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The Gentle Violence of Therapists: Misrecognition and Dis-location of the Other

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ABSTRACT *Using Pierre Bourdieu's 'theory of symbolic violence' and 'misrecognition' this paper focuses specifically on the way sexuality and gender are negotiated in therapeutic training. Drawing from UK-based research over the past decade with 70 qualified and registered, predominantly cis-gendered, heterosexual and non-heterosexual therapists, I reflect upon, and offer reasons for, the way therapeutic studies continually struggle to offer legitimacy and recognition to mainstreaming anything other than heteronormative versions of social, sexual and emotional life and how an alternative reading using queer theory, can complicate the terrain of sex, sexualities and genders and offer a way out of the present impasse. My own interest in 'misrecognition' focuses on the epistemic violence perpetrated when there exists a complicit subordination to the dominant group, and how this is a far more violent practice towards those who are already marginalized, disempowered and socially excluded in relation to sexed, sexualized and gendered bodies because it legitimates oppression, resists radical shifts in power and has wider implications for citizenship (particularly emotional) and sociality. I focus on the strategies employed by therapists to perpetuate this type of 'gentle violence' and how it impacts on the construction of the social and emotional self. Although sex, sexuality and gender form the basis of this research, I am only too aware of how these may be used to provide discrete categories within 'interlocking systems of oppression' that also include race, ethnicity, class and ableism. For the sake of this article, intersectionality is considered a useful tool, from which to re-negotiate and re-cognize the violent context of therapy and its underlying practices. Copyright © 2011 John Wiley & Sons, Ltd.*

Key words: symbolic violence; misrecognition; sexuality and gender; therapeutic practices

INTRODUCTION

> A politics of recognition . . . aims towards seeing and valuing individuals, groups, identities, experiences, knowledges and expertise (potential) contributions, humanity and personhood; upholding citizenship status and rights; and affording people dignity and respect. (Lewis, 2009, 259)

Over the past decade or so, numerous articles have appeared suggesting therapists feel ill prepared to work with lesbian, gay male, bisexual and trans (LGBT) clients (Moon, 1994,

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Moon, 2002, 2008, 2009, 2010; Mair, 2003; Galgut, 2005). This is often put down to a failure to 'recognize' the gendered and sexual context of those who present as lesbian, gay male, bisexual, transsexual, transgender, gender variant or queer (Butler and Byrne, 2008, 102), which resonates with 'a lack of knowledge' and/or 'training' (Coyle et al., 1999; Barker and Evans, 2010, 375). For example, my own research found that therapists in training receive as little as 2 hours to a maximum of 16 hours input on 'issues' of 'diversity' (which include race, ethnicity, disability, gender, sex, sexuality and age) over the entire course of 5–7 years of training that leads to full qualification status (Moon, 2009). While these 'issues' may form the core of an individual's understanding of selfhood, they are often ghettoized into a sub-category named 'Social Context' or 'Difference and Diversity', while the euphemism 'issue' somehow misrecognizes felt meanings and separates the felt experience from its social meaning for those who occupy this contested space. It could be argued that therapists are 'prepared', or trained, only to work effectively with heterosexual clients and their contexts, lifestyles, issues or experiences. My own findings also disappointingly show that qualified therapists still struggle to come to terms with meanings about non-normative sex, sexuality and gender in a therapeutic context and very little has changed in relation to the formation of knowledge in 'diversity training' in the 15 years between 1994 and 2009 (Moon, 2009) despite the increased numbers of lesbian, gay and bisexual trainees and tutors who teach and/or train therapists. Therefore, the paper questions what is happening to prevent disruption to traditional therapeutic studies, whether and how this meets with resistance and whether therapeutic 'training' as a form of 'pedagogic action' is merely condoning and reproducing the 'pedagogic authority' of the dominant group (Jenkins, 1992, 105).

Bourdieu and Passeron (1977) suggests that where the formation of knowledge and the construction of reality privilege the culture and knowledge of the dominant group, through practices of social exclusion and inferiorization of the other, then this constitutes a form of domination and oppression – a form of 'symbolic violence'. This type of 'violence' refers to a complicit, almost silent form of violence 'in some ways "gentler" than physical violence, but is no less real' (Grenfell, 2008, 184). The theory of symbolic violence is the imposition of a 'cultural arbitrary' or 'systems of symbolism and meaning (i.e., culture) upon groups or classes in such a way that they are experienced as legitimate' (Jenkins, 1992, 104). The arbitrariness of culture depends upon the way it is primarily imposed through family, education, social networks and such like. Symbolic violence is a form of 'misrecognition', operating where those from the dominant group 'let the system they dominate take its own course in order to exercise their domination' (Bourdieu, 1977). Far from resisting, oppressed groups are understood to legitimate their subordinate position and are found to become complicit to dominant regulatory regimes by internalizing the practices of the dominant group (Lewis, 2009). Those from subordinated groups do not fully participate within society on their own terms and do not 'feel' recognized for their own worth, while their values remain unacceptable to the dominant group. In light of this, I will question the content of therapeutic training in relation to sex, sexuality and gender, how 'heterosexuality' and what I refer to as the 'privilege of feeling' is imposed and how it constitutes a emotional authority, and I will explore the regulatory regimes imposed when, in attempting to portray a more 'balanced' approach, lesbian and gay therapists are recruited to teach issues related to gender, sex and sexuality.

At a deeper level I am questioning what happens if therapists are unable to offer recognition to those considered 'to be different to oneself' or 'other' (Weis, 1995); how can they possibly

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argue they are self-reflexive and self-reflective? How can a therapist legitimately establish their 'authenticity' while at the same time failing to recognize how they are disempowering, stigmatizing and distancing one identity (possibly their own) from another (possibly that of the client)? On what basis does a client defined as 'other' become subordinate to a dominant group and at what point does the therapist interrogate the wish to dominate a subordinate group? Therapy makes grand claims to allow for the development of a 'unique individuality' as key to 'having a fulfilling and true identity, and accordingly, for the experience of living a meaningful life' (Sointu, 2006). It depends upon providing a space for 'affective recognition' (Sointu, 2006) where the 'client' may begin to gradually reveal knowledge, feelings, emotions and experiences to self and other. The relational reflexivity between therapist and client allows the client to see (themselves) and be seen (by others, in this case the therapist) in a dyad of client/practitioner intersubjective interaction that allows for 'feelings of mutual recognition' (Sointu, 2006). As Majid Yar remarks: 'the establishment of one's self understanding . . . is inextricably dependent on recognition or affirmation on the part of others' (Yar, 2001, 59). However, recognition does need to be based on a mutuality of self in relation to 'others' (not simply the 'other' as comfortable) and therefore means the therapist must be open to 'reflection' about self and 'other' – not self alone as often advocated in therapy. Recognition is not only a powerful acknowledgement of self and other – it is a mirror image, concerned with both personal and social identity and the interaction between the two (Lewis, 2009). Thus recognition is core to developing a social identity, while developing a social identity is central to the formation of subjectivity and sense of self (Lewis, 2009). The subject only comes into being because of recognition by others and the self – through an ongoing reflexivity, a process of an individual looking back upon itself. In order that the therapist may take a reflexive stance, I argue that it is as important to understand the 'self' in relation to social identity as it is to understand individual felt experience.

One way out of this impasse, I argue, is to embrace queer theory and to consider an approach that takes the stance of intersectionality and positionality where the therapist as a 'researcher' of another's life, history and case study is located within a complex interplay of race, ethnicities, bodies, genders, sexualities etc. and, far from regarding these as 'issues', we begin to accept that the identity of 'therapist' 'contributes to the kind of findings and representations offered about the identity of the other' (Rhoads, 1997). Therefore, time must be spent, in therapeutic training, considering the complexity of 'heterosexuals exploring the lives and identity struggles of lesbian, gay and bisexual people' or, likewise, the complexity for white, middle class, heterosexual female therapists exploring the lives of black, working class youth. Rather than endure the subordination of dominant narratives and the inculcation of regulatory regimes that designate these meanings into a 'ghetto', queer theory challenges and usurps everyday binary meanings such as black/white, male/female, homosexual/heterosexual and provides new ground for rethinking, re-contextualizing and re-cognizing present-day therapeutic practices by questioning taken-for-granted knowledge. Rather than sidelining 'the social' it positively challenges the 'liberal violence' perpetrated against those who are considered 'non-normative and irrational' (Reddy, 2011). Ultimately, this paper questions whether therapy is, in fact, being used to impose a 'cultural arbitrary' by delegitimating and misrecognizing those who are routinely labelled as 'other'. The aim must surely be to provide a substantive new ground where social identity is no longer quarantined out of mainstream teaching but is made central to therapeutic knowledge, where the individual and the

DOI: 10.1002/ppi

social are reflexively understood as fundamental to the integrated, intersubjective notion of 'self'. This represents, as Rhoads (1997, 7) states, 'a growing concern about how one thinks about the self and the other as societies progress towards increased globalization, expanded cultural diversity, and postmodernity in general'.

BACKGROUND

My own efforts at questioning therapy, sexualities, genders, sex and 'recognition' have often led to frustration and a shift in my own position in relation to what I believe therapy should incorporate into its mainstream understanding about sex, sexualities and genders. Over the past decade I have conducted two major nationwide studies. The most recent research, conducted between January 2008 and August 2008, was a nationwide study. It involved 40 therapists (10 gay male; 10 bisexual; 10 lesbian and 10 heterosexual) who were either Chartered (British Psychological Society); Accredited (British Association for Counselling and Psychotherapy) or Registered (United Kingdom Council for Psychotherapy), which means they met established criteria and had at least 450 hours of theory and practice. Data taken from episodic interviews lasting a minimum of 1 hour were analysed using grounded theory and narrative analysis. This added to research with 30 qualified therapists between 1999 and 2000 using 1-hour-long semi-structured interviews and analysed using grounded theory. All therapists had experienced their own therapy for at least 40 hours. Therapeutic models named by therapists from both studies involved a broad spectrum of those made available to the public either privately or through voluntary sector/National Health Service centres. They included: cognitive behavioural therapy (CBT); psychosynthesis; transactional analysis; neuro-linguistic programming; Gestalt; systemic; psychodynamic; psychoanalytic; Jungian; person centred; feminist; integrative and behavioural.

The debate about models and approaches often fails to delineate what these mean. My own understanding is taken from training, where we were informed that there were three main approaches (interpretative, humanistic and cognitive behavioural), with transpersonal added later as a fourth major approach. Within each of these approaches any number of models may exist. This stance would prevent the limited outlook presently governing some teaching; e.g., the British Psychological Society dictates that practitioners must know at least one 'model' in depth for doctoral-level study. Knowledge of an 'approach' would mean incorporating far more 'models' and therefore offering clients a much wider access to understanding their distress.

Demographically, all 70 therapists were aged from 28 to 70 years, predominantly white, able bodied and middle class. They had been working as qualified therapists for anything between 3 and 30 years. This is important to include, as most therapy training courses do not consider social demographics important, and this is implicated in the paper as a reason for the lack of recognition offered to sex, genders and sexualities as well as race, ethnicity, disability and age. Although I worked to have categories of an equal representation for heterosexual, lesbian, bisexual, and gay male sexualities, and male /female sex and gender, the research was not adequately inclusive of non-white or trans therapists. Also, in outlining the field of therapy, therapists reported how their experiences in training did not reflect societal representation, with virtually all interviewees saying the bulk of their training cohort was white, middle-class, heterosexual, able bodied and female in most training institutions at the

DOI: 10.1002/ppi

time of their training between 7 and 20 years ago. Sex, gender and sexuality were rarely, if ever, addressed in training. The professionalization of therapy, its ever increasing marketable value and its insurgency into public service settings (education, National Health Service, family, law) is beginning to alter this profile but there is still resistance to change.

TRAINING AS A FORM OF PEDAGOGIC ACTION

As shown in the demographic detail above, therapists I interviewed were an accurate representation of therapy trainees over the past 15 years up to 2009 and appear to represent a typical window on those selected for training. For example, all interviewees remarked upon the constitution of their training cohort, and the following comments are consistent with opinions voiced by all interviewees when I asked them about the composition of their courses:

> Well, exclusively white . . . don't have any ethnic minority groups at all, in any of the courses. When I did my training at X there were a couple of black women . . . that was it through all that training. And the doctorate . . . there ain't no black faces there . . . and I have consistently . . . been the only gay man on all the courses that I've done'. (White gay male therapist)

> White, middle class, female. I use that in the sense of social standing not a natural standing because a lot were poor. (White bisexual/trans therapist)

> . . . eighty per cent white, middle class females, heterosexual. (White, heterosexual female)

> . . . it's mostly women. I would say it's probably eighty per cent women on the courses. (White, gay man)

> . . . they were all white. I think there were two blokes in the diploma group and . . . one gay woman. (White bisexual therapist)

> . . . in their nice, closed, sort of typically middle class world, they never thought what the pink triangle represented . . . we had four men, all of whom were straight . . . and the rest were all . . . I would classify as middle class women. Straight women . . . so it was tricky because not only was I not straight, I was also not middle class. (White lesbian therapist)

> . . . heteronormative, suburban housewives, predominantly white people . . . I guess with some little sex problems. (Mixed heritage queer bisexual trainee)

The selection of those who will train and later qualify as therapists is arguably a form of cultural reproduction as they represent a 'privileged position' within society which is directly related to the position of knowledge and the power to examine those who are members of 'a non-privileged identity group' (Rhoads, 1997). As we witness above, far from recognizing 'the other' the choice of trainees simply bolsters privileges such as middle class status, hetero gender and sexuality, whiteness/colonialism. Arguably, therapeutic training is deeply entrenched inside social structure as it persists in maintaining a particular social identity, by legitimizing and valorizing a system (white, middle class, hetero sexual and gendered, predominantly Christian and able bodied) that continues to reify certain aspects of the dominant culture. Rather than interrogating these social categories through a queer lens by questioning what is meant, for example, by 'whiteness' and its importance to notions of authenticity and self or the binarisms of male–female in the context of colonial histories or the role of emotional emancipation in relation to embodied differences, instead therapy appears to ignore privilege and elitism. In fact, not only does it prevent an interrogation of traditional narratives

DOI: 10.1002/ppi

and what each of these factors may mean for the inner life of the therapist but, more importantly, what this will mean for the feelings that will emerge when working with people who present from outside these categories or social identities, suggesting it will frame feelings in ways that fit traditional meanings.

The selection of trainees and the type of training on offer are aspects of 'pedagogic action' that underpin 'symbolic violence' in the way they reproduce the powerful ideas of the predominantly white, middle class, heterosexual, able-bodied, Christian culture in which 'society' and its social mores, values and morality are located. The question is whether therapeutic training recognizes this type of violence and challenges this outdated and monolithic system. The answer is an abject 'No'. In fact, legitimate and covert power relations continue to put these systems into position so they remain unrivalled – for example, the criteria for entry onto courses seems to mean that particular groups are not targeted because the idea of 'equal opportunities' has become bureaucratized. As I was constantly reminded when I asked why specific populations were not being targeted: 'How would it make a difference?' For example, as one interviewee, who was a university masters and doctoral programme leader, commented:

> The structure is such that the University does the equal opportunities bit. And that gets separated out and sent off before the admission panel gets to meet anybody . . . and you get about ninety of them [applications] . . . and you kind of go through them and it's this kind of attempt to be . . . but possibly a charade of being . . . somehow objective . . . So sometimes we get surprised on the day when the candidate walks in for the interview . . . that they're . . . you know . . . might be . . . I don't know . . . quintessentially British name, but actually you've got someone from Jamaica or something. So, sometimes those things that happen . . . I think that's quite a good thing. But predominantly, we've got white women on the course.

The selection of trainees is embedded in power relations that highlighted a determination to maintain particular symbols and cultural meanings. Thus people in positions of authority within the field of therapy maintain cultural privilege as normative by refusing to recognize anything other than the dominant culture. They impose their own authoritarian meaning onto the shaping of knowledge to such an extent that training now consists of its own discourses and style of language which 'determines what is seen . . . what things are valued, what questions can be asked and what ideas can be thought' (Webb et al., 2002, 13). In effect, symbolic violence leads to the domination of heteronormative values, rituals and rules 'which constitute an objective hierarchy, and which produce and authorise certain discourses and activities' (Webb et al., 2002, 21). The next section will focus on the way therapy continues to develop to maintain a dominant cultural imperative and how it seems to struggle to accommodate alternative meanings.

NORMATIVE IDEOLOGY AND THERAPEUTIC TRAINING

The cultural dominance of therapeutic training continues to reproduce itself – it essentially produces and reproduces cultural privilege. Trainees are gradually exposed to legitimated 'systems of symbolism and meaning' such as therapeutic theories and models (person centred, CBT, psychodynamic) which are metaphors for understanding social life, experiences, feelings, thoughts and behaviours and act as legitimate modes of inculcation (Jenkins, 1992,

DOI: 10.1002/ppi

104–7). Their monolithic qualities as 'grand narratives' cannot be underestimated because they provide recognition to the formation of subjectivity and relational inter-subjectivity. Of course, there are many hundreds of models and each presents a template for ways of working with individuals or couples or groups or all of these populations. But, most of the therapists I have interviewed over 15 years in the UK say they have been fed a diet of person-centred, psychodynamic and cognitive behavioural models throughout training. The majority of those interviewed said they often start with person-centred and then move into either a psychodynamic or CBT framework. Within the structural framework of the 'model' are perspectives that are often presented as 'examples' of how to operationalize a particular way of working. For example, psychodynamic theory places a great deal of importance on unconscious life, hermeneutics, gender dynamics and the development of childhood and adolescence, while person-centred theory emphasizes subjective experiences, 'congruency' the relational and CBT is less concerned with the 'past' as it is with cognitive restructuring, behavioural modification and motivational goal setting. The main issue to think about here is how the population of trainees seem unlikely to contradict or challenge the thinking presented as representative of a 'model' if, as witnessed above, those who train and those who are being trained all invest in the privileged and dominant 'cultural arbitrary'.

For example, 'the family' as a highly ideological organizing structure is presented within therapeutic models as central to the formation of identities, perceptions and cultures and often reflects an idealized and mythical notion of 'family' (Jones, 2002). It is presented as representing a heteronormative environment, where heterosexuality is seen as 'the elemental form of human association, as the very model of inter-gender relations, as the indivisible basis of all community, and as the means of reproduction without which society wouldn't exist' (Iantaffi, 2010, quoting Warner, 1993, xxi). Iantaffi, a queer therapist, notes how her experience of training as a systemic therapist meant sexuality was left 'unspoken', 'in parenthesis' throughout training, while the term 'family' was left unchallenged as it was taken for granted that it meant a more traditional and heteronormative framework even when discussing non-heterosexual kinship structures. In my own interviews, therapists made similar comments. For example, as the following two therapists remarked:

> All models are in a heteronormative framework. Examples include the idea of the unconscious and the family … All constellations are heterosexual … No room for anything whatsoever as non-heterosexual … the word family is used in a very heteronormative sense.

And a lesbian therapist added that therapy is out of step with 'the rest of society' because to those construing the meaning of therapy 'normality's therapeutically healthy', adding:

> However, in the first place, they're … they're not presenting an inclusive picture … Like … 'Childhood and Lower Unconscious': *completely* heterosexist. *Nothing* about what's it like to be, um, a different child … a different teenager: that for *me* … I was *different*, you know.

Therapeutic models invoke a predominantly rationalistic model of 'the family' underpinned by rules of reciprocity and a 'family logic' that constructs ideas in relation to gender, sexuality, sex etc. that shape subjectivities and the 'affective life' of people (Jones, 2002, 23). The family is assigned a mythical status – 'it is a story whose premises are not questioned' –

DOI: 10.1002/ppi

and especially within therapy this myth underpins the significance of the family so that assumptions about the 'power' of families becomes 'so culturally embedded and "obvious", or commonsensical, that they are not questioned' (Jones, 2002, 5). Within this are meanings about gendered relations and the very basis of 'the family' is structured on heterosexual and hetero-gendered meanings. Their significance is seen in theories running through attachment therapy, object relations, psychoanalytical perspectives etc. where it is taken for granted that bodies, psyches, feelings and emotions will respond to normative meanings. However, as the landscape of sexed and gendered meanings begins to alter, as it just begins to take on queer dimensions, then trans-men and trans-women, gender-queer bodies and gender-variant people are reshaping what is meant by 'he' or 'she', male or female and challenging the limitations of language when discussing feelings and embodied meanings. This will hopefully open up discursive spaces and render traditional understandings as obsolete or at least in need of urgent revision. Think of how a therapist will respond to the following statement made by one participant, Pietra (pseudonym) who defines as a 'queer trans boi' and how it challenges therapeutic concepts as he states he is:

> . . . an equal opportunities lover in a positive sense of the word. Fairly poly as well, although that keeps changing as well . . . I've been in open relationships, umm closed relationships, promiscuous, abstinence, non-relationships . . . like the person I'm seeing at the moment is kind of into trans boys but you know, at the same time he's open to all kinds of other people and umm and is curious about, you know, where I'm gonna go next I guess.

Surely, we would think it important for the therapist in training to really understand how 'he' or 'she' feels not just in the relationship to Pietra, but to their own feelings in relation to experiencing new meanings and words (trans boi, poly, equal opportunities lover) and what these may mean for a reconfiguration of more traditional and 'safe' meanings of 'him' and 'her'. And outside of this, how do reconfigurations of meanings for gendered and sexual and sexed bodies challenge traditional models and theories as they take on new formats for symbolic sexualities and genders? How do therapists begin to incorporate new 'feeling worlds' and restructurings for emotions? It is these 'felt' discomforts that bring about a change to match those changes in the sexual and gendered landscape.

GHETTOISING THE OTHER

It is the dominant hetero-gendered and sexual and sexed culture that is, more often than not, recognized as legitimate by subordinated groups. During the research I felt an certain unease at the way predominantly lesbian, gay and bisexual, black and Asian, dis-abled body, discourses were forced into a 'ghetto' and easily subsumed under the heading of 'difference and diversity' without any resistance – even from lesbian, gay male and bisexual trainers. It seemed to represent a form of 'censorship' or 'exclusion' of the material reality of those situated in 'the ghetto' which, as Jenkins (1992, 105) points out, becomes 'the most effective mode of pedagogic action'. The question is how this happens. What was preventing lesbian, gay or bisexual (LGB) trainers from challenging the content of courses? Everyday practices are shaped by training, not just in relation to therapeutic practice with clients but in relation to

DOI: 10.1002/ppi

the way trainees experience their own acts and conversations. In a reflexive process, the trainee therapist is 'shaped' via their training. One major finding was how reports of open transgression of heteronormativity often led to trainees feeling they did not 'fit in', or they were excluded and, in many cases, completely isolated. This form of misrecognition or symbolic violence from those members of the dominant group became a major finding of both studies. For example, a bisexual therapist told the story of what happened to her while she was in training and the response from a heterosexual colleague when his gay client made a cup for this therapist:

> I mean this guy, this particular [gay] guy had made a cup in pottery for his counsellor and I was in the counselling room one day and his counsellor said he wanted a cup of tea but there wasn't a cup and he didn't like to use that cup [the cup made by the gay man] because it had been made by this gay guy, and he didn't like to use that cup.

Most non-heterosexual trainees could cite examples of how they were silenced or censored through their treatment on the course. A number of examples particularly left me quite disappointed with the training provider's sheer refusal to recognize what was actually taking place for trainees positioned as 'other' on the course. In the first example below, the trainee is the only 'out' gay man, while in the second piece the trainee was a student on a well-known relationship training course:

> It's quite isolating really . . . But I was the only person there . . . you know . . . you're just kind of like . . . a bit wearying really . . . I remember walking past a couple of other people on the course in the corridor . . . and I just over heard one of the other men saying 'Oh, of course, but I mean I really struggle with the fact of there being a gay man on this course' . . .

> And I remember one fellow student . . . and she's the one that stared at me for several months and wouldn't stay in the same room as me. I was a real shock to her . . . like having a trans person in the room. You know, she would literally like sit on the other end of the room from me and just stare at me.

Heterosexual trainers in particular seemed to struggle when faced with a group of trainees who represent 'the norm' and who are actively discriminating against particular students. As one lesbian student, Red (pseudonym), disclosed:

> . . . the trainers tend to reflect the dominant group in my experience. And I think that's an unconscious element and I think they don't challenge themselves perhaps.

Red continues and, along with one other lesbian and two gay men on her course, is left to do the 'emotional labour' (Hochschild, 1979) of the larger group because of the experience of misrecognition. For example, her trainer makes numerous comments about the place of 'homosexuality':

> . . . then she mentioned that this guy was over and about curing homosexuality and of course it is still in DSM IV [and] it was considered a disorder of the self etc. etc. and the three gay people just sat there sort of thinking which one of us is going to say something first? And it was really interesting because we all

DOI: 10.1002/ppi

> looked at each other and there was quite a lot of collusion amongst us that we wouldn't say anything until we gravitated together in the next break and said 'Okay, how are we going to handle this?' and I was really struck by those different processes, the processes going on within and the fact that we were acutely aware that the trainer didn't see anything wrong in what she'd said.

Her trainer is unable to recognize how her comments are affecting those who are not heterosexual. Likewise, it is the affective content that resonates for Red so that she and her friends are left to 'handle' the way material is discharged. I consistently found in the research that most non-heterosexual trainees experienced this type of knowledge about 'the other'. Occasionally they were taught by tutors who were 'out' as lesbian, gay male or bisexual. In many ways, it could be expected that this population will openly critique dominant discourses and practices. However, this was not found to be the case. I found that most tutors who defined as LGB had either been recruited specifically to teach sex, gender and sexuality or had somehow found themselves in this role because they recognized the lack of input during their own training. It was not unusual for LGB tutors to have designed and delivered the course, often without having any training from other disciplines. Thus, while some were informed about LGB issues, they could be equally discriminatory towards gender queer or gender variant, trans, or queer clients. In fact, they often regurgitated knowledge about therapeutic models or rhetoric about issues in a way that failed to challenge the established heteronormative order. As one gay male trainer commented:

> I do teach now at five different universities because I decided there wasn't . . . It was pathetic there wasn't much at all, there wasn't enough on sexualities, there wasn't enough on sex to begin with uhh it was ridiculous.Me: So, you've taken it quite personally?Yes, I've taken it on and I've decided I need to do something. Because I think we had one afternoon by a service user who came in. It was very odd.

In many ways this seems to emphasize the overall lack of recognition offered to sex, gender or sexualities as well as how these intersect with race, ethnicity or disability. In effect, LGB trainers are simply making attempts to install some type of training so that trainees can accommodate clients who are 'other' than heterosexual. However, without these tutors it seemed highly likely that the 'ghetto' would remain just that! In fact, although most were willing and open to delivering information about contemporary gender knowledge and emancipate sexualities from traditional order, they seemed to struggle with how this could be done and therefore they institute a training that is complicit to the dominant cultural expectations. Liberating 'feeling' and allowing an exploration of how trainees experienced gender and sexuality seemed limited to a specific arena such as 'difference and diversity' rather than being incorporated into mainstream teaching.

CONCLUDING REMARKS

The idea of 'recognition' is acutely challenged within therapeutic training as the 'other' is often dislocated from the 'real' content of the course and made subordinate to the more mainstream modules. Rather than ideas of 'difference' or diversity' rebutting mainstream ideas and providing multiple perspectives integrated as 'dynamic, intersecting and constantly in

DOI: 10.1002/ppi

process' (Storr, 1999, 10, summarizing Brah, 1996), instead, a form of 'ghettoization' operates. Not only are alternative perspectives to heteronormative meanings slotted into 'static, hierarchical social divisions' (ibid.) but there is very little room to learn about the production of discourses that inflect a wider scope of citizenship issues. It can be argued that the 'self' of therapy is, in fact, simply a more developed and nuanced version of what Bourdieu terms 'the cultural arbitrary', legitimized by and through therapy to uphold the values and morality of a predominantly heteronormative culture. In fact therapists, having undergone training and personal therapy, reflect not so much a deeply personal and authentic 'self' but a 'therapeutic' self that represents a durable training, the inculcation of knowledge and 'the internalization of the principles of a cultural arbitrary' (Jenkins, 1992, 106) to the point where selfhood is the imposition of culture onto and into the body as an enduring set of practices that continue long after training has ended. And it effectively obscures the power relations involved and censors or excludes alternative narratives. For example, queer theory has emerged as an ideal discourse through which to challenge and debate therapeutic issues such as emotional intimacy, the formation of subjectivity and the dominance of heterosexual identities. It rebukes heterosexuality and offers ways to reconsider kinship structures via the shift to polyamory and non-monogamies, and in particular to challenge the failure of the binarisms 'male' and 'female' in a time of queer, transgender and trans meanings. However, none of the therapists interviewed had any formative knowledge of queer narratives and their therapeutic value. Thus heterosexual homogeneity underscores an understanding of human subjectivity to such an extent that it becomes impossible to interrogate 'the posited universalistic model of affect [that] ties in easily with an imperialist narrative of the West as sexually and emotionally advanced and superior' (Haritaworn et al., 2006). It is a universalist position. In effect, therapists not only act as the purveyors of oppressive social systems but are patrolling the very borders of citizenship for the gendered and sexual 'other' through a quiet, but violent, set of practices.

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