sex.... [that includes] infection with, or transmission of, a sexually transmitted disease ... [and that incurs] injuries ranging in extent from minor to

life threatening” (APA, 2000, p. 567).

Shockingly, there is no scientific evidence beyond “clinical observation” to support this portrait (Moser, 2001; Weinberg, 2006). To the contrary, the few studies that actually include adults who engage in BDSM practices show results in direct contradiction to this stereotype. First, BDSM practices are not as rare as previously thought and are found among women at rates close to those for males. Janus & Janus (1993), in a national study of 2800 respondents to a lengthy questionnaire asking about sexual practices, found that about 12% of male and female respondents had engaged in some BDSM behavior. Moser & Kleinplatz (2006), reviewing multiple studies that attempted surveys of BDSM, estimate that about 10% of adult have participated in these practices. Richters et al. (2008) in the only population-based prevalence study to date found that about 2% of respondents, male and female, had engaged in BDSM activities in the twelve months prior to the survey, greater than the percent who declared their identity to be gay. Both Cross and Matheson (2006) and Weinberg (2006) conclude that SM practitioners have the same rates of mental illness and the same degree of psychological adjustment as non-practitioners. And Richters et al. (2008), who included mental health measures in their survey, found identical rates of pathology in the BDSM compared to non-BDSM sample, but a more diverse range of sexual activities in the BDSM practitioners. They concluded, “Our findings support the idea that BDSM is simply a sexual interest attractive to a minority, not a pathological symptom of past abuse or difficulty with ‘normal’ sex.” (p. 1660)

Countertransference: If it is Not Sick, Why Does it Seem so Weird?

For many clinicians, negative countertransference is the greatest impediment to working with kinky clients. Despite the research findings, a few of us find it difficult to see BDSM as ‘normal’ because

some of the sexual behaviors seem strange, frightening, and inexplicable to an outsider. Because of the difficulty in imagining how a particular activity can be genuinely pleasurable, the tendency is to judge its appeal as “sick.” It is therefore helpful for therapists to try to gain a personal understanding of the appeal of BDSM. Many people can find something in their own personal experience that helps them understand BDSM practices. Those who have ever had sex someplace where it isn’t “supposed” to take place – the in-laws’ bathroom or the kitchen table – or fantasized having sex with someone “off limits” will understand the appeal of transgressive sex. People who have liked “dirty talk” during sex may understand how erotic a little

Because of the difficulty in imagining how a particular activity can be genuinely pleasurable, the tendency is to judge its appeal as “sick.”

bit of humiliation can be. Those who have experienced a hickey as erotic, enjoyed a love bite or love scratch, or liked having their hair pulled have a glimpse of dominance and submission, sensory distortion, and sado-masochism. Discovering that corsets, silk undergarments, or thongs are a turn-on is similar to the erotic pull of a fetish. Even if none of these experiences appeal to you, consider other activities where positive affect seems, at first blush, counterintuitive: horror movies, amusement park rides, extreme sports, car racing, zip gliding, boxing. These common experiences illustrate the fact that pleasure can come from many seemingly contradictory sources.

In working with people in the kink community, it is helpful to try to extend one’s own experiences to find common ground. But sometimes this is difficult; there are times when a certain activity seems bizarre or repugnant, and it might be hard to not pathologize those who participate. People in

the BDSM community have a word for this: it is called being “squicked.” “Squicked” is an invented word meant to connote an uncontrollable physical revulsion that includes no moral judgment. If you are strongly turned off to an activity and therefore decide that those who participate are “sick,” you are exhibiting judgment. But if you are squicked, you may feel repulsed, but remain non-judgmental. When members of the BDSM community face this visceral reaction they assume it might come from ignorance, or be a reaction formation to their own arousal, or simply express an idiosyncratic distaste. When a clinician is squicked, it is neither cause for alarm nor a reason to judge the client, but rather an opportunity to examine our own countertransference feelings, perhaps with a colleague or supervisor sensitive to BDSM issues. Clinicians who are troubled by their own reactions may also benefit from more information, such as one of the excellent books explaining and describing BDSM practices (Califa, 2001; Morpheus, 2008; Thompson, 1992; Wiseman, 1996).

Sometimes, understanding how a practice produces pleasurable sensations helps quell the squicked feeling. Steel nipple clamps can look frightening. But they make more sense when one understands that, once the clamps are removed, the nipple is left exquisitely sensitive. Spanking and flogging make sense as well in the context of the physiological phenomena induced by extremes of sensation. The flow of blood to the surface of the skin, the rush of endorphins and other chemicals create an experience known to BDSM practitioners as “sub space” (i.e., a psychological submissive space) – an experience often described as an out of body altered state like flying or floating weightless. This experience – which some people interpret as spiritual (Thompson, 1992) – can be deeply fulfilling on levels beyond sexual.

Another common barrier to understanding BDSM is the perceived need to explain the origin of the behavior. “*Why* would someone want to (fill in the blank: be a bottom, flog their partner, get

tied up, etc)?” The question itself is a subtle way of pathologizing behavior. Just as people want to know the origins of homosexuality, but do not question how heterosexuality develops, we often assume a psychodynamic reason for nonstandard sexual practices. Therapists want to know why someone likes spankings, but not why they like oral sex. Therapists question why a man would want to urinate on a partner’s body, but not why he wants to ejaculate on her. Before pursuing psychodynamic explanations for unusual sexual behavior, a therapist might ask herself whether she would do the same for more mundane sexuality.

How to Tell When a Behavior Really is Problematic

Therapists sometimes encounter cases where sexual behaviors really are problematic and/or pathological. Some of these situations are easy to discern, like rape or child sexual abuse. Other behaviors, however, require contextual assessment: when does someone have a sex addiction and when are they merely very sexual beings? Sexual issues, like other socially charged concerns (How much drinking is too much? When is child corporal punishment of a form of abuse?) evades simple agreement, even among experts. This problem may arise more often for clinicians relatively less experienced in working with BDSM practitioners. The clinician may not automatically know if a behavior is safe or sane, two of the three criteria for appropriate BDSM activity. Many of us harbor unconscious biases regarding sexual risks as compared to other more common risks. We often tend to accept common risks more than uncommon ones, for example, the risk of allowing a child to play football.

Most clinicians, at least those who have training in domestic violence, will have more ability to assess the third component, consensuality. One of its key aspects is mutual enjoyment. The difference between a violent sexual sadist and a sadist in the BDSM community is that the former

has no interest in the needs or well-being of their partner, while sadists in the BDSM world usually pride themselves on how well they take care of their “bottoms.” Mutually arousing and agreed upon sexual activities are consensual. Non-consensual BDSM relationships are a particular form of partner/spousal abuse, and this abuse is marked by the lack of pleasure and the presence of real fear on the part of the submissive partner, a fear that is not confined to the sexual encounter, but pervades the relationship. When consensuality is not obvious, the therapist can assess the couple for domestic violence. It is also important to recognize that domestic abuse can also occur towards the more dominant partner, from the one who is more submissive. The therapist should interview the partners separately to assess safety and look for non-sexual violence, and evidence of rage and/or contempt for his or her partner. The therapist can assess for signs of fear and intimidation, incidence of non-sexual abuse, and a sense of being trapped in the relationship.

Resources and Suggestions for Working with BDSM Clients

As therapists begin to work with clients practicing BDSM, they may be comfortable having an affirmative stance, but not yet ready for complex cases. There are numerous resources available for therapists wanting to develop a more kink-friendly practice. Communities often have local resources that may not be well-known, including colleagues with experience working with the BDSM community who are available for supervision. A national listing of providers is available through KAP (Kink Aware Professionals), a referral directory listed on the NCSFreedom.org website. Additionally, clinicians who desire more training in how to better serve BDSM clients can contact CARAS (Community-Academic Consortium for Research on Alternative Sexualities) and can view their DVD on clinical “do’s and don’t’s” as a way to begin. CARAS also provides special programs given through sex therapy organizations like the

American Association of Sex Educators, Counselors, and Therapists (AASECT: www.aasect.org).

The belief that BDSM behavior automatically needs to be assessed for clinical significance is itself a biased belief. Ironically, a therapist might best display sensitivity by not bringing BDSM into the therapy when it is not warranted. In general, it is unwarranted unless the client brings it up as a problem. Hoff and Sprott (2009), in a study of the therapy experiences of members of the BDSM community, found that many people were critical of therapist who they perceived to be “voyeurs,” because they kept inquiring about sex when it was not part of the presenting problem. Positive BDSM experiences can however be highlighted for couples where they exemplify connection and collaborative communication.

Occasionally BDSM practitioners come into therapy needing assistance with advocacy. BDSM activities are still pathologized and misunderstood, and in some parts of the country BDSM sexual play is viewed as spousal abuse. The partner of a spouse with visible minimal bruises may be automatically arrested and charged with assault, even if both partners maintain that the sexual activity that produced these bruises was consensual. There are occasions when child welfare organizations remove children from the home of the parents because of BDSM activities, or when such activities are used in divorce suits to challenge custody or visitation. A therapist can play an important role in these situations by being willing to give affidavits or court testimony in support of the couple and in defense of their sexual preferences.

Individual therapists may also encounter clients who have internalized societal stigmatization of BDSM, who express self-hatred and may even ask to be cured. Hearing a therapist officially state that their sexual behavior is not an illness can be an incredibly powerful experience. Encouraging such clients to view their self-hatred

as socially induced may liberate them to accept their own sexual behaviors. Finally, some therapists refuse to help clients rid themselves of their paraphilia, believing that, like homosexuality, it is nearly impossible to extinguish strong, specific sexual desires.

By far the most common problem a couple and family therapist will encounter when working with BDSM clients is marital discord following the revelation that one partner is kinky. Just as, for example, some gay men still repudiate their own sexuality and mask their orientation behind a heterosexual family, many people with a kinky orientation do the same. These clients hide their sexual preferences from their spouse and may or may not practice them in secret. Sometimes they are “found out,” and sometimes they themselves come to abhor the deception inherent in their double lives and desire a fuller and more honest expression of their sexuality. The traditional treatment for these couples has been to label the BDSM partner’s behavior as pathological, both as a paraphilia and as infidelity. Attempts are made to cure the transgressing partner of his or her desires, or at least to convince him or her to suppress them. Sometimes the BDSM partner enthusiastically endorses this approach, internalizing the view that the behavior is “sick.”

A different approach is, first, to separate out the issue of fidelity and of sexual preference, and, second, to normalize the sexual behavior of the BDSM partner and frame the situation as a (possible) mismatch of sexual scripts. Of course, if the BDSM partner has engaged in secret activities, many of the issues of betrayal and mistrust are the same as those encountered when one partner has had an affair. But there is an important difference. The BDSM partner is more like a gay man who has spent a lifetime avoiding his sexual orientation than he is like a cheating spouse. Even if the partner forgives the infidelity, it will not be very effective to simply dismiss the BDSM sexual preferences. The partner who feels betrayed has

far more to deal with than the partner of someone who has had an affair. He or she must not only cope with the pain and shock of infidelity, but also confront the reality that, as partners, they have sexual differences that may not be resolvable. The partner of the BDSM-oriented individual has been deceived on a much deeper level; one partner has concealed fundamental parts of his or her identity, not just sexual behavior, even if the deception has been wholly a by-product of the lack of readiness to cope with ego-dystonic sexual desires. The couple faces a number of threats to their integrity, and the therapist must shepherd the relationship through what will certainly be a profound transformation. However, it is not usually necessary to deconstruct the relationship to understand what “caused” the sexual straying. Many couples in this situation have admirably intact relationships in other respects, and the revelation of the BDSM partner’s secret life probably has more to do with chance rather than with relationship dynamics. Working with these couples can be deeply rewarding, as couples can become more creative in finding common sexual interests. If the romantic or sexual component cannot be salvaged, these marriages can successfully transform into close and affectionate friendships.

Clinical Vignette

Michael, a man in his mid-thirties who had been married for ten years to a woman he adored, consulted me in great distress about what he initially presented as a problem with erectile dysfunction. Within the first session it became clear that his erectile difficulties were related to his suppression of his intense desires to be placed in bondage. While he enjoyed more common forms of sex (which he called “vanilla sex,” as many members of the BDSM community do), his secret unfulfilled wish to be a “bondage bottom” gradually dominated his thoughts, disrupting his ability to function sexually with his wife. Michael had never revealed his interests to Judy because he was sure they would repel her.

When Judy was brought into the sessions, she did initially react with confusion, shock, and a sense of being betrayed. The psycho-education I provided helped her accept the idea that Michael was not “sick.” While metaphorically comparing Michael’s situation to one of a closeted gay man helped her feel less personally betrayed, she still felt some repugnance for the sexual behaviors he desired. However, the two partners had an extremely strong bond, a great deal of quality intimacy, and both were strongly motivated to work through this problem. Through some individual sessions that included the use of EMDR to help Judy resolve her own childhood abuse issues, Judy lost the sense of distaste she had about Michael’s sexual interests. She became curious and open to experimentation, and together the partners enacted some of Michael’s fantasies. To her surprise, Judy found that she was not only able to tolerate being a “bondage top” – putting Michael in restraints and controlling his behavior in a sexual situation – she discovered that this role produced a powerful sexual high for her as well. Several years later, they still periodically update me. The two continue to enjoy this sexual behavior and have connected with others in the kink community by participating in BDSM events.

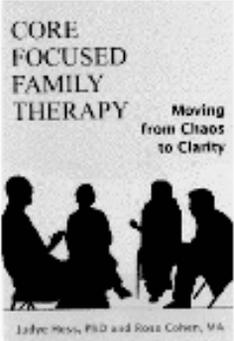
Not all such situations have such happy resolutions. Some couples with discordant sexual preferences do not find a satisfying agreement and choose to part. But even when the outcome of therapy is divorce or separation, much can be accomplished. The therapist can help the BDSM partner rid him or her self of shame and can keep the non-kinky partner from personalizing and blaming him or herself for the partner’s sexuality. Child custody and visitation issues can be prevented from becoming enmeshed with the partner’s sexual behavior. In some future world, we may all understand and accept our diverse sexualities at an earlier age, before we enter serious, committed relationships. But in this world, a couple and family therapist can help prevent an unfortunate situation created by stigmatization of non-normative sexuality from becoming a tragedy that destroys both partners in a relationship.

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Families in Transition: Supporting Families of Transgender Youth

Melissa MacNish, LMHC and Marissa Gold-Peifer, Psy.D.

Abstract

This article explores themes and clinical implications for supporting families following the disclosure of a youth's transgender identity and subsequent desire to transition. The four themes – construction of meaning, support, flexibility and stability, and sensitive communication – are used to guide clinicians as they attempt to stabilize the family system after a child's disclosure. These themes have been derived from a qualitative dissertation study conducted by Gold (2008). The clinical implications suggested are drawn from both authors' work as therapists for families of transgender youth, facilitators of a parent support group¹, and parent liaisons for a camp for transgender youth.

Gender is a core construct around which families explicitly and implicitly organize. As a result, the impact of a family member expressing a desire to change gender presentation is not limited to the individual, but extends to the family system as well (Hill et. al, 2010; Lev, 2004). A shift in a family member's gender identity can have a wide-ranging impact on roles in the family, internal cognitive schemas, and family traditions and rituals.

According to the American Psychiatric Association (APA; DSM-IV-TR), Gender Identity Disorder (GID) is the current diagnosis for individuals who exhibit behaviors consistent with cross-gender identification and who experience “discomfort with one's sex or gender role” (APA, 2000, p. 871). The inclusion of GID in the DSM has stirred considerable controversy centering on a number of issues, one being that the diagnosis pathologizes gender “nonconformity” (Gainor et. al, 2000; Hill et. al, 2005; Lev, 2005; Schwartz & Barber, 2010; Spack, 2009). The authors of this article do not view gender nonconformity as pathological. Clinical work with this population is approached as collaborative, helping guide families along their journey of self-exploration.

Gender “nonconforming” behavior may first be expressed and recognized by caretakers as early as two years old (Brill, 2008; Ehrensaft, 2009; Pleak, 2009; Vanderburgh, 2008). However, this is not to say that all children who present this way in childhood will go on to identify as transgender later (Cohen-Kettenis & Pfafflin, 2003; Ehrensaft, 2009; Pleak, 2009). While there is an emerging body of literature and awareness about the experience of being transgender, this topic remains vastly underrepresented in clinical training (Carroll & Gilroy, 2002; Ehrbar et. al, 2008; Gainor et. al, 2000; Pleak, 2009). This body of literature includes family adjustment stage models, as well as models of transgender identity development (Devor, 2004; Emerson and Rosenfeld, 1996; Lev, 2004). Although each individual and family is unique, these stage models can provide a useful framework for understanding the experience of transgender individuals of different ages and their families (Saeger, 2006). While the scope of this article does not allow for an exploration of the models, it is important for clinicians to be aware of them in working with this population.

Many families disconnect during the coming out process for gays, lesbians, bisexuals, and transgender individuals. Others are able to grow and even flourish from this experience, often

¹ The parent support group was co-sponsored by Greater Boston PFLAG (Parents, Families, and Friends of Lesbians and Gays) and the Sidney Borum Junior Health Center.

in ways they did not consider possible (Gold, 2008). This article explores how clinicians can foster connection in families. For purpose of this article, youth are defined as ages 15-23 as this is the age range of the people with whom the authors worked. Therapy with families whose children remain home and with families whose children have left home presents different challenges. The term transgender will be used as an umbrella term for variations of gender identities that deviate from the expected gender presentation at birth and the roles a family and society hold for those expectations. For the purpose of this article, the term transition is used to mean any significant changes in gender expression causing turmoil in the family. This could range from a change in dress, to the request to be called a different name, the use of different pronouns, and/or the desire for medical intervention such as hormone or surgical treatment.

This article is organized by a discussion of each individual theme derived from Gold's (2008) qualitative dissertation study, followed by a discussion of the clinical implications. As with any family, when a family presents with concerns surrounding their child's gender, the initial focus of treatment is assessment (Hill et. al, 2010; Vanderburgh, 2008). The family structure should be analyzed and other possible forms of psychopathology ruled out as primary explanations for gender differences or comorbid dysfunction (Israel & Tarver, 1997).

Construction of Meaning

For some parents, a disclosure of transgender identity comes as a surprise, while for others there has been an existing awareness that their child may be gay, lesbian, bisexual, or transgender. Frequently parents experience a sense of urgency to create a new understanding of their child's identity, as well as their own identity as the family of a transgender person. This is fueled by the fact that youth have often engaged in internal processing of their gender identity for quite awhile prior to disclosure and are

further along in the process of transitioning. This gap, between the youth's and other family members' understanding, can increase the pressure to find a way of making sense of this experience and integrating the new information. Parents may be left feeling that their child is strides ahead of them in the process of making meaning and/or even in moving forward toward transition.

The way family members make meaning has an important impact on the adjustment process. One of the ways parents integrate their experience is by attempting to locate an etiology. Some of the information available on etiology of gender "nonconformity" points to parental pathology (Ehrensaft, 2007; Emerson & Rosenfeld, 1996). It is important that clinicians be aware of this and steer parents away from making meaning based on blame (Hill et. al, 2010). Research on family resilience supports the notion that the assignment of blame to oneself or one's children can hinder adjustment to a stressor (Walsh, 2003). When parents recognize that no one is to blame for the youth's gender identity, their abilities to cope and adjust are supported.

The authors of this article have often observed that caretakers make sense through the process of developing *narrative coherence*, the integration of past and present experiences in a way that allows for a sense of continuity (Beeler & DiProva, 1999). In the experience of a family with a transgender youth, this integration develops as parents begin to see the youth's earlier behavior and/or distress in light of this new information. For many parents, this new information is helpful in the process of adjustment. Moreover, many youth show improvement in overall functioning and emotional well-being after disclosure and, for some, as they continue with a transition process (Ehrensaft, 2009; Gold, 2008). In many cases, the authors of this article have seen that individuals' increased levels of general functioning as they are allowed to express their gender identity more freely contributes to the parental acceptance.

Clinical Implications

When first working with families after the initial disclosure of a youth's transgender identity, it is crucial to set up agreements identifying how to keep the therapeutic space safe for all family members. These agreements are necessary because each family member will likely be at a different place in their acceptance/tolerance of this issue. The therapist must balance holding multiple alliances while always monitoring respectful communication between members. It is also important to assess each family's understanding of gender and gender stereotypes from their cultural perspective.

Therapists must have an understanding of the distinctions between biological sex, gender expression, gender identity, and sexual orientation.

Therapists must have an understanding of the distinctions between biological sex, gender expression, gender identity, and sexual orientation (Devor, 1993; Ehrensaft, 2009; Lev, 2004). Psychoeducation and experiential exploration of the fluidity of these dimensions, as well as the fundamental differences between experiences of gender identity ('who one is') versus sexual orientation ('who one is physically attracted to'), is essential for clients, parents, and other family members. A useful intervention is to visually create the dimensions and encourage individuals to map themselves within each dimension according to their understanding of the term in general, their own positions, and the position of the transgender youth. The mapping may correspond to the present time, a time in the past, or a future time. This helps to experientially convey the fluidity among the dimensions and also across time.

While families are trying to make sense of this issue, there may be a discrepancy between members as to what people understand about gender

and the transgender experience. Family members may find it helpful to research the topics outside of sessions. Therapists should assess family members' receptivity and provide appropriate resources (Vanderburgh, 2008).

One intervention the authors of this article have found extremely useful for bridging the gap between a youth's understanding of his or her gender identity and the family's view is the *gender timeline*. First, without the family present, the youth is encouraged to make a timeline starting from birth to the present including any memories related to gender. Providing the youth with time to identify the first salient gender-related memory is often useful. From that point, the individual can be asked to construct a timeline on large paper according to the time increments he or she feels are meaningful. For example, some individuals have very early memories that have persisted across many years and find it most useful to break down the timeline year by year. For others, it may be more useful to break down the timeline according to developmental stages. This timeline can then be explored further with the therapist and, once the youth is comfortable, it can be presented to the family. This often provides the family with a better understanding of the progression of the youth's experience of his or her own gender identity. The clinician can then invite the family to add their own memories, experiences, and questions, allowing for integration of a more cohesive collective family narrative. This collaborative intervention serves to enhance all family members' understanding of the gender narrative and may provide the youth with a sense of being more deeply understood.

Support

Research on family resilience consistently supports the idea that families who seek and obtain social support demonstrate greater resilience in the face of stressors (Simon et al., 2005). Adjustment to the disclosure of a transgender identity is

no exception. Families who are able to reach out, locate, and make use of support systems frequently describe great relief in discovering others who are struggling with a similar experience (Gold, 2008). Parents further describe how helpful it is to have their thoughts, feelings, and concerns normalized and validated.

This support and connection is especially important in relation to gender identity/expression because the stigma that surrounds gender variance in this culture can create a sense of isolation for family members. While there have been advances in the understanding and acceptance of variance from cultural gender norms in recent years, our society is still anchored in a dichotomous view of gender (Ehrensaft, 2007). The stigma of being transgender often prevents individuals from seeking out and obtaining needed social support. Parents often describe their own dilemmas about how to “come out,” worrying about to whom it is safe to disclose their child’s identity. When local or face-to-face support is not available, social supports on the internet provide anonymity and allow for access to information and support from family members of transgender youth (Carroll & Gilroy, 2002; Gold, 2008).

Clinical Implications

Family therapy perspectives and systemic thinking are especially salient when working with families with transgender youth because a gender transition will have implications for many relationships within many systems in ways that are different from disclosure of other secrets such as sexual identities. Families, and thus their friends, must relate to the transgender person in a much different way. The use of a sociogram in a family therapy session may help assess support and guide planful disclosures within those systems (cf. Imber Black, 1998 for ideas on helping families disclose secrets in general). Visually creating a diagram with the family can help them collaborate and conceptualize the people in their lives to whom and when

disclosure is necessary. An initial task for the family is to identify those supports they predict may be more understanding and begin disclosure with them. Role playing with clients and working collaboratively around the disclosure process can not only help reduce the fear and anxiety associated with disclosing secrets, but also provides an opportunity to strengthen the family as they discuss these actions together.

When family members feel more comfortable about the youth’s gender identity, disclosures will proceed more smoothly. Families must consider the multiple systems within which their lives intersect, such as neighborhood, community, school system, and religious community, when making determinations about disclosure. For example, navigating school systems can be quite difficult for adolescents and their parents (Hill et al., 2010; Pleak, 2009). Unfortunately, it is common for transgender youth to encounter stigma, including harassment in school (Toomey et al., 2010). Families should be prepared for negative and even hostile reactions (Vanderburgh, 2008). One concrete way to prepare for adverse reactions is by the creation of a “safe folder” as suggested by Trans Youth Family Allies (TYFA, 2010). A safe folder consists of documents from individuals such as healthcare providers, family friends, or religious leaders that detail and support the youth’s gender identity and the family’s stability.

Clinicians working with this population should become familiar with safe spaces in the community such as support groups or drop-in centers and refer families and youth when appropriate. These safe spaces can be especially important given the stigma around gender variation (Stone Fish & Harvey, 2005). Support groups for parents, whether virtual or in person, can offer needed connection where parents do not have to censor their feelings from their child. PFLAG (Parents, Families, and Friends of Lesbians and Gays) meetings serve this purpose for some families.

Because there are unique issues in having a transgender child that differ from a child's disclosing an alternative sexual orientation, it became clear to the authors of this article that there was a need for a support group specific for parents with adolescent/young adult children who identified as transgender in the Boston area. The authors partnered with Greater Boston PFLAG to start such a group. This group has been in existence for over two years and it keeps growing to include more parents of younger and older children alike. It is amazing to witness parents who are struggling come into a group for the first time and meet other parents who are further along in the process of acceptance. These parents offer support and hope, and form strong connections, while modeling a path to regaining stability and normalcy.

The authors of this article have also witnessed the power of a supportive environment for transgender and gender nonconforming youth and their families through serving on the board of directors and acting as parent liaisons for Camp Aranu'tiq², a week long summer camp for transgender/gender nonconforming youth ages 8 to 15. The camp's inaugural summer in 2010 highlighted the profound value even a week of support and acceptance can have for youth and their families. Many of the youth described feeling safe, understood, and proud of who they are for the first time in their lives. The authors observed, and others reported, improvements in self-esteem, family acceptance, and peer relationships. The campers were also able to discover other aspects of themselves, and were able to explore and exercise their capacities for leadership.

This camp provided parents an opportunity to meet as a group when they dropped their children off. Parents and caretakers from all different parts of the country were present, and for some it was their first opportunity to meet other parents of transgender youth. Watching these family members nod their heads in understanding and relief

that they had found others in similar situations was extremely powerful to witness. However, the most profound moments were when parents and caretakers reunited with their children after the children had been allowed to have a week to be their authentic selves. Watching the reactions of amazement that their children fit in, made friends, and, in some cases, even performed in the talent show, solidified for us the power of a supportive environment. Many of these families and youth have remained in contact and continue to support each other.

Flexibility and Stability

A balance between flexibility and stability is often demonstrated by families who are moving towards acceptance of their children's transgender identity. Flexibility is critical for family coping as it enhances the family's ability to more readily develop a new sense of normalcy (Patterson, 2002). Flexibility within a family facilitates movement toward a new homeostasis after the disclosure and throughout the transition process. While flexibility and the capacity for change are critically important, it is equally important that flexibility be balanced with consistency and stability. Those families that have been able to adjust more readily to the adolescent's gender identity often report that they have established family routines, traditions, and rituals that have continued in the face of the family stressor. At times, families may need to re-work routines, traditions, or rituals according to the new information about their child's gender identity. This continued stability often provides a sense of safety for the family and serves as a foundation from which the family is able to engage in the work necessary to adjust to this experience.

Similar to the need for balance between flexibility and consistency is the need for balance between cohesion and individuality within the family unit. The literature on family resilience and coping suggests that it is important for family members to allow space for a range of emotions in dealing with a crisis (Walsh, 2003). This is evident in the responses of parents in Gold's study (2008)

2 For more information on this camp see www.camparanutiq.org

and in the clinical experience of the authors of this article. Many parents talk about the need for and value of having a space where they feel permission to express a range of emotions. Parents who are partnered speak of the importance of allowing their partners to be in a different place in their process of acceptance. Conflict often results when there is not an understanding that family members may experience different feelings at different times and in different ways.

Clinical Implications

Most importantly, therapists who work with transgender youth and their families must be flexible in their thinking, in practice, and their professional roles. For example, clinicians may take on the role of advocate for the families and youth with whom they work. Clinicians may become advocates for transgender individuals within schools, communities, and even political systems, yet must balance this with helping youth and families to advocate for themselves.

Clinicians working with families and transgender youth must also be flexible in their consideration and implementation of interventions. One example of a powerful, yet nontraditional, intervention is to connect them with other families of transgender youth, after receiving permission from all parties (Vanderburgh, 2008). This can be especially helpful to those families experiencing isolation. In addition, putting families in touch with transgender mentors they trust in the community may be useful. Seeing transgender adults who are living rich and authentic lives can help families envision the possibility of normalcy.

Clinical attention should be paid to how a change in gender identity and gender roles will affect the family system and relationships within the family (Cooper, 2009). Creating space for the exploration of these different and changing relationships is important. One useful intervention involves working with different subgroups in the family in order to strengthen those relationships

that are experiencing greater difficulty. Some but not all existing conflicts between parents, siblings, or other family subgroups may be explored in the presence of the transgender youth. Meeting with individual family members to assess their unique experiences is another important intervention (LaSala, 2010).

While a family may need to change in many ways following the disclosure of transgender identity, it is also important that at least some family traditions or rituals are continued in order to provide a greater sense of homeostasis and stability during the adjustment period (Gold, 2008). Clinicians are encouraged to inquire about past and present family traditions or rituals, and to help create them when they have not been central to family life. Family therapy provides an instrumental forum to think through and renegotiate any family rituals or traditions that are specific to gender. Examples of family rituals that may be related to gender range from daily tasks, such as meal preparation and yard work, to annual family traditions, such as male only basketball games before holiday meals. Clinicians can provide “homework” assignments to help upset and realign these rituals. While traditions and rituals aim to create a sense of belonging, they may lead to a sense of alienation if not renegotiated sensitively and carefully, including those traditions with extended family members. Helping a family to identify, create, renegotiate, or reengage in ritual and tradition will help provide a sense of stability as families adjust following disclosure.

Sensitive Communication

There is a unique challenge inherent in communication around changes in gender identity. Often, parents and family members are faced with adjusting their use of pronouns and names, and use of terms such as son/daughter and brother/sister. A change in the youth’s name can be particularly difficult for parents, especially if the birth name was chosen because it had special meaning. The change in language is often an emotional one

and requires a significant cognitive shift that takes effort and time to achieve. Those families who are more readily able to adjust to this experience and maintain connection often describe the considerable effort they made and continue to exert to use language consistent with the youth's preferred pronoun and name. The authors have witnessed that it is often very helpful for parents to identify the difficulty and to anticipate the inevitable mistakes they will make when it comes to language around gender. It is also important that youth be allowed and encouraged to articulate how it can be painful and/or embarrassing when a parent misuses a pronoun or given name. For example, a youth's transgender identity may be inadvertently disclosed by parents if they use "son" or "daughter" incorrectly in a social situation. A great deal of respect and support is conveyed to youth when parents and family members demonstrate sensitivity to communication and language.

Therapists must have an understanding of the distinctions between biological sex, gender expression, gender identity, and sexual orientation.

Sensitive communication has a bidirectional impact on the family adjustment process. The youth's sensitive communication is particularly important during the disclosure process. Related research on the disclosure of gay, lesbian, and bisexual orientation suggests that the response to the disclosure can be mediated by the manner in which it is disclosed (Beeler & DiProva, 1999; LaSala, 2010). For example, finding out about an adolescent's sexual orientation by unexpectedly seeing him or her with a same-sex partner may be received more negatively than a youth's coming out in a more planned and verbal way. The authors of this article have found this is similar for the disclosure of a transgender identity. Especially for families who have not had a pre-existing awareness of their

child's gender difference, sensitivity about communication on behalf of the youth when disclosing to their parents can be an initial step in the ability of families to adjust in a more resilient way. It also demonstrates maturity on the part of the youth.

Clinical Implications

Given the importance of sensitive communication in the adjustment process, assessing how youth disclosed their identities to each member of the family is often useful. Understanding more about the disclosures and family members' responses may provide valuable information on future family interactions. Feelings about how the disclosure was made may need to be processed further.

The therapeutic space often serves as a place for family members to explore implications of language and to practice using new language without judgment. Probably one of the greatest challenges for therapists is holding sensitive communication within the space. Making agreements at the beginning of therapy for how to keep the space safe reinforces respect for everyone. It should also be made explicit that there will likely be mistakes given the difficulty inherent in changing language. The more each family member is able to practice, especially in the safety of the therapy space, the more comfortable the family will feel, and the youth will feel increasingly seen.

Conclusion

This article explored four themes—constructing meaning, support, flexibility and stability, and sensitive communication—related to the family adjustment process following a youth's disclosure of transgender identity. The authors of this article have found these themes to be helpful guides in clinical work with families of transgender youth after initial disclosure and throughout family therapy. Clinical implications pertaining to each theme were also provided.

Parents have conveyed that the process of adjustment is indeed a process that takes time. Consistent with stage models, acceptance of the transgender

identity does not mean that there are no remaining areas of difficulty, rather that there has been movement away from isolation and shame toward more integration of the adolescent's identity into the family and broader family community (Lev, 2004). Families are able to move to a place of acceptance and even become activists for change in their community. This is captured by Brill and Pepper (2008) in the following statement: "There is a natural overflow into your daily life when you realize that there is nothing wrong with your child. If the problem lies with the system, then you work to change the system that discriminates against your child" (p. 59). Many families, some of whom even doubted their ability to ever accept their children's transgender identities, are now combating discrimination and fighting for the rights of their youth and all transgender individuals.

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Discussing Sexuality in the Context of Family Therapy: A Teaching Tool

Mary S. Green, Ph.D., LMFT and Margaret M. Reed, M.S.

Sexuality is part of being human and, thus, is an inherent part of all family systems. Messages about sexuality are transmitted by families, cultures, and society. They create a legacy that is passed along to children. The term *family sexual legacy* refers to the meanings about sexuality that are transmitted through multiple generations and how these meanings influence the current functioning—sexual and otherwise—of all family members. Parents are accountable for the sexual legacy that they share with their children; however, parents carry the legacy they have inherited, one that often includes misinformation and emotional reactivity. Every parent navigates the topic of sexuality with their children based on the legacy that they received from their own parents, extended family, culture, and other social influences, creating a multigenerational legacy of sexuality. Parents' sexual legacy greatly impacts what they share and pass along to their children when it comes to whether, how, and when they communicate with their children about bodies, identity, gender roles, intimate relationships, and sex. Family therapy is an opportunity for therapists to assess, clarify, and make explicit all messages, including the sexual legacy that parents wish to pass along to their children.

Family therapists are uniquely positioned to negotiate these complexities, yet the family therapy field remains mostly silent about sexuality in clinical consultations with families when children are present. By ignoring sexuality as a concept that affects family functioning, therapists may be missing a key component that influences the families with whom they work. Therapists should be intentional about including sexuality as part of the normal clinical assessment.

A History of Silence

There has been a paucity of research on sexuality within family systems theory although as early as the mid-1980s, nascent discussion was emerging. Maddock (1983) proposed a dialectical method of healthy family sexuality that is systemic in nature and focuses on the process of family sexuality. Hof and Berman (1986) suggested the use of a sexual genogram to explore family sexual history and patterns. Schnarch (1997) incorporated Bowenian theories about anxiety and differentiation into his sex therapy techniques. Perel (2006 and this issue) discussed the influence of family and cultural legacies as erotic blueprints that strongly influence intimate encounters, as illustrated in her work on couples' erotic blueprint. However, all of these theories were developed for work with adults in couples. Discussing messages about sexuality *with the children present* has been a topic largely ignored in the family therapy literature (Harris & Hays, 2008). Iasenza (2010) purported that childhood and adolescent messages about sex, sexual attractions, and sexual behaviors need to be considered in order to expand the functional sexual menu for couples, although the focus of her work remained with the couple, not the family legacy of sexuality and how it impacts children.

The family therapy field as a whole has been hesitant to discuss the clarification of messages about sexuality as an important part of the parenting process, many themes related to sexuality can be discussed in family therapy, such as communication about sexual issues, exchange of affection, physical sensation, grooming behaviors, gender identity and roles, acceptance of partial or full nudity, privacy, and interpersonal closeness,

as well as more complex issues like age of consent and incest (Iasenza, 2010; Maddock, 1983; Perel, 2006). Family therapists can play an important role in initiating these types of conversations and bring particular skills that can facilitate these often challenging conversations.

In order to understand the influence of overt and covert messages about sexuality on individual and family functioning, therapists can assess family sexuality as part of the normal intake and assessment process. Therapists can include questions about sexuality on biopsychosocial intake paperwork, which would help normalize the discussion of sexual matters. Like all potentially difficult topics, such as death, legal issues, and family dynamics, a therapist would use clinical judgment in discussing sexuality in family therapy. With each family, therapists could hypothesize how sexuality might intersect with the family's presenting problem and, when clinically appropriate, assist in exploring these often sensitive intersections.

With each family, therapists could hypothesize how sexuality might intersect with the family's presenting problem and, when clinically appropriate, assist in exploring these often sensitive intersections.

Therapist Discomfort

A postmodern feminist therapy paradigm creates an environment for therapists to be aware of the beliefs, values, and biases they bring to the therapy room (Cheon & Murphy, 2007). An exploration of a therapist's values about sexuality is paramount because his/her gender, religion, and political values might influence his/her work pertaining to sexual issues (Ford & Hendrick, 2003; Hecker, Trepper, Wetchler, & Fontaine, 1995). If

a therapist is uncomfortable with sexual content, it decreases the likelihood they will explore sexuality in the family context. In order to be comfortable discussing sexuality issues, a therapist should be knowledgeable about and comfortable with sexual content (Harris & Hays, 2008). After therapists have explored their own family sexual legacy, they can begin to incorporate family sexuality into the clinical assessment process.

Assessment of Family Sexual Legacy

The overall goal of assessing the family sexual legacy is to assist clients in becoming intentional about the messages they transmit to the next generation. The assessment involves 1) creating a safe place during the assessment process to talk about sexuality; 2) using language that is family appropriate; 3) normalizing sexuality in the family system; 4) communicating transparently the choice of bringing up or highlighting sexuality as an important component of the family therapy; 5) empowering the family to consider and discuss sexuality; 6) making sexuality a positive topic instead of a hidden reality; 7) meeting clients within their current values surrounding sexuality; 8) assisting in re-authoring family stories about sexuality, especially negative and damaging stories; 9) creating acceptance for a variety of gender identities, gender roles, sexual orientations, and sexual practices, as well as diverse family and relationship forms; and 10) serving as a source of knowledge, information, and referral for parents and children.

A Case Example

The Lockhorst family presents for therapy because of intense conflicts between the mother and her 15-year old daughter. The family also includes the father, an 8-year old son, and a 19-year old son. Most of the conflict revolves around the mother's dislike of her daughter's boyfriend. One hypothesis could be that the mother's dislike of the boyfriend is rooted in her concern that her daughter is sexually active. This may stem from messages or experiences of the mother's own adolescence. The therapist,

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then, could be intentional about offering the parents an opportunity to explore the messages they provide about sexuality. The parents might want to examine or change the messages they are conveying in order to create a family sexual legacy that they have consciously chosen. Topics such as affection, sexual behavior, and morality might be addressed in order to further explore the presenting problem and its meaning for the family. Below are some questions that may assist this family, and other families, if they choose to address these issues with a therapist:

What are the rules about displays of affection in your family (at what age it is appropriate and with whom)?

How did you learn about these rules?

How do conversations about displays of affection start?

Who starts these conversations?

Who talks/does not talk about sexuality and sexual behaviors (could include peers and others outside the nuclear family)?

What does it mean if someone does not want to talk about sexuality and sexual behaviors?

How do family members react when sexual issues are discussed?

What parts of talking about sexuality are comfortable/uncomfortable?

What would make it more comfortable to talk about sexual issues?

How are the rules about sexual behaviors different for boys and girls?

How do media messages influence the rules about expressions of sexuality in your family?

Where did the parents learn about age appropriate sexuality and discussing sexuality with children?

Have the parents discussed their ideas or

values about teenage sexuality with each other?

What purpose does the rule about teenage displays of affection and sexuality serve in your family?

How do the rules surrounding displays of affection and sexuality work for your family?

How could the rules about displays of affection and sexuality be different?

How would you (parents) like the rules about discussing sexuality to look?

Through exploring different aspects of sexuality in therapy parents: 1) increase their knowledge about different facets of their own and their children's sexuality; 2) consider the importance of being intentional about the sexual messages they are giving to their children, and; 3) engage in clear communication about what they want their family sexual legacy to be. For example, by addressing the affection between the daughter and boyfriend as a conflictual topic between mother and daughter, the therapist is addressing the family's concerns. Seeing this in the greater context of their own sexual legacy is also helping the family re-author the family story about affection and sexuality.

The therapist needs to be aware of the possibility of overwhelming clients with information and know when to slow down or find a new way of asking questions. The therapist must also be attuned to the possibility of a deeper issue, such as a parent's infidelity or abuse, that would be better suited to discussion in a non-family modality.

Conclusion

This article discusses a brief overview of assessing the legacy of family sexuality within the therapy room. By exploring sexuality within the context of family therapy, the therapist is in the position to consider the sexual development of all family members, perhaps lessening the chance of adolescent and adult sexual concerns.

When families shift from being silent about sexuality to beginning that conversation, even if it is an awkward one, then parents are enabled to choose their messages. They can listen to their children's responses and together they can shape the sexual legacy that will serve them well and that, in the next generation, will be reconsidered, conversed about more comfortably, and possibly changed, consciously, to fit the new family's choices.

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Clinical Internship Program in Marriage and Family Therapy and Pastoral Counseling

Living Systems is a non-profit organization in Vancouver, BC, committed to the use of Bowen family systems theory in its clinical work, training and education programs. The clinical training is a two year, part time program, from October to June, for clinicians and other professionals interested in learning to 'think systems' about human behavior and how to apply it. Trainees ordinarily either have or are pursuing a Masters degree in their field. The first year of the program provides a thorough introduction to Bowen theory. The second year provides an opportunity to specialize in particular areas of interest. Contact Randy Frost, Training Director at livingsystems@telus.net or 604 926 5496 ext.304 and visit www.livingsystems.ca for more information.

Discussing Gender in the Context of Family Therapy: a Developmental Perspective

Lisa Maurel, MA, MFT

We live our lives within the fabric of a family system composed of the endeared and estranged, living, and deceased. Within this context, we navigate our individual lives. Birth, launching children, partnering, separating, divorce, and death may compose the life cycle passages of a family system and are celebrated or mourned with accompanying cultural rituals. Though less common, gender transition is a life cycle event for the transgender person and the family system as a whole (Ashton, 2010). The process of identifying, coming out, and transitioning is rooted in a psychological and individual experience of one's own gender identity. However, gender is also a social experience, entwined in our relationships. Gender transition touches upon every aspect of the transgendered person's relational life. It is part of every subsequent stage of individual and family life cycle development at both subtle and profound levels (Lev, 2004).

Until recently, family systems theory has been largely silent on the effect gender transition has within the family. This omission in the literature and the classroom is a theoretical blind-spot reflective of the larger cultural bias. Transgender people have been rendered invisible in the literature. The rare attention to treatment describes them as exiled from their families of origin, implying that transition effectively ends the transgender person's connection to family (Malpas, 2006).

The World Professional Association of Transgender Health

The World Professional Association of Transgender Health (WPATH) is an organization of "diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect,

dignity, and equality for transgender, transsexual, and gender-variant people in all cultural settings" (www.wpath.org). WPATH has outlined ten tasks of the mental health professional as part of their Standards of Care. Individual therapeutic goals include the accurate assessment of Gender Identity Disorder (GID), as well as a course of therapy to address gender concerns and decisions regarding transition when clients meet the qualifications for diagnosis of GID, and desire physical and social transition. The Standards also recommend that the therapist assist the transitioning client in anticipating "familial, vocational, interpersonal, educational and economic and legal consequences" of transition, as "change of gender role and presentation can be an important factor in employment discrimination, divorce, marital problems, and the restriction or loss of visitation rights with children." WPATH also recommends that the mental health provider be available to provide "support, information and advocacy to family members." Providing education can be a key element in family adjustment. However, the complex systemic, relational, and emotional processes must also be addressed. Family therapy provides a broader lens to recognize the therapeutic challenges of gender issues overlaying other long term family system dynamics, as well as other intergenerational family issues (Lev, 2010).

This article describes a family therapy approach to the provision of mental health services to families with a gender-variant member. Utilizing affirmative approach to transgender identities as an equal and positive aspect of family life with a larger family systems model, therapists can assist gender-variant clients and their families in addressing the relational roles impacted by transition.

LGBTQ Affirmative Family Therapy

With few historical exceptions, gender roles and norms spring from a binary or male/female conceptualization of gender, one that is assumed to automatically correspond to one's anatomical sex (Lev, 2004). This theory of duality as a means of social organization also assumes heterosexuality, i.e., one can either be heterosexual or homosexual, based on their assigned sex and presumed gender expression. The conception of identity and family formation that is exclusively heterosexual and that ignores or penalizes non-heterosexual forms of identity or family formation is defined as heterosexism (Herek, 1990). Heteronormativity, the presumption that a family functions best when organized around a heterosexual couple, is the underlying assumption within society, and culture. Heteronormativity is also found within models of psychotherapy. These biases are a source of profound internalized homophobia, trans-phobia, and stress for LGBTQ families and necessitate the practice of affirmative therapy as a form of cultural competency.

Gay Affirmative therapy emerged following the de-pathologization of homosexuality in the 1970's. Gay Affirmative therapy is rooted in the assertion that sexual orientation (gay, lesbian, bisexual) is a personal and integral aspect of self and that same-sex forms of identity, relationships and family formation are equally valid and loving ways of relating, which do not in themselves indicate psychopathology (Lev, 2005). In recent years, affirmative principles have been expounded to include gender-variant identities and relationships including transgender and gender-variant people. Affirmative therapy emphasizes the importance of pride in non-heterosexual and gender non-conforming forms of relationships, and identity which can be collectively understood as non-heterosexual, gender-variant, or queer forms of identity and relationships.

Affirmative therapists are committed to raising consciousness about heterosexual and gender conforming bias and privilege within the family, culture, and society, as well as the psychological

theories in which one has been trained (Hudak & Giamattei, 2010; Lev, 2010). Affirmative therapists evaluate their own beliefs about gender and sexuality and examine the ways in which their own gender expression and sexuality may have led to privilege or prejudice within their particular family and culture (Crisp, 2007). When gender is understood as a construct of society, rather than as a physiologically defined "identity," family therapists can envision how the gender roles and norms of a particular society are transmitted, regulated, and preserved through the structure of the family system and how these constructs are then challenged by the presence of non-heterosexual, gender-variant identities emerging within families.

Gender Variance Within The Family System

Transgender identity incorporates a broad category of gender variance including people who identify as transsexual, male-to-female (MTF), or female-to-male (FTM). Transgender people may identify as heterosexual, lesbian, gay, bisexual, or asexual. The common denominator is the gender-variant expression and identity which challenges, overturns, or "queers" the socially sanctioned forms of gender expression traditionally affiliated with each sex.

When a family member "comes out" as transgender, the entire family system is shaken: they are caught between the traditional cultural assumptions of gender and the reality of their loved one's variance from that tradition. Family members often struggle to reconcile their relationship with a family member whose gender has been redefined. Gender, after all, is traditionally one of the major characteristics of an individual. When gender is redefined, does that mean the individual is also redefined? Is he the same person? Is my daughter still my daughter? Is this person still my child? These questions are alarming because they threaten very basic assumptions we have about our family member, as well as the entire family system. Family therapists may meet families when they are alarmed, struggling, questioning, and longing to reconcile with and to nurture their child. Family therapists can respond

in ways that foster reconciliation and adjustment for gender-variant clients and their families, as illustrated in the following clinical vignette.

Sykes Family: A Clinical Illustration

The Sykes family includes Sean, a 25 year old FTM, Sean's parents, and his paternal grandmother. The Sykes only other child, Sean's twin brother, died at age five from a brain tumor. Sean lives at home with his parents while he works to complete his bachelor's degree. Sean has previously identified as a lesbian, but now states that he "has always felt male" and intends to transition to living as male. He has begun binding and virilizing his appearance. Sean's parents have asked the therapist to help "deal with our child's gender problems" and want to help Sean "figure herself out." Mr. and Mrs. Sykes express concern and guilt about how their own parenting "might have made Sean this way." Sean's grandmother does not attend the initial family sessions, because the family has not yet disclosed Sean's gender transition. The Sykes have not yet decided how to explain Sean's appearance either to his grandmother or to their extended family.

Using this fictionalized case discussion, themes common to gender-variant families will be addressed: The family system as an agent of socialization; homophobia and trans-phobia in the family system; gender narratives within the family genogram; family life cycle stage and transition; grief and loss; triangulation and transition; coming out as a family process; and, post-transition support.

The family system as an agent of socialization

All family systems operate within a cultural milieu that dictates the values, norms, and privileges of a particular society. The family unit is the primary agent of gender socialization and the enforcer of gender roles and norms with varying degrees of flexibility. The family with a gender-variant child generally experiences significant anxiety and may verbally and non-verbally transmit this anxiety to the child. As Bowen (1978) described, this can be understood as a multi-generational or societal

emotional process by which the family regulates its anxiety about the issue of gender variance and homophobia. Parents are often motivated to enforce cultural norms, both to protect their child from anticipated rejection or harassment, and to manage their own anxiety about the social sanction that may be imposed by extended family, friends and community. Many transgender clients describe these signals by which the family communicates their disapproval and rejection of transgressive behavior.

Sean's parents recalled their own unspoken anxieties about Sean's "boyishness" as a young girl and their attempts to curtail its expression. This anxiety was exacerbated by the religious and cultural imperatives which plagued them and influenced their attempts at "managing" Sean's behavior and expression. Sean's mother reported that once Sean reached puberty, her anxiety increased and her attempts to feminize Sean resulted in frequent conflicts and a growing sense of her child's unhappiness. In one family session, Sean's mother recalls shopping for school clothes. "I remember we had to get an outfit for school pictures and she (Sean) insisted on a denim jacket with a sheep collar, like all the other boys were wearing. I was beside myself. She already had cut her hair short. Now she really looked like a boy."

Homophobia and trans-phobia in the family system

Mrs. Sykes' dread about her child's gender variance is an expression of her fear/loathing of non-heterosexual and gender non-conforming ways of being. Her fears are reflections of the homophobia and trans-phobia prevalent in our culture which are in turn transmitted within the family and internalized by the gender-variant child. Life cycle family rituals are generally limited to a heterosexual expectation of identity and family formation. Because most parents assume that their child is heterosexual and gender congruent, "coming out" events are often experienced by the family as a shock or crisis. The family is then faced with their own assumptions and biases, as well as the impact of heterosexism and gender bias within the larger

cultural milieu. Whether this “coming out” is the result of a long simmering battle throughout childhood and adolescence, or a stunning revelation in adulthood, it is a profound event in the life of the family, bringing to a head all of the family system dynamics (Lev, 2004).

The gender narrative within the genogram

During the initial assessment with the Sykes, the construction of a family history and genogram was an important tool for generating dialogue and visualizing family dynamics that could impede or support their adjustment. The family’s collective remembering helped to uncover forgotten stories and to mirror Sean, who had often felt invisible, shamed, and unseen. Sean carried the belief that his true nature would be lethal if unleashed upon the family. This created a kind of psychic death for him. As a surviving twin, Sean felt the burden of his parents’ unresolved grief and loss, which led him to feel responsible for their sadness. His parents’ conflicts and unhappiness were a source of anxiety for Sean and he responded by playing the role of the “hero” in the family. Mr. and Mrs. Sykes focused their energy on Sean and often neglected their own relationship.

Sean was asked to create a “gender time-line” by plotting significant memories, experiences, and fantasies about his gender identity and expression throughout the course of his life. Sean’s parents contributed to this history as they held important threads of the family’s memories and experiences with Sean. They began to see aspects of their child that had been silenced and hidden. Sean had taken on the “role” of female, much like a false self, in order to comply with social and familial pressure and to protect his parents. Sean explained his need to come out in this way: *“Looking ahead, I can’t see a future as a woman. I can’t see myself living out my life as a woman at all. It’s blank. I can only imagine my future as a man. That’s the only way life makes sense to me. If I keep going like this, I’m dead inside.”*

The exercise of the gender time line offered many opportunities for psycho-education about gender variance, which allowed for a more de-pathologizing,

healing experience. The family gained an understanding of the price Sean had paid by conforming to gender role expectations. They came to realize that his authentic identity would need to be integrated into their family at this stage and beyond.

Family life cycle stage and transition

Each psychosocial developmental stage presents specific challenges and, therefore, the therapist must ask the question: how does this individual’s gender identity and coming out relate to this person’s life stage developmental tasks? Transgender people feel an impossible tension between the lives they live in their natal sex and the gender with which they identify. Regardless of age or life stage at which they come out, the tasks of the family therapy will be shaped by the developmental stage of the client as well as the life cycle stage of the family system and the role they play within it. In the case of the Sykes family, the resolution of gender identity at this stage becomes important both to the adjustment of the family system as they simultaneously experience launching, mid-life marital adjustment, and an aging parent. Family relationship dynamics and life cycle stage then become a lens through which gender transition and adjustment is considered (Ashton, 2010).

At age 25, Sean is engaged in the task of formulating his adult identity within the family and larger culture. This adult identity includes the formation of relationships, career, and adult sexuality. Sean, however, says that he cannot fully move forward in his life until he transitions. He struggles to complete his studies and dreads the prospect of graduating from college and beginning a career as a female. Often, transgender clients express that they cannot go on with their lives until they have transitioned. Thus developmental stalemates can occur. While “living two lives,” Sean has developed the skill of “performing” to meet the societal expectations of being female. Sean’s male identity has been hidden out of fear of rejection and shame. This has left him struggling to fully differentiate from authority and parental structures.

Sean’s coming out is a critical step, not only in

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his transition from female to male, but also in his development as an adult. His gender identity will need to be integrated into his current family roles, as well as his future roles as a couple partner or a parent. Hallmarks of identity such as the person's given name and gender pronoun become profound issues around which the family distills this grief. Through the process of therapy, Sean's family began shift-

“I realize now that his choice of a new name signifies his embarking on a new life not only as male, but as an adult. I chose his name at birth when I thought I had a daughter. My son must choose his name for this chapter of his life. I celebrate my son, but I grieve my daughter.”

ing their language to reflect Sean's male identity. They began to call him by his chosen name, rather than his given name. However, “slip ups” were frequent. While Mr. and Mrs. Sykes made all possible efforts to show support, it also proved important to attend to the grief and sadness they were experiencing through Sean's gender transition. Mrs. Sykes was particularly saddened by Sean's name change because Sean's given name was especially significant for her. “I realize now that his choice of a new name signifies his embarking on a new life not only as male, but as an adult. I chose his name at birth when I thought I had a daughter. My son must choose his name for this chapter of his life. I celebrate my son, but I grieve my daughter.” Exploration of the significance of “naming” included Mrs. Sykes voicing her grief about Sean's transition, his eventual launching, and the impact upon her own relationship with Sean, and Sean's role within the family.

Grief and loss

Grief work was a significant part of the Sykes therapy. Every family will in some way encounter

grief and loss around family roles and identities during a gender transition. It is not uncommon for family members to feel that their loved one has “died” or is no longer the same person. As the parents are able to acknowledge Sean's transition, they begin exploring their feelings of loss about Sean's transition as well as the grief carried for twenty years since the death of Sean's twin brother. As a result of keeping a grief journal, Sean's father reveals that he has carried a great deal of guilt about the death of his son, and that his rejection of Sean's masculine expression is related to his unresolved grief for Sean's twin brother. One particular incident stands out in his mind: “Sean asked to get a short hair cut when she, I mean he, was about ten years old. After years of fighting with her over it, with her constantly putting it in a cap, we finally gave in. But I could barely look at her. All I could see was the face of my little baby boy.”

Triangulation in transition

The family process around a gender transition will likely highlight triangulation and unfinished business within the family system. For the Sykes, intergenerational concerns and the triangulation around Sean and his gender expression came to the forefront. Sean's parents, similar to many parents in the launching stage, had distanced themselves from each other over the years, and focused their attention on “managing” Sean's gender expression. This triangulation of Sean had been stabilizing for their marriage, strained by years of unresolved grief since the loss of their other child. Grief and Loss work (psycho-drama and empty chair) were employed to enable the Sykes to address long held grief and to re-engage their living child, whom they feared they might also be “losing” to transition.

Addressing the Sykes' protection of the paternal grandmother involved Sean's father recalling his own gender shaming experiences in childhood and including Sean's grandmother in a family session for psycho-education and support. Mr. Sykes could relate to Sean's gender variance in that his parents had been critical of his interest in music rather

than sports. Mr. Sykes' talents and interests were viewed as too "feminine" by his parents. To please his parents, Mr. Sykes pursued a business degree, rather than his passion to become a musician. This was a decision he had always regretted. The pain he felt as a child was invoked as Mr. Sykes witnessed his mother's criticism of Sean's masculine features and expression. Concerned for the grandmother's age and health, the Sykes had kept Sean's transition a secret from her, fearful that this information would "kill her." Here we see the enforcement of a strict gender binary and the threads of homophobia throughout the family system enforced by the fear of familial rejection.

Bringing these fears to consciousness was instrumental in addressing intergenerational concerns and supporting a more inclusive understanding of gender and gender expression. In addressing his own homophobia and its impact on his experience of Sean's gender expression, Mr. Sykes was encouraged to engage his mother through letter writing. This process enabled him to release his shame and more fully support his son. Sean's grandmother attended family sessions in which this history and Sean's masculine expression were explored and discussed. Psycho-education regarding gender identity was provided and the elder Mrs. Sykes showed a marked shift in her support for her grandchild as she became involved with the family discussion. Sean's family also benefitted from bibliotherapy. Family narratives such as *Transforming Families* (Boenke, 1999) provided the Sykes with models of other families navigating gender transition from a broad array of cultural, ethnic and religious traditions.

Coming out as a family process

At the heart of the coming out process, Sean faced what is often the biggest obstacle for the client in coming out – fear of loss, rejection, or abandonment by those he most loves. Coming out is a means of disclosing one's true gender identity. Sometimes, when the transgender adult comes out of the closet, the family enters it (Buxton-Pierce, 1994). Family members can experience the news as a kind of

systemic trauma to which they must respond by either holding the information, integrating it, suppressing it as a family secret, rejecting their loved one, or moving forward with the necessary relational and social adjustments. These stages of adjustment, that Lev (2004) refers to as "family emergence," can be navigated most successfully when the therapist provides critical sources of information and support. The Sykes were referred to a local PFLAG (Parents, Families and Friends of Lesbians and Gays) chapter where they obtained support from other families helping to reduce their isolation, while providing a normalizing function. The Sykes decided that a family coming out letter was the best way to communicate the news of Sean's transition, while conveying their hope for familial support as they support their adult child. The letter was brief, informing family members and close friends about Sean's new name, gender pronouns, and requesting support for Sean and for their family. Family emergence, like coming out, is a life-long process. It brings family members into contact with perhaps previously unknown aspects of privilege, heterosexism and trans-phobia, as they negotiate acceptance and rejection with their family and community.

Post-transition support

Sean's family began family therapy in a state of mild crisis, disorganized by the new information and caught in the fear associated with such systemic trauma. However, the interventions of the transgender narrative, psycho-education, grief and loss work, and couple dyad work helped to stabilize the family system, improve communication, and reduce triangulation while supporting Sean's coming out and transition.

Although many clients resist continuing treatment following transition, it is important to recommend it. Future life cycle issues such as dating, coupling, and family formation should be explored as part of the ongoing process of transition. Premature termination is a serious problem in the transgender community and too many clients terminate therapy

upon receipt of their letter of medical referral or upon completion of surgery. They are at risk for isolation and post-operative depression (Reid, 2007). While most post-op clients adjust, some experience serious depression and are at a significantly higher risk of suicide. Therefore a post-operative treatment plan is essential for good continuity of care.

The skilled family therapist, having created a therapeutic alliance with the transgender client and the family, will have provided skills, information, referrals, and a positive therapeutic experience. Employing the therapeutic modality of affirmative therapy, with a family systems perspective, will strengthen healthy relating through the catalyst of gender emergence. It is hoped that this will encourage family members to utilize therapy in the future as additional life cycle events unfold.

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BOOK AND MOVIE REVIEWS

Lust in Translation: The Rules of Infidelity from Tokyo to Tennessee

by Pamela Druckerman

The Penguin Press: New York, 2007

Reviewed by Michele Scheinkman, LCSW

While stationed in Latin America as a foreign correspondent for the Wall Street Journal, Pamela Druckerman discovered that her notions about infidelity were incongruous in that part of the world. Intrigued by her own “moralizing streak,” she decided to travel the globe to understand and compare the rules of infidelity and to shed light into what she was beginning to realize were North America’s complicated ideas about cheating.

Druckerman begins *Lust in Translation* saying: “This is a book about adultery. If you’re American and don’t read on, I’ll understand why. Adultery provokes more outrage in America than in almost any other country on record.” She acknowledges that all over the world people become heartbroken when faced with infidelity. Druckerman says, we all have “. . . the same menu of emotions.” However, cultural scripts instruct us how to think about adultery and which emotions to evoke in what situation. Infidelity may seem a lawless realm, but there are shared narratives in every culture that define what is “normal” in a long term marriage, what the rules are, and where one’s own behavior stands in relation to the rules.

While visiting two dozen cities in ten countries, Druckerman interviewed adulterers and their mates, psychologists, sexologists, and historians. She read research studies and advice columns. All through the book she offers vignettes regarding the different cultural meanings she encountered. In America for example, a cheating husband often tells his mistress that he is unhappy with his wife to indicate that he’s not “a lousy two-timer,” but rather a sensitive person looking

for affection. In contrast, married men in China routinely praise their wives to their mistresses, to prove they respect women and to set boundaries for their affairs. In one occasion, Druckerman asked a married Japanese woman if she felt guilty about having a lover. Confused by the question, the woman had her repeat the question several times until it became clear that feeling guilty was not an issue. In a typical Japanese conception, she considered marriage to be about fulfilling family obligations and not about sexual pleasure. Since she was a dutiful mother and wife she had nothing to feel guilty about. In another example, Druckerman asks a French man whether he had gone into therapy to sort out his double life. Surprised by her question he explained that, in fact, he had dropped out of therapy soon after starting the affair since he was finally happy.

Sometimes a “sexual culture” has less to do with geography than with a moment in time. Druckerman interviewed Florida retirees who explained that during the fifties and sixties affairs were considered part of a glamorous life. Inspired by the romance of Sinatra songs, these women not only had many affairs, but considered those to be the “best times of their lives.” Nonetheless, they told Druckerman, they would never reveal their affairs to their adult children who, now in their forties, would certainly be appalled.

Druckerman points out that although Americans are aware that cheating is widespread in this country, paradoxically, expectations about marriage and fidelity have risen to extremely high standards. In North America today people enter marriage with the naïve belief that their partners *will never* be unfaithful. Like a birth right, spouses feel *entitled* to unwavering emotional fulfillment and bullet proof fidelity for the rest of their lives. Infidelity is considered so ethically wrong that one is guilty simply for fantasizing about it. Given these expectations, when infidelity surreptitiously

happens it's not only a painful human dilemma, it is *world shattering*. The aftermath of an affair tends to last longer, cost more, and seems to inflict more emotional torture and guilt in America than it does in anyplace else she visited. This prevailing social narrative, described by Druckerman, is what I've referred to in my work as the framework of "trauma and betrayal". Within this narrative, an affair is a betrayal of intimacy in which one partner is a victim and the other a guilty perpetrator.

In Chapter Four, Druckerman describes the *forum* in which this narrative about marriage and infidelity is being developed in America today. According to her, the "marriage industrial complex" is the conglomerate of marriage counselors, professional organizations, conferences, self-help book authors and publishers, courses, online web sites, retreats and treatment programs that disseminate the current paradigm. This "complex" propagates the notion of "affair as symptom." It explains "why relationships go wrong," and then proposes innumerable measures and remedies. Although the experts involved may be sincere in their intentions to help, they participate in an industry that is business driven, she explains. Druckerman also points out that ideas developed by marriage and family therapists have blended with a Christian brand of salvation, in which religious and conservative groups counsel and save their members. Christian courses, workshops, books, blogs, and retreats flourish in America today propagating the notion that marriage is a *holy* institution that should be preserved and "restored" after infidelity at any cost.

Druckerman points out that, unlike in any other culture, the *confession cure* is the most widespread prescription for solving the crisis of infidelity. It encourages partners to tell the truth no matter what, and assumes that talking about the details of an affair is essential for the recovery of intimacy and for healing. Related to the moral necessity of transparency is the American faith in what she refers to as the "redemptive power of marriage counseling." She observes

that a recovering American adulterer can spend "thousands of hours" discussing the facts of the affair and begging for forgiveness, which may never be granted. The wisdom of this ubiquitous confession/talking cure is questionable, she adds. "There is no empirical evidence that telling your spouse all the gory details of your affair will help him get over it or that couples are happier the more truthful they are." People in other cultures are baffled by this view of honesty as a panacea. What both Druckerman and I observe is that talking about details of an affair can actually backfire, amplifying the wounds that if probed enough, will lead to obsessive thoughts and flashbacks that may never get assuaged.

The current paradigm has penetrated so deeply into popular culture that, today, couples from all segments of life believe infidelity is a moral/pathological problem that should be *solved* in therapy, through confession, penance and redemption. "It is hard to overstate the reach of the marriage-industrial complex ... Even people who are secular find themselves following the script," Druckerman says.

Druckerman concludes the book with a point worth noting. In spite of striving for monogamy, people outside of the U.S. tend to start from the assumption that our love lives are full of contradictions and that "it is normal for married people to have little crushes and attractions, and in some places to even act on these feelings." When they do, it does not necessarily mean – in the American parlance – that they are living a lie. They see it as related to their right to privacy, believing that they do not *have to* reveal the entire content of their minds to be close to their partners. In fact, in many places, such as France and Latin America, *mystery* is viewed as an essential ingredient keeping long-term relationships alive and enticing.

It is uncanny how Druckerman's observations as an American foreign reporter are similar to mine, a Brazilian therapist who sits with couples from diverse cultures weekly. Without idealizing other

cultures, which have their own share of problems and contradictions, we both have reached the same conclusion: the current *zeitgeist* about marriage and infidelity in America is problematic and

Although we live in a pluralistic society, the field of couple and family therapy has insisted on reinforcing one particular cultural discourse about fidelity and intimacy.

at times damaging. Although we live in a pluralistic society, the field of couple and family therapy has insisted on reinforcing one particular cultural discourse about fidelity and intimacy that funnels couples, no matter what their particular values are, into one scripted way of dealing with fidelity and intimacy. The prevailing standards are not only narrow and insufficient, they have become canonized to such an extent that it is difficult for couples and therapists alike to step away from these particular meanings. While for some couples the current paradigm of “trauma and betrayal” is congruent with their values, for others it creates an oppressive cultural mystique against which couples end up measuring themselves, instead of figuring out what fidelity and intimacy means to them as individuals, as partners, and within broader cultural parameters.

Most cultures Druckerman investigated – and I avow for similar observations in my practice – contain a wisdom that marriages are *imperfect arrangements* laden with ambiguities, limitations and risks. This is in direct contrast with the American ideal that marriages are bastions of healing and safety. Within a more humble set of expectations there is more room for the diversity and quirkiness of relationships as well as more acceptance of the ebb and flow of contentment and discontentment, connection and disconnection, privacy and sharing that tends to occur

throughout the life of most long-term relationships. Within these parameters, even when couples *hope* for monogamy, they enter marriage aware that infidelity *can happen*. Such awareness may lead to insecurities and jealousy, but it can also be a strong stimulus for partners not to take each other for granted. In situations where infidelity does happen, it is usually painful, messy, and may lead to a reevaluation of the relationship. However, when fidelity is conceived as a difficult human dilemma rather than an absolute moral standard, infidelity is not necessarily experienced as a cataclysmic event from which the partners may never recover.

Lust in Translation reads like an entertaining conversation with a friend rather than a serious professional study. However, its message is poignant to therapists. It cautions us from buying into the dominant narrative and reminds therapists that love and couplehood come in many configurations. Druckerman takes us through her voyage with curiosity and amusement. She also uses this opportunity to poke at the proselytizing sometimes associated with our profession, alerting us to remain open.

Coming Out, Coming Home: Helping Families Adjust to a Gay or Lesbian Child

by Michael LaSala

Columbia University Press: New York, 2010

Reviewed by Deidre Ashton, LCSW

In his book, *Coming Out, Coming Home*, Michael LaSala elegantly and compassionately describes the process through which parents come to accept, tolerate, and even celebrate having a gay or lesbian child. In the preface, LaSala references his coming out and his family’s adjustment. He emphasizes the importance of connection in the face of conflict and turbulence. He implies that connectivity helped his family move through grief, loss, worry, fear, and anxiety to acceptance, integration, strengthened family bonds, and authentic relating. Perhaps his personal story and those of

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the families he encountered in his clinical practice motivated him to undertake this qualitative study focusing on the ways in which 65 White, African American, Latino and Asian youths and their families negotiated the coming out and adjustment processes. As an African American lesbian who came out at the age of 38, I am impressed and inspired by the narratives of these young people and their families who begin the lifelong process of coming out during what is probably the most challenging developmental and family life cycle stage.

LaSala outlines a five-stage process through which families move from an unspoken awareness that their child is somehow different, to disclosure and upheaval, and finally to acceptance. He places the family trajectory squarely in the context of heteronormativity, highlighting the ways in which the adjustment process is a normative developmental process in a world that constructs gender and sexuality in very narrow, sexist, and heterosexist terms. Using a strengths-based perspective, LaSala intentionally chooses to learn from the experiences of families who adjusted to the unanticipated sexual orientation of their children.

Stages of adjustment

Family sensitization

The parents and child may suspect that the child is different, but dare not speak this awareness to one another. Instead, they engage in what LaSala characterizes as a “mutual dance of denial.” The child deals with the distress of moving into a devalued social status or, if a child of color, taking on an additional devalued status in isolation, while parents suppress suspicions that their child may be lesbian or gay.

Family discovery: Youth come out

Youth may disclose their orientation to their parents because they need parental support, or because they desire to be closer to their parents. In some instances parents sense their child’s distress or find evidence of a lesbian or gay orientation and

confront the child. Youth may experience symptom reduction, while parental symptoms escalate.

Family discovery: Parents react

Parents may experience feelings of failure, self-blame, and grief as they mourn their heterosexual dreams and expectations for their children. The parent-child relationship may become distant and LaSala reframes this disengagement as protective for both parent and child. In some families overt conflict emerges as the child’s desire for acceptance clashes with parental responses.

Family recovery

A positive circular interactive pattern begins to emerge which propels families into recovery. As parents sort through their feelings they notice that, following disclosure, their child seemed to function better and the parent-child relationship improved. These improvements seem to enhance parental acceptance and reduce some parental distress.

Family renewal

LaSala reminds us of the importance of solid systemic thinking and of best healing practices, and offers specific application of these practices in working with lesbian and gay youth and their families.

As parents move into acceptance, families engage in difficult conversations that lead to family renewal. Some parents come to feel that having a gay or lesbian child is a benefit to the family, and a source of pride. Often families experience an expanded worldview, increased awareness of experiences of oppression (especially if not already a member of a marginalized group), enhanced closeness, and more authentic connection.

LaSala reminds us of the importance of solid

systemic thinking and of best healing practices, and offers specific application of these practices in working with lesbian and gay youth and their families. He provides guidance for setting up the treatment and for working with families based on the salient issues of each stage. LaSala encourages clinicians to connect to all members of the system, while meeting with subsystems in preparation for conjoint meetings. In conjoint meetings, LaSala emphasizes the importance of helping parents and children share their fears, concerns, and hopes while connecting to their positive intentions.

LaSala attends to the ways that gender roles and race intersect with sexual orientation and how they impact family adjustment. He emphasizes the exclusionary effects of traditional gender role socialization that keep mothers emotionally involved with the family and fathers marginalized. He encourages clinicians to be creative in their efforts to reach fathers in order to facilitate family adjustment.

Among families of color, the intersection of racism and heterosexism seemed to amplify parental concerns for safety and made the adjustment process more arduous. Among white families, white skin privilege complicated acceptance as families struggled to understand why their children would want to adopt a devalued status. It also served to impede adjustment as white parents seemed to expect that their children would lead “normal” lives. Black and Latino parents seemed to mourn the loss of normal life for children less than white parents because racism already creates a significant obstacle to achievement of the American dream. I would add that Black and Latino families may see obstacles and adversity as expected and thus do not experience a sense of loss. Some families of color who indicated that race was not relevant to the adjustment process tended to be multi-problemated, so LaSala suggests that they may have been too overwhelmed to examine structural factors such as race and class. I would also add that dominant culture has trained us to believe that

discussing race and oppression is impolite, racist, and particularly taboo in cross racial interactions. I wonder if families of color may have been reluctant to acknowledge the impact of race and oppression to LaSala, a white researcher.

The study seems to imply that coming out is a direct, declarative, and verbal process. It is important to remember that among some families of color coming out may be indirect, implied, and/or accepted, but not discussed (Walters & Old Person, 2008). As LaSala noted, many white youth also eschew the practice of adopting a single label to reflect their sexual orientation. For many same-sex loving individuals who occupy a more visible stigmatized status, sexual orientation may not be the most salient aspect of identity (Bowleg, Burkholder, Teti, & Craig, 2008; Loue, 2008, 2009), thereby limiting the significance of coming out or the need for family adjustment. For this study, family has been defined as nuclear. For many families of collectivist cultures the definition of family includes extended family, fictive kin and perhaps community. We must be mindful that in addition to parents, these kin may play a critical role in family adjustment. Although not indicated in this study sample, practice wisdom indicates that religion and spirituality may play a critical role in family adjustment, particularly among families of color. Clinicians must be mindful of this and attend to these issues to support family movement toward acceptance.

LaSala’s work is tremendously valuable and instructional for working with lesbian and gay youth and their families. Additionally, his research promises to be inspirational for all families who find themselves working to come to terms with the knowledge that their child is lesbian or gay. The very personal narratives provided will likely help families feel less alone, validate their experiences, and engender hope where little may exist. While LaSala’s writing is well grounded in theory, research, and clinical wisdom, he speaks in a way that is accessible to parents. They are likely

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to identify with the thoughts and feelings of the parents in the study and may feel as if they are sitting in the therapy room with LaSala himself as he provides empathy, support, and validation while respectfully challenging and encouraging parents to move toward acceptance.

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The Kids Are All Right

Directed by Lisa Cholodenko,
starring Annette Bening, Julianne Moore,
and Mark Ruffalo

Reviewed by Jackie Hudak, Ph.D, LMFT

“Now THAT was the story of my life!” exclaims my fifteen-year-old son as we leave the movie theater and step into the warm summer night. He is obviously moved by something in this film, the story of a family with lesbian parents, two teenage kids, and a sperm donor.

Nic (Bening) and Jules (Moore) are in a long-term committed relationship that is both loving and imperfect. Their kids, eighteen-year-old Joni and fifteen-year-old Lazer, were each conceived using the same sperm donor. It is an “open” situation, in which the kids can search for the donor at age eighteen if they so choose. When Joni turns eighteen and is preparing to go away to college, Lazer pleads with her to contact their sperm donor. Thus, the plot unfolds as Lazer and Joni meet their sperm donor, and their family struggles to integrate this new relationship.

I was left with many mixed feelings about this movie, the first of its kind, really, a mainstream film about a lesbian family. So, when I watched it again on a cold November evening with my nineteen-year-old daughter, I hoped for some sort of epiphany about its wild popularity, and my own very mixed reactions.

I laughed at the same places the second time I saw it. I also grew equally uncomfortable in anticipation of what I found so distasteful the first time: for a movie about a lesbian family, there was a great deal of heterosexual sex. I asked myself, “Was that part of what director Lisa Cholodenko had to do to make a movie about a queer family recognizable by a wider audience?”

Recent research has found that gay couples with children were represented in 68% of Americans’ definitions of family in 2010, a noted increase from 54% in 2003. This family was certainly familiar to most viewers: white, middle class, sharing a large suburban home, and driving the kids in a Volvo station wagon. Perhaps the racial and class privilege enabled a larger audience to relate to them as a family regardless of their sexuality. Perhaps a majority of the viewers could resonate with the “breadwinner” and “stay-at-home” roles of Nic and Jules, and the attendant, achingly familiar marital dissatisfactions which compose dominant narratives about gender, home and parenting. The intimate daily banter between Nic and Jules portrayed

the discontentment with chosen roles, emotional trade-offs and power imbalances that can creep into any relationship. Like all families at this stage of the life cycle, as they prepare to launch the children, questions arise about the couple relationship, its durability and adaptability to the next chapter of its life.

Their “world” seemed painfully similar to the cultural context of mainstream heterosexual films. For example, people of color were represented as peripheral and subordinate (for example, the white family’s gardener is Mexican and the sperm donor’s lover, who is also the hostess at his restaurant, is African-American). In her blog essay, “The Kids Are All Right – But Not the Queer Movement,” Daisy Hernandez (2010) states: “Part of the success of Cholodenko’s movie rests in that, intentioned or not, she’s rendered on the big screen the racial realities of this new gay world order.” Clearly, this new gay world is White.

Perhaps, certain parts of the story line were believable because they were played out with common heterosexist assumptions: the straight man as exotic interloper moving in on this family; the vulnerability of a lesbian to his appeal (a male sex partner, that’s all she needed, right?); and the son, parented well by two Moms, who nonetheless inevitably desires that connection with a male.

I even feel that the title of this movie “The Kids are All Right” may be suspect. Granted, it is apt, considering the discourses that have surrounded queer families. For instance, mandates that require therapists/researchers to prove that children in queer families are “normal” and “no different” when compared to the children of heterosexual parents, as if heterosexuality was the gold standard in parenting. Indeed, kids of gay and lesbian parents *have had to be* alright, lest their difficulties become an indictment of their parents’ sexuality. In the not too distant past, a parent could lose custody of his or her child because of that parent’s sexual orientation, and the ability of Lesbian Gay

Bisexual Transgender & Questioning (LGBTQ) to adopt is still unclear even now in several states. It is only recently that we tenuously began to research and articulate the qualitatively different experiences of being raised in a queer household.

Having duly noted these critical questions, I also want to express my appreciation for the moments where the movie resonated with my life. I keep thinking about our son’s response, and it occurs to me that with all of the media he consumed as a teenager, there are no accurate depictions of his experience of living in a home with two Moms. Which brings us back to the ubiquitous climate of heteronormativity. You don’t know something is missing until you see it. Then, you register the absence and subsequent isolation of your own experience.

As parents in the queer community, it is useful to see aspects of our reality represented: We have known for a long time that some of the families we create require the participation of a third party (donor, surrogate). And we have lived out the complexity of those narratives with multiple storylines about how we relate, honor, include, and protect family membership based on what we determine. For example, the non-fiction movie *Choosing Children* (Groundspark, 1984), made over 25 years ago, was one of the first to document the real, lived experiences of becoming a family that does not succumb to heterosexist assumptions or dominant narratives that limit the depiction of queer family life.

So, with all these narratives to choose from, why this? The lesbian partner sleeps with the sperm donor? Even the representation of the sperm donor (brilliantly played by Ruffalo) is rife with stereotypes such as the non-committal-free-spirit-drifter moving through life with little to tie him down. Can we imagine a sperm donor who is a mature adult, with a family and children of his own?

Surely Cholodenko raises interesting and provocative questions about the role of the biologi-

Book and Movie Reviews

As our definition of ‘family’ continues to expand, we will no doubt be challenged to further embrace relational depictions that do not conform so rigidly to white, middle class, and binary norms of gender and sexual orientation.

cal sperm donor in the lives of children of lesbian couples, but she misses an opportunity to more fully express the stories of queer families. Yet, by making this family so recognizable, she may have contributed in some way to a wider acceptance of queer family life.

As our definition of ‘family’ continues to expand, we will no doubt be challenged to further embrace relational depictions that do not conform

so rigidly to white, middle class, and binary norms of gender and sexual orientation. There are stories just waiting to be told about queer life that do not reflect what we already know. Cholodenko got the “two Moms” part right. But I long to experience that place somewhere between the exotic and familiar, as those polarities falsely depict the beautiful complexity that is queer family life.

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Real Time Family Systems Coaching and Neurofeedback Training - Andrea Schara’s book in Spanish features Bowen family systems theory and 10 Mexican leaders clarifying the benefits of defining family systems knowledge. One of these leaders, Francesco Piazzesi-Anahuac, of the University MBA program, ADOBE HOME AID, received the Presidential medal for work with sustainable housing. He noted: *“Even though I teach strategic management, my students always have the willingness to find their own vision. The ‘Crea Tu Brújula Interior’ has become a marvelous tool and a must read.”*

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with Transgender People and their Partners,” and the upcoming *Family Process* article “Every Step of the Way: A Multi-Dimensional Family Approach to Gender Nonconforming Children and their Families.”

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Erotic Fantasy Reconsidered: From Tragedy to Triumph



Esther Perel, MA, LMFT is an acknowledged international authority on couple therapy, cross-cultural relations and culture and sexuality. Her book, *Mating in Captivity: Unlocking Erotic Intelligence*, is now in 25 languages and is an international bestseller. It won the 2009 book award from the Society for Sex Therapy and Research. She was trained by Dr. Salvador Minuchin, and she serves on the faculties of The Family Studies Unit, Department of Psychiatry, New York University Medical Center, The International Trauma Studies Program, The Ackerman Institute for the Family, and The Scandinavian Institute for Expressive Arts Therapies. A frequent keynote speaker and media commentator around the world, and fluent in nine languages, Esther brings a rich multicultural perspective to her work.

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Open Relationships: A Culturally and Clinically Sensitive Approach



Deanna M. Fierman, MA is a graduate student at the University of Colorado Denver completing her master's degree in Counselor Psychology and Counselor Education. She has a prior master's degree in Cognitive Psychology from the University of Colorado at Boulder, and currently works at UCB as an academic advisor. She is an active member of the Boulder Polyamory Group, Out Boulder, and the Center for Sex Positive Culture in Boulder, CO, in addition to being a student of aikido and karate. Clinical and research interests include open relationships, LGBTQ issues, sexual harassment and assault, and crisis counseling.

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Couples and Kinky Sexuality: The Need for a New Therapeutic Approach



Margaret Nichols, Ph.D. is a licensed clinical psychologist and AASECT-certified sex therapist. A therapist, writer, and social activist for 40 years, she specializes in populations and topics ranging from feminist therapy to HIV to L/G/B/T issues and work with the kink and polyamory communities. She was involved in the founding of a battered women's shelter in Monmouth County and the statewide Hyacinth AIDS Foundation. Her primary professional focus is the Institute for Personal Growth, a group psychotherapy practice with offices in 3 locations in New Jersey that specializes in work with sexual minorities. She is the grateful mother of four children, and sometimes identifies as a queer bisexual lesbian mom.

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Families in Transition: Supporting Families of Transgender Youth



Melissa MacNish, LMHC, is a licensed mental health counselor practicing in Boston Massachusetts. She got her Master's Degree from Lesley University in Cambridge, MA. She sees youth, young adults, and families at the Sidney Borum Jr. Health Center and in her private practice at The Meeting Point. She started and consults with Greater Boston PFLAG to run a support group for parents with a transgender child. Melissa is also on the Board of Directors and a parent liaison for Camp Aranu'tiq, a week-long summer camp for transgender and gender-variant youth ages 8-15.

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Discussing Sexuality in the Context of Family Therapy: A Teaching Tool



Mary Sue Green, Ph.D., LMFT is an Assistant Professor at Texas Woman's University. She has published and presented on sexual minority issues in therapy, feminist collaborative research, feminist mentoring,

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Discussing Gender in the Context of Family Therapy: A Developmental Perspective



Lisa Maurel, MA, MFT, is an active speaker, writer, radio guest and trainer in the area of LGBT mental health and civil rights. She has been especially active in promoting policies and practice standards within the

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Book review, *Lust in translation: The rules of infidelity from Tokyo to Tennessee* by Pamela Druckerson



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Book review, *Coming Out, Coming Home: Helping Families Adjust to a Gay or Lesbian Child* by Michael LaSala



Deidre Ashton, LCSW is a couple and family therapist, whose work focuses on the concerns of LGBTQ individuals and their families such as coming out, negotiation of multiple aspects of identity, family and couple conflict, and family planning. In her work, she attends to the ways in which power, privilege, and issues of social justice influence relationships. She is especially drawn to the construction of narratives that empower people to heal through storytelling and witnessing. Deidre is a faculty member at the Center for Family, Community, and Social Justice, and the Multicultural Family Institute.

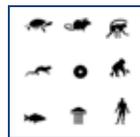
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Movie review, *The Kids Are All Right*, directed by Lisa Cholodenko



Jacqueline Hudak, Ph.D, LMFT, is in private practice in Red Bank and Atlantic Highlands, NJ, and is an adjunct faculty member in the Couple and Family Therapy Programs at Drexel University. She maintains a supervision practice in Philadelphia. Her research and clinical work has more recently focused on sexual fluidity and midlife identity transitions for women and their families, and the impact of heteronormative culture on family therapy theory. Her blog on *Psychology Today* is called “FamilyLife.”

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Thank you, Dr. Bowen.

Victoria Harrison and the Board of Directors of CSNSF wish to also thank AFTA, Sally Miller, Monica McGoldrick, and Carolyn Moynihan-Bradt for this opportunity to recognize the contributions of Bowen theory to the field and to the future.

New

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Michael C. LaSala

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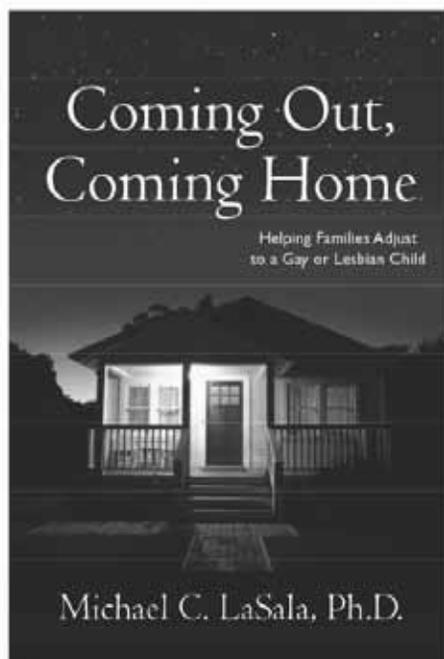
Through a qualitative, multicultural study of sixty-five gay and lesbian children and their parents, Michael LaSala, a leading expert on this issue, outlines effective, practice-tested interventions for families in transition. His research reveals surprising outcomes, such as learning that a child is homosexual can improve familial relationships, including father-child relationships, even if a parent initially reacts strongly or negatively to the revelation. By confronting feelings of depression, anxiety, and grief head on, LaSala formulates the best approach for practitioners who hope to reestablish intimacy among family members and preserve family connections—as well as individual autonomy—well into the child's maturation. By interviewing parents and children of the same family, LaSala accurately captures the reciprocal effects of family interactions, identifying them as targets for effective treatment. *Coming Out, Coming Home* is also a valuable guide for families, enabling adjustment through relatable scenarios and analyses.

Michael C. LaSala is director of the Master of Social Work Program and associate professor at Rutgers University. He has been in practice for more than twenty-five years and is a much-sought-after lecturer and researcher. He currently treats LGBT families and individuals at the Institute for Personal Growth in Highland Park, New Jersey, and his work can be found in *Social Work*, *Family Process*, *Journal of Marital and Family Therapy*, *Families in Society*, and *Journal of Lesbian and Gay Social Services*.

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Summer. The **Annual Summer Conference.** July 15. Focuses on clinical practice based on Bowen theory. Roberta Gilbert, M.D., faculty member of the Bowen Center, author of *Extraordinary Relationships* and other books, will be this year's presenter.

Fall. Daniel Papero, Ph.D., faculty of the Bowen Center, is the presenter for CFC's fall conference each year. October date to be announced.

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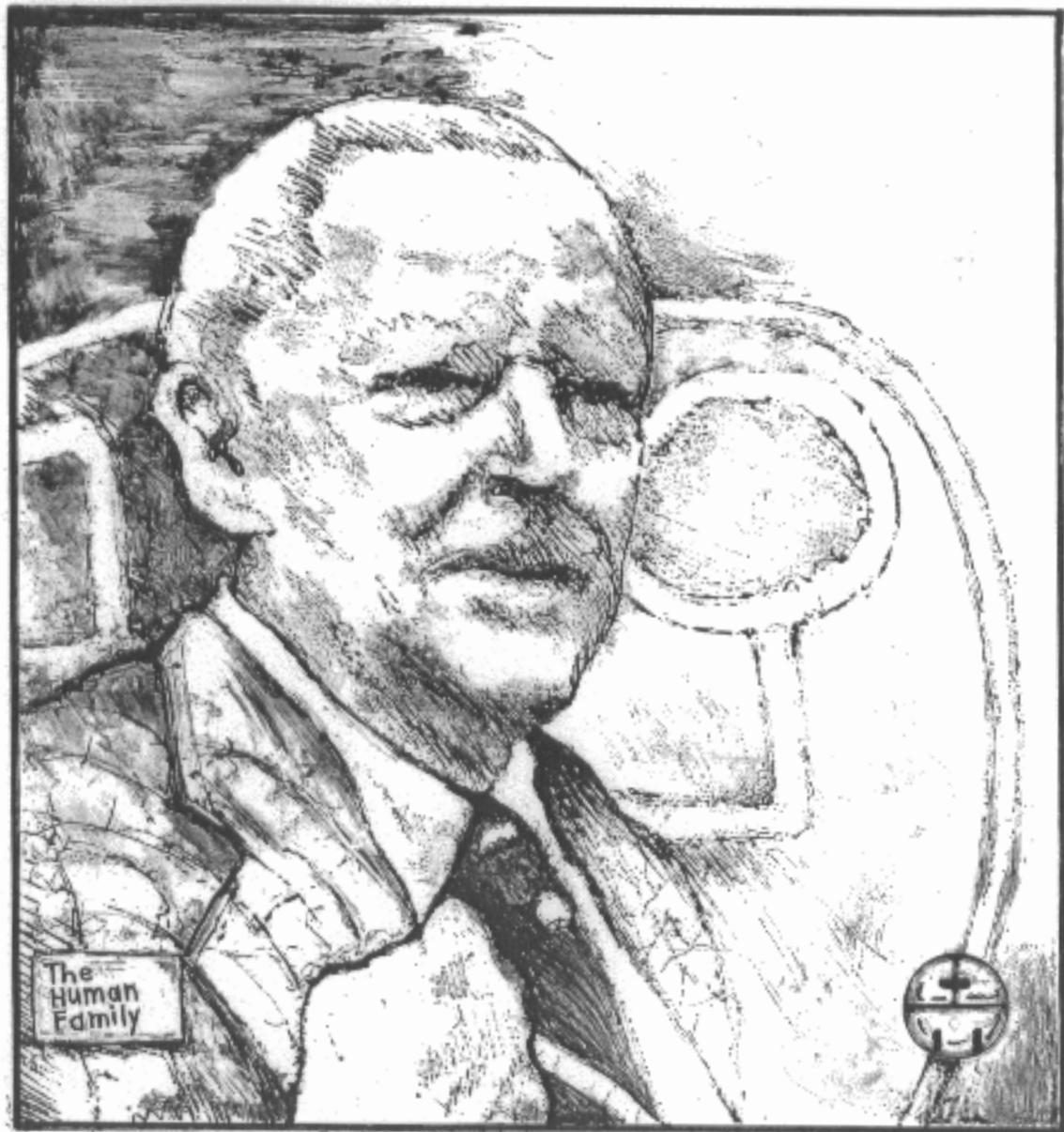
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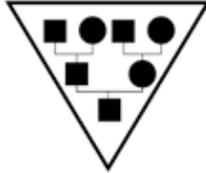
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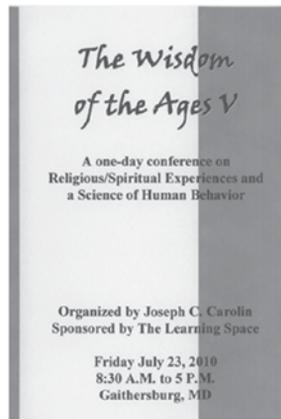
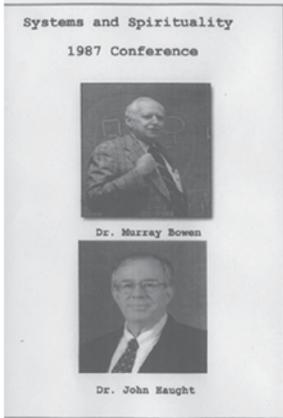


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Plenary IV:

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