

VIOLENCE AND EMPOWERMENT
PSYCHOLOGICAL SUPPORT
FOR LGBTQ PERSONS

KATARZYNA DUŁAK / JAN ŚWIERSZCZ



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INTRODUCTION

We feel pain because we harm each other, and we shall suffer as long as we continue to harm. To break the circle of oppression, let us take care of the world and other people, instead of curing and fixing them.

DAVID SMAIL

Dear Reader, in this book we are trying to provide you with essential information that may be helpful in supporting persons experiencing oppression motivated by homophobia. It is not a publication about victims of violence. We do not call them “victims”, for we are convinced that this term labels, incapacitates, and may become a self-fulfilling prophecy. We perceive leaving the situation of violence as empowerment and regaining control over one’s own situation and life, that is leaving the role of victim behind. Everyone has experienced an oppression or violence of some kind, but nobody wants to remain a victim: a helpless person, with no possibility of initiative, feeling guilty for their situation, and placing difficulties in themselves. Therefore, the personal responsibility of therapists working with persons experiencing violence motivated by hatred is enormous. All these persons are exposed to violence motivated by homophobia; it may include both LGBTQ1 persons, and heterosexual persons fitting into gay or lesbian stereotypes. To a large extent, this violence concerns persons breaking with stereotypical expectations regarding women and men, that is „effeminate men”, „manly women” or persons whose gender is not unambiguous in social reception.

In this publication we shall focus mainly on LGBTQ persons, that is homosexual and bisexual women and men, transgender persons, and persons that do not specify their sexuality or gender in a traditional (heteronormative, cisgender) way. We believe that psychologists providing therapeutic support, that is also you, have necessary compe-

1 | Lesbian, gay, bisexual, transgender, queer. Letter Q is an acronym for “queer”, referring to persons who identify themselves non-heteronormatively and/or outside of dichotomic division of genders. For the needs of this text, we employ the word “queer” as an umbrella term covering all named (but less popular than LGBT) and unnamed sexual and gender identities which elude heteronormative assumptions. Depending on context, in the book we use either LGBTQ or LGB abbreviation. At the end of the book you can find a dictionary explaining special terms.

tences and tools for work, their own therapeutic styles, and wisdom that allow them to assess skills and apply them to various therapeutic situations. However, sometimes there is not enough experience and knowledge. Professional development consists precisely in acquiring new experience and enriching one's knowledge. Therefore, you may treat this publication more as an essential resource of information that introduces you into the context of work with LGBTQ persons and indicates a direction, rather than a textbook with therapeutic tools.

Violence motivated by prejudice is a specific form of violence; psychologists working in this area, except competences necessary to work with persons experiencing violence, need additional knowledge, experience, and skills that consider the social context of persons experiencing violence. The element indispensable for competent aid in this area is knowledge about mechanisms contributing to formation of discrimination phenomenon, the most extreme symptom of which is violence motivated by prejudice, or knowledge about functioning of persons remaining in a situation of permanent stress, what is characteristic of those belonging to minority groups. In this publication we extensively discuss social context contributing to occurrence of specific difficulties in members of socially disadvantaged groups. Self-awareness concerning one's own attitudes, stereotypes and prejudices, as well as critical reflection on homophobia and, resulting from it, transphobia present in many psychological trends and theories, are key elements needed for efficient and ethical psychological assistance.

Homophobia present in the society increases the exposure of LGBTQ persons to violence in comparison to heterosexual persons. In addition, as a result of common and silent consent to heterosexism and homophobia in society and political debate (e.g. homophobic statements during politicians' and publicists' debates), reacting to this kind of violence requires greater self-awareness and knowledge of mechanisms connected with prejudices and discrimination. When working with persons experiencing homophobic violence, it is extremely important to notice context in which that violence occurs. Therefore, we encourage to first paying careful attention to social situation in which LGBTQ persons function and its consequences.

In the second part of this publication we shall thoroughly discuss the competences of assistance profession specialists – their knowledge and awareness which are essential for effective work with persons experiencing violence motivated by homophobia. In this part we shall discuss current guidelines and standards, focusing on ethics of undertaken actions within the scope of psychological support for LGBTQ persons. We shall discuss basic issues connected with professional work with LGBTQ persons, such as: careful language usage and awareness of messages carried by the language; guidance on where and how can one increase their competences through supervision and education, participation in specialist trainings, as well as one's own work (e.g. by consulting thematic literature, filmography, knowledge of support networks).

In the last part of the publication we invite you to familiarize with individuals engaged in counselling for LGBTQ persons in Poland, who work with or for them and agreed to share their experience. Such work entails various dilemmas and challenges, as well as seeking one's own, best method of professional development. In conversations with us, specialists from Poland share guidance and good practices which may be useful also for you.

At the end of the publication we have included a dictionary containing basic definitions connected with the subject of gender and sexuality which you may consult should there be any term unknown to you.

We treat our psychological work as a mission. We work with LGBTQ persons on a daily basis; providing support, we strive to have the best insight into issues and joys connected with this social group. We are also engaged in educational activities, cooperating with various professional groups and community life actors for anti-discrimination. Moreover, we are not observers of LGBTQ person's reality; we participate in it, merging our professional life with social and personal one. In this publication we share our knowledge, acquired experience, and also perspective and approach to assistance work.

We hope that this book will become a valuable source of knowledge and inspiration.

CHAPTER I

THE ORIGINS OF HOMOSEXUALISM

As defined by the old civil and canon law, sodomy was counted among tortious acts, with the offender being nothing but a defendant. Nineteenth century homosexual gained a personality, had a past, history and childhood, character and way of life, as well as morphology with incorrect anatomy and, possibly, mysterious physiology.

He completely withdraws into his sexuality, it is pervasive within him: hidden in all behaviours, for it is their insidious and, in a way, active principle; he wears it unashamedly written on his face and body, as this secret always reveals it. It coexists with him, not so much as a sinful habit, but rather as a peculiar nature (...), certain way of mixing the masculine and the feminine within him. Homosexuality turned out to be one of forms of sexuality when it was shifted from the scope of sodomitic practices to a kind of internal androgyny, a hermaphroditism of the soul. Sodomite had been a dissenter; homosexual was now a species.²

//

Homosexuality has not always existed. Scientists “invented” it in the 19th century. Such is the basic thesis of Michael Foucault, French philosopher and sexuality researcher. In fact, sexual behaviours between individuals of the same sex may be observed both in the natural world and throughout history in different cultures and different societies; however, they have only recently been elevated to a special status. In the Western world culture with Judeo-Christian roots, they have been present throughout ages and valued differently – in ancient Greece they constituted an element of maturation and initiation into adulthood, in Christian world – a sin, an act of sodomy, a depravity. However, until the development of psychiatry and sexology, they had been nothing more than acts, affects, or behaviours. Only the development of medicine in 19th century gave them a special character and started the classification of persons, based on these behaviours, into normals and deviants. Michael Foucault’s observation is significant because it creates an unique perspective and a starting point

2 Foucault, Michael (1978). *The History of Sexuality. Volume I: An Introduction*. New York: Pantheon Books, p. 43

for searching answer to the question of functioning of non-heterosexual persons and the role of therapists working with them.

Sexology and psychiatry have come a short yet turbulent way in describing and classifying homosexuality. It should be emphasized that precisely naming, labelling, categorizing of various behaviours and their assessment for standard/pathology has been the centre of interest of these nascent science disciplines. It was derogations from standard indicated by traditional customs that attracted the greatest attention. Researchers searched for reasons of such behaviours, their correlatives and consequences, and, on the basis of their hypotheses, they formulated categories and classifications of psychiatric and sexual disorders. In this exact sense, as Foucault writes, a homosexual was born – a person having, according to science of that time, a certain scheme of disturbed behaviours that had their origins, physiological regularities, and personality. Behaviour became a person's determinant, its immanent part, an essence. Simultaneously, scientific establishing of existence of a certain category of deviants went hand-in-hand with pathologization and penalisation. Science perception of homosexuality³, despite strictly claiming objectivity, was firmly rooted in cultural standards that sharply defined gender roles and permitted behaviours. Foucault writes that „we are subjected to production of truth by the authority and we cannot exercise power in a way other than production of truth”.⁴ Therefore, sexology experts sought rational and objective justification for common beliefs and applicable morality. They were accompanied by deep belief that there exists a certain truth concerning nature of human – his functioning and characteristics, objective and absolute truth that is discoverable by a scientific method. This trend, still present in psychology and psychiatry, is called essentialism. It entitled and still entitles to judge about presence or absence of the issue and pathology in the patient and, consequently, to undertake certain interventions compliant with diagnosed symptoms.

3 Together with the evolution of psychology and medicine approach to the issue of sexuality, also discourse changed. In this chapter, due to historical references, sometimes we shall employ terms “homosexuality” and “patient”, despite the fact that these words originate from medical terminology and nowadays are replaced with terms “homosexuality” and “client”. Transformation of „patient” into „client” reflects the spirit of the empowerment process and removal of stigma from persons using psychological assistance.

4 Foucault, Michael (1970). *The Order of Discourse*, in: Young, Robert (ed.) *Untying the Text: A Post-Structuralist Reader* (1981). Routledge & Kegan Paul: Boston, London, and Henley

Therefore, psychiatrists became experts on human nature, including sexuality; in the first stage of science on homosexuality development, it was diagnosed as disorder requiring analysis and corrective treatment. Until the second half of 20th century, women sexuality had not been particularly interesting for science and researchers⁵; as a result, psychiatrists' offices were filled with homosexual men. Therapeutic work with them involved attempts to diagnose causes of homosexual drive, most often sought after in the childhood period and early relations with men, with father's role deemed crucial, and development of methods to suppress this drive and engaging in sexual relationships with women.

A significant change in approach to human sexuality was brought by works of Magnus Hirschfeld, presently considered a pioneer of research on sexuality, and the father of sexology. In 1914, Hirschfeld, a German physician and judicial expert, published an extensive study of human sexuality, including women, based on anthropology, medicine, psychology, law and history data. In his publications, Hirschfeld shifted from the pathologizing approach to sexual non-prescriptiveness and, following results of his research, he tried to break the dichotomy of "man" and "woman" categories that dominated in science⁶. He introduced the notion of "third gender" which included androgyny, hermaphroditism, homosexuality, and transvestism. According to him, certain psychological traits, sexual drive, biological sex, and physical traits position homosexuality between masculinity and femininity. Magnus Hirschfeld's views and interest contrasted with other researchers and physicians because he placed great emphasis on research and description of social situation of persons belonging to the "third gender". His motto was a Latin saying *per scientiam ad justitiam* (Justice through science) and, in fact, he attempted to influence the legal situation back then. He acted in sup-

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5 It may have resulted from the stereotype of woman and her attributed gender role: a sexually passive person, infantile, set on satisfying man's needs and lacking autonomous sexual needs. This image was significantly changed thanks to Alfred Kinsey's *Sexual Behavior in the Human Female* report from 1953, which shocked the American society with data on women's sexual activity (also extramarital).

6 Mijas, Magdalena (2012). *Sodomici, Inwertyci, urningowie. Homoseksualność w dziewiętnastowiecznym dyskursie medycznym* [Sodomites, Invertites, Urnings. Homosexuality in the 19th Century Medical Discourse] {Translator's note: if a given position has not been released in English, approximate translation of the title shall be provided in square brackets}, in: Iniewicz G., Mijas M., Grabski B. (eds.) *Wprowadzenie do psychologii LGB* [Introduction to the LGB Psychology] Wrocław: CONTINUO

port of decriminalisation of homosexual behaviours between men and, in 1912, the Scientific-Humanitarian Committee founded by Hirschfeld successfully protested against the attempt to extend the Prussian penal code and forbid sexual acts between women⁷. Magnus Hirschfeld's achievements also include the world's first Berlin-based Institute of Sexology that conducted researches and gathered data and artefacts concerning sexuality from various cultures. After Hitler came to power in 1933, the Institute was devastated by Nazi militias and about 120.000 unique books and volumes were demonstratively burned.

Magnus Hirschfeld was the first to research men's sexual orientation on large samples of population. According to his estimations, the percentage of homosexuality widespread in the society amounted to around 2%. However, it was Alfred Kinsey in 1948 and 1953 who conducted ground-breaking research that changed the perception of homosexuality. Together with his research team, he conducted over 18.000 in-depth interviews with men and women representing various social groups. Researchers' assumption was to reach sexual experiences of the population, without taboos, guaranteeing anonymity to the participants. In research reports, Kinsey departs from categorization of sexual orientation into homosexual, bisexual and heterosexual. According to him, sexual orientation may be presented on a continuum consisting of six categories and may not be a trait constant in time. Kinsey also pointed at the fact that his scale measures a stimulus of sexual arousal, while the sexual orientation itself may be understood through actual sexual experiences, desires and fantasies. Results of researches conducted by Kinsey's team showed that human sexual behaviours are much more varied than it had been previously assumed. The report demonstrated that about 10% men identify themselves as exclusively or nearly exclusively homosexual, and 37% had at least one sexual experience with another man in their lifetime. About 28% women experienced homosexual fantasies in their life. These numbers raised many controversies but also **caused ferment** in the research community, for it turned out that penal-

7 Biedroń, Robert (2012). *Nazistowskie prześladowania osób homoseksualnych* [Nazi Persecution of Homosexual Persons], in: Remin, K. (ed.), *Różowe Trójkąty. Zbrodnie nazistów na osobach homoseksualnych w kontekście edukacji antydyskryminacyjnej* [Pink Triangles. Nazi Crimes Against Homosexual Persons in the Context of Antidiscrimination Education], Warsaw: Campaign Against Homophobia.

ised and pathologized homosexuality is not a trait of a “social margin deviant” but may be a common phenomenon in the population.

Scale of sexual orientation proposed by Alfred Kinsey

INDICATOR	DESCRIPTION
0	EXCLUSIVELY HETEROSEXUAL
1	PREDOMINANTLY HETEROSEXUAL, ONLY INCIDENTALLY HOMOSEXUA
2	PREDOMINANTLY HETEROSEXUAL, BUT MORE THAN INCIDENTALLY HOMOSEXUAL
3	EQUALLY HETEROSEXUAL AND HOMOSEXUAL
4	PREDOMINANTLY HOMOSEXUAL, BUT MORE THAN INCIDENTALLY HETEROSEXUAL
5	PREDOMINANTLY HOMOSEXUAL, ONLY INCIDENTALLY HETEROSEXUAL
6	EXCLUSIVELY HOMOSEXUAL

Alfred Kinsey’s research intensified a strongly developing trend in American psychology and psychiatry of 1960’s that depathologized homosexuality. Its favourable factors included observed inefficiency of actions aimed at reorientation of homosexual sexual orientation, and developing emancipation movement of gay and lesbian community. Increasing number of research reports demonstrated common presence of homosexuality in populations and negative effects of reparative actions. Attempts at changing orientation to heterosexual consisted in, among others, behavioural influences that connected a sexual stimulus with pain (in a form of electric shocks or emetic agents), or psychoanalysis resulting in deepening the sex-related stereotypes and lack of self-acceptance by the patients.

In 1973, with the adoption of a new version of DSM (*Diagnostic and statistical manual of mental disorders*), it was voted on the removal of homosexuality from the list of disorders. In 1980, the new version of DSM-III includes a *egodystonic homosexuality* disorder describing difficulties to accept one’s own homosexual orientation, and a desire to change it. In

1990, the World Health Organization also removed homosexuality from ICD-10 list of disorders, replacing it with egodystonic homosexuality that described unaccepted homosexual feelings. Since psychologists had been more and more aware of society's disapproval towards homosexuality, such feelings did not surprise them anymore.

Despite depathologization of homosexuality by authoritative research communities and its removal from employed classifications of disorders, some psychotherapists still present their clients with a possibility of reorientation to heterosexuality, and social stigma of homosexuality as a disorder remains. American psychology and psychiatry communities focus more and more on studies of non-heterosexual person's situation, their welfare and social conditioning of disorders, at the same time accepting responsibility for legacy of decades of sanctioning oppression and reinforcing prejudice against non-heterosexual persons. In 2007, the American Psychological Association constituted a research team with an objective to conduct a meta-analysis of all available research reports concerning the change of sexual orientation to heterosexual, and develop recommendations for psychologists and therapists – *Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. In a report prepared two years later, this team stated that “actions aimed at changing the sexual orientation are unlikely to be effective, and they carry the risk of harming”⁸.

Simultaneously, it is assumed that:

- Same-sex sexual attractions, behaviour, and orientations per se are normal and positive variants of human sexuality – in other words, they do not indicate either mental or developmental disorders.
- Homosexuality and bisexuality are stigmatized and this stigma can have a variety of negative consequences (e.g. minority stress) throughout the life span.
- Same-sex sexual attractions and behaviour occur in the context of a variety of sexual orientations and sexual orientation identities, and for some, sexual orientation identity (i.e. individual or group membership and affiliation, self-labelling) is fluid or has an indefinite outcome.

8 American Psychological Association (2009). *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*.

- Gay men, lesbians, and bisexual individuals form stable, committed relationships and families that are equivalent to heterosexual relationships and families in essential respects.
- Some individuals choose to live their life in accordance with personal or religious values (and, e.g. reject their homosexuality)⁹.

THE SOURCES OF HOMOSEXUALITY

Research on homosexuality began with separation of behaviour and classification of behaviour recognized as deviant, and construction of the homosexual-deviant category. Then, roots and causes of a described deviation were searched for in order to prevent its proliferation and to discover the most efficient treatment methods. Psychoanalysis greatly contributed to the development of psychodynamic theories that searched for the grounds of homosexuality in disrupted childhood relations, injury, trauma, or unresolved complexes. Making an assumption about environmental conditioning of non-heterosexual sexual orientation has opened, and still opens, the way for therapists to search for methods of changing the sexual orientation. It happens despite acknowledging that neither homosexuality nor bisexuality are distorted ways of experiencing one's own sexuality, and therefore are not subject to treatment.

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For many persons, the source of homosexuality seems to be crucial: this question is posed by students, teachers, and persons providing psychological assistance, who participate in specialist trainings. One should think where does this question come from and what would be the consequences of answering it. Also, it should be noticed that the mechanism of formation of heterosexual orientation does not enjoy such interest and does not incite similar curiosity.

Sometimes, the need to gain answers is connected with one's not fully defined approach towards homosexuality. If homosexual orientation is conditioned by biological factors independent from socialization, then could therapeutic attitude towards homosexual client be different than in the case in which the source of his orientation would lie in experiences of the early childhood? What if sexual orientation is decided by biological factors (e.g. during prenatal period) which may be influenced by hu-

⁹ Ibidem.

man? Sometimes, in social discourse on homosexuality, there appears a theme of cause as a condition of acceptance. In such situations, there are noticeable views that if human cannot influence the sexual orientation, then there is nothing left to do but accept non-heterosexual persons in the society. However, should there exist a possibility of influence and change the homosexual orientation into heterosexual one, then “there is still hope” and chance that should be used. Such reasoning involves valuation and hierarchal perception of various sexual orientations. Precisely this valuation caused the pathologization of homosexuality, painful attempts at therapy, prejudice and oppression against non-heterosexual persons.

The issue of origins of sexual orientation is certainly cognitively intriguing but in vast majority of cases it is pointless in therapeutic process. A question that seems more interesting than that about the source of sexual orientation is why the client or a person aiding him wants to know it, where does the need of knowledge come from, and what could be changed by the answer. During work with persons experiencing homophobic violence, the issue of the source of sexual orientation of the abused person is meaningless. We believe that the occurrence of this question itself is much more significant than the answer to it.

DISCRIMINATION IN SOCIAL PSYCHOLOGY

For more than half a century, intergroup processes resulting in divisions, mutual animosity, limited access to resources, and conflicts have been in the centre of interest of social psychology. Various antidiscrimination influences aimed at ensuring harmony in the society via integration of minority groups often employ the concept and approaches proposed by researches, and use already widespread terminology of social psychology. Learning about basic intergroup phenomena that cause exclusion and oppression is essential to understand homophobic violence, and to hold a helpful meeting with persons who experience such violence.

The foundations of social cognition, that is efficient understanding in the world of complex interpersonal relations, consist of processes connected with social categorization and usage of cognitive schemes. A special kind of schemes is **stereotypes**. Stereotypes are schemes concerning social groups, ascribing a certain set of characteristic traits to their members; these traits distinguish a given group from all other groups and are common traits attributed to members of stereotyped groups. For example, a common stereotype ascribes the trait of sexual promiscuity to gay men, as opposed to the rest of society. While stereotypes do not notice individual differences inside the stereotyped group, they exaggerate differences between groups. Therefore, traits ascribed to the group are generalised to all its members. Stereotype content may refer to various characteristics that psychologists (Dovidio, Gaertner 2010)¹⁰ reduce to two dimensions: warmth and competence. Therefore, some traits ascribed to groups may refer to their abilities in a certain field (e.g. artistic skills), and other traits may be grouped based on their emotional background (e.g. emotional instability and envy). Due to their generalising character, stereotypes never describe reality, most often replacing knowledge and actual information about the group

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¹⁰ Dovidio, John F., Gaertner, Samuel L. (2010). *Intergroup Bias*. in: S.T. Fiske, D.T. Gilbert, L. Gardner: Handbook of Social Psychology.

and its members. However, they are common, which means that they are shared by a significant part of the society, using them as a certain type of semantic and communicative code. Some consider stereotypes as group beliefs, for it is observed that members of one social group possess common stereotypes about other, often deemed antagonistic, social groups. Functioning of stereotypes, as well as cognitive schemes, is secondary in relation to consciousness and will – they automatically organize information and activate in every person, unless they deliberately control their judgments and reactions. Stereotypes emerge from the need of effective information management, ordering of fragmentary information, adding and supplementing it, so that navigation in the social world would be quite easy, comprehensible and non-threatening to self-esteem. Stereotypes explain and allow to accept certain phenomena (e.g. the stereotype of homosexual men promiscuity explained the AIDS epidemic), and justify unequal intergroup relations (e.g. as a result of the stereotype of caring women, the employer facilitates taking maternal leaves and encourages to take low-paid care work). Also, stereotypes are formed in a conflict situation or competition of social groups for goods and resources (e.g. prestige, money, decision-making, time) and are used for legitimacy of one's own group interests and justification of oppressions against the foreign group. It is not easy to change stereotypes. When an information or occurrence confirming a stereotype appears (e.g. a person who believes that lesbians are women with “manly” features meets a lesbian with a short cut, in worn trousers and without make-up), then this event is given a special meaning, for it confirms the belief¹¹. On the other hand, when an information contrary to the stereotype is encountered, it is trivialized (“exception proves the rule”).

Stereotype specificity indicates that it has an automatic, unreflective character and is a naturally occurring cognitive process. Such understanding of stereotypes may relieve of responsibility for having and using stereotypes. In fact, it is assumed that everyone has stereotypes developed in the socialization process and may not be aware of them. At the same time, stereotypes distort perception of reality and may cause inadequate and harmful behaviours. It is especially important for in-

11 Nelson, Todd N. (2006). *The Psychology of Prejudice*. 2nd edition. New Jersey: Pearson Education.

dividuals working with social groups characterised by numerous stereotypical messages functioning about them, such as LGBTQ persons. Assuming that people are not responsible for having stereotypes, it is difficult to assume at the same time that they are not responsible for perpetuating them. A stereotype is not ascribed to an individual forever – it may be reflected upon, verified, and its influence on attitudes and behaviours subjected to conscious control. Stereotypes towards LGBTQ persons most often appear due to lack of knowledge, unreflective acceptance of simple media messages, and usage of unjustified assumptions. They may be replaced by knowledge, critical approach to commonly widespread opinions, and observation of one's own reactions and views, their sources and validity.

Stereotypes with strong emotional charge take a form of **prejudices**. A prejudice is a judgement, most often negative and emotionally charged, of a person or a group, based on a single trait, e.g. sex, sexual orientation, gender identity, age, skin colour, nationality, serological status. Prejudices often go hand in hand with reluctance to change an attitude and with beliefs about necessity to take some actions towards the group that is an object of prejudice, which would create or maintain unequal situation of that group in comparison with one's own group. When prejudices cease to be cognitive-emotional attitudes towards a group or a person and become deeds, discrimination emerges.

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Discrimination is an unequal treatment of an individual or a group due to their possessed or attributed trait. The aim and effect of discrimination is to limit the access of members of the discriminated group to specific goods and resources, possibilities, and rights which are available to other groups. It may follow prejudices or emerge as a result of applying discriminatory politics, traditions, legislation, ideologies, and leads to marginalization and exclusion of social group with a specified trait. What is important, not only persons who possess a given trait may be discriminated, but also these persons, to whom this trait is ascribed (discrimination by assumption) and their closest persons (discrimination by association). Considering the trait that is the premise of discrimination, and the discriminatory behaviour, various forms of discrimination may be distinguished. In the context of social situation of

LGBTQ persons, the one mentioned most often is homophobia. **Homophobia** denotes a form of discrimination, and sometimes also a prejudice, expressed in antipathy, aversion, irrational fear, distance, hatred, or violence towards persons perceived as gay, lesbian, bisexual or transgender, only on the basis of presumption that they are LGBTQ. It should be noticed that not only gays/lesbians may be subjected to homophobia, but also bisexual and transgender persons who are perceived as such. Therefore, it is often said and written about LGBTQ persons experiencing homophobia, but not biphobia or transphobia. Phenomena defined by two latter terms do occur but in a situation where prejudice or discrimination is motivated by bisexuality or transgenderism, and not attribution of homosexual sexual orientation. The concept of discrimination is present in the law of the European Union. It also appears in the Polish law where it is strictly defined and limited to cases precisely fulfilling certain legally specified requirements. Because of this, in this publication we more often decide to employ terms “oppression”, “violence”, and “homophobia” in order to include broader range of LGBTQ person’s experience.

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From the point of view of functioning of minorities in the society, **social standards** governing desired behaviours of persons and groups in specified contexts are vital. Standards emerge from culturally conditioned beliefs about what is correct and what is incorrect, which methods of proceeding and expression are permitted and which may contribute do social sanctions that may assume a form of subtle disciplining non-verbal signals (e.g. wincing, frowning), verbal disapproval, discrimination (e.g. non-admission to work), or violence. Standards governing such areas of social life as, e.g. relations between genders, way of expressing emotions, manner of conversation, and dress style depend on culture (e.g. physical closeness between men may be common in Tunisia but inadmissible in Texas) and change over time. Behaving in accordance with standards grants the feeling of community with a group, group’s approval, safe predictability of behaviours, and allows for identification with a group.

Standards are strictly connected with social roles which they govern and guard. Social roles consist of a set of beliefs, obligations, expecta-

tions and privileges which concern persons in society due to their certain possessed traits (e.g. sex, age, skin colour). Roles indicate proper behaviours and specify limits of acceptable behaviours; roles constitute a basis for expectations towards these persons, and people are accounted for fulfilling these roles. Social role may be accepted and internalised by a person, resulting in conformist perception of its associated behaviour standards. Persons internalising their roles may not only subject themselves to them, but also become their guardians and apply various sanctions towards persons who do not fulfil their role ascribed by the society and culture. In the majority of societies, the clearest division of social roles takes place on the axis of so-called biological sex. Biological men and women are expected to have different interests, aspirations and life choices, determining the way they construct their identities. However, if a person does not fulfil social expectations related to their sex, it may become a reason for their oppression.

The social attitude that probably governs the life of non-heterosexual persons in the largest degree is heteronormativity. **Heteronormativity** (heterosexual norm) is a present in society and commonly acknowledged belief that there are two complementary genders, with certain ascribed gender roles that are deemed natural. Heteronormativity assumes that heterosexuality is the only present sexual orientation and romantic, sexual and marital relationships take place and may take place only between men and women. Therefore, heterosexual behaviours are valued as correct, desired and expected from all members of the society. A differentiation into morally good and morally wrong (standing in drastic opposition towards the standard) practices is formed, where heterosexual, monogamous relations aimed at reproduction are deemed natural and morally proper (Rubin 1993)¹². An attempt to go beyond a standard may result in homophobic reactions in everyone who accepted it. Effects of maintaining heteronormativity in the society include invisibility of LGB persons and lack of relationship patterns other than heterosexual. Persons living in non-heteronormative relationships (e.g.

¹² Rubin, Gayle (1994). *Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality*, in: Abelow, H. Barale, M. A. Halperin, D. M. *The Lesbian and Gay Studies Reader*: New York: Routledge.

relationship between two women) and establishing non-heteronormative relations often do not disclose it for fear of social ostracism.

Heteronormativity gives rise to **heterosexism** – an attitude according to which heterosexual persons and relationships are better than others (e.g. single-sex, or relationship in which one person is transgender). Heterosexism assumes that the only situation that is desired and not subject to oppression is when men and women fulfil their strictly ascribed roles resulting from their sex, including forming relationships and procreation. All other ways of life are considered worse and not deserving acknowledgement. Transgender persons may disrupt heteronormative assumption, both in terms of ambiguity of sexes, and in direction of emotional needs that, when sex of a person is not unambiguously masculine or feminine, not always may be defined as heterosexual. It is an additional factor because of which transgender persons experience homophobia.

24 What connects all stereotypes and prejudices with discrimination and heteronormativity is the category of power. In Polish language, **power** is most often associated with formally sanctioned governance. We employ a category of power understood as an access to authorities, prestige, financial resources, opportunities for promotion and development, network of connections, ability to influence the law, independence, decision-making. In a heteronormative and patriarchal society, the greatest power belongs to heterosexual men whose decisions largely shape the destiny of minorities (in a symbolic and actual sense). Simultaneously, oppression most often emerges between power and lack of power. Groups in possession of power care about the presence of standards, social roles and social systems of control (including violence) in order to maintain heteronormative status quo.

Stereotypes, prejudices, discrimination, social standards and roles constitute basic concepts of social psychology, facilitating understanding of underlying processes of oppression and violence towards LGBTQ persons. However, it should be mentioned that history of social psychology shows that also this science could not avoid dead ends and simplifying assumptions.

Over the years, research conducted on intergroup relations has been abstracted from social contexts. Participants of the experiments who served as a basis of conclusions about the nature of intergroup processes included mainly white students from privileged social groups. Persons experiencing discrimination and exclusion on a daily basis very rarely participated in the research; theoreticians were not familiar with this actual experience.

Discourse on stereotypes, prejudices and discrimination is present in programmes of antidiscrimination trainings, and already is a basis of social reality analysis. At the same time, one should be aware that categories employed in social psychology simplify this reality and avoid exploring its complexity. The situation and experience of a person suffering from violence are influenced by a number of interacting factors. Not only one trait of group identity may be an indicator of an oppression, but socio-historical context, socio-economic status, and a full set of other, overlapping traits as well. Prejudices against lesbians from big cities would be different than these against gays in the countryside; situation and experience of discrimination of a black, transsexual person living in a refugee centre would be different as well. In such situations, sometimes a term **intersectional discrimination** or **multiple discrimination** is used, emphasizing that circumstances of an individual may result in being subjected to discrimination for various reasons at the same time, with identity traits of that individual shaping a unique, qualitatively different experience of oppression which should not be considered as a sum of prejudices of various kinds.

PATIENTS AND EXAMINED PERSONS

An approach that is still dominating in psychology assumes a skewed relationship between the examined person and the examiner, between therapist and patient or client. When participating in psychological examinations, examined persons are rarely informed about benefits which, in a longer perspective, they will gain from participation in the examinations; also, the direct and primary objective of the research team rarely aims at bringing greater good for the examined persons or striving for social change that may improve their situation as a group. However, for the purpose of examination, researchers often seek for and “use” the representatives of minority groups who are in socially worse position; therefore, results of such examinations do not have direct effect on the reality and do not contribute to improvement of the examined persons’ life. Similar skewedness of relations also penetrates into therapeutic relations and a situation when a person providing psychological support meets a person seeking it. Conventional psychological aid has strict medical roots, with the role of the supporting person being to perform a diagnose and assign remedial measures, and the diagnosed person’s to open and subject oneself to doctor’s knowledge and expertise. Psychoanalytical approach, being one of the significant pillars of psychotherapy development, assumed that the patient is not aware of his own conflicted drives and intrapsychical processes, and will be able to recover only thanks to arduous work with a therapist who knows necessary interpretative keys to human psyche¹³. A popular term “patient” for the person using psychotherapeutic assistance defines the relation in advance and implies a disease or psychopathology.

It should be noticed that such definition of the meeting and roles does not have to be disadvantageous and may respond to the needs of many persons seeking aid. It establishes a safe feeling of dependency and allows to hand the control of the situation over to a person attributed with

¹³ Kratochvil, Stanislav (2003). *Podstawy psychoterapii* [*The Foundations of Psychotherapy*], Zysk i S-ka Wydawnictwo: Warsaw, pp. 30-31.

expertise, competences, and knowledge of solutions – a psychotherapist, doctor, healer.

Defining the relation between therapist and person seeking assistance and their roles, as well as becoming aware of this relation and its consequences is important not only because it affects the support process and result. In the case of persons who experienced violence motivated by prejudice, or in general work with marginalized groups, actions in the therapist office are reflected in a way in which the abused person seeking aid shall establish relations with the society. Therapist's attitude and their proposed definition of roles and relations may reinforce the attitude of passive "victim" in the abused person, or empower, granting strength to face adversities.

Traditional and popular approaches in psychology propose explanations of human behaviour in isolation from socio-political, historical and cultural context. The analysis focused on internal experiences and feelings of persons, their subjective interpretation, reactions of a person to external factors, pathological style of experiencing world and events, or incompetence in coping with difficulties. Due to such perception of the psychotherapy process, causes and solutions to difficulties of the person seeking support are sought for precisely in that person; it also conditions the work on overcoming one's limitations and weaknesses which takes place in the confined space of therapist's office. At the same time, the fact that individual dispositions may be developed by specificity of social relations and roles fulfilled and imposed by social structure is ignored. Failing to notice this fact and lack of reflection on client's position in the society (standards, privileges, hierarchy) may lead to incorrect attribution of socio-political issues to the individual. Perception of behaviour of persons oppressed in the society through their intrapsychical processes, and not life in alienating and adverse environment, poses a threat of reinforcing the message that the issue lies in the person, and not conditions in which they happen to live.

Psychologist and therapist approaches to the subject of homosexuality and mental health of LGBTQ persons have affected the methodology of conducted research, hindering the effective acquisition of credible and

unbiased data regarding this population. It is recognized that there had been three waves of psychological interpretations of relations between psychic disorders and non-heterosexuality¹⁴. The first wave lasted until ground-breaking 1970's when American Psychological Association and American Psychiatric Association officially depathologized homosexuality. Until that time, the majority of researchers, assuming psychopathologic connotations of non-heterosexual orientation itself, did not search for representative samples of population, but limited their research to clinical groups (e.g. gays/lesbians using psychiatric care) and generalised results to all LGB persons. Presently, because of sampling error, research conducted at that time may be used only for purposes of critical analysis or propaganda, promoting the thesis of homosexuality as a disorder. During the second wave of research, in their search for examined gays/lesbians, scientists moved from psychiatric hospitals and support groups to clubs, bathhouses, bars and meetings organized by LGBTQ activist movement. It is easy to guess that they still failed to observe a representative, or at least diversified, group of examined persons. Most often, it resulted from lack of trust towards psychologists among LGBTQ society, and the fact that many non-heterosexual persons lived in hiding.

However, these were non-clinical groups, and differences between non-heterosexual persons and general population appeared only during consumption of alcohol and other psychoactive substances (which should not be surprising, considering the fact that research was done among club-goers). In the third, current wave of research, a strong emphasis is put on representativeness of the sample; moreover, questions concerning sexual orientation appear in large epidemiologic studies, allowing reaching LGB persons from various social and age groups. Examinations conducted according to the most common trend of the third wave also include previously omitted environmental factors, observing how they determine the health of non-heterosexual persons.

14 Cohran and Mays (2009); qtd. in B. Grabski, *Zdrowie psychiczne osób homoseksualnych i biseksualnych* [Mental health of homosexual and bisexual people] in: Iniewicz, G., Mijas, M., Grabski B. (eds.) (2012). *Wprowadzenie do psychologii LGB* [Introduction to LGB Psychology]. Wrocław: Wydawnictwo Continuo.

PERVERSE SOCIETY¹⁵

In Poland, life situation of gays, lesbians, bisexual and transgender persons is radically different from situation of heterosexual persons. If we want to understand their needs and circumstances which interact with therapeutic interventions, it is worth to take a look at social structure in which the person seeking aid lives and, for a moment, forget about safe void of the therapist office. Social orientation considers the role of history in creating the current state, and the method in which various historical events contributed and contribute to oppression and discrimination of some social groups. In such perspective, it is essential to realize and critically analyse structures of power and domination in the society which may determine the disposition and state of LGBTQ persons. Simultaneously, one should realize that violence and oppression which may be experienced by the client is not interpersonal, but is a part of a larger whole of society structure.

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Such perception may lead to discoveries that symptoms diagnosed as behavioural or mood disorders, psychosis, neurosis or psychological issues called otherwise are natural (which does not mean constructive) reactions to abnormal social situation. Authoritarian and non-democratic principles which deprive of personal freedom and possibility of self-determination may result in man's poor psychological condition.

History of psychology has numerous examples of diagnosing behaviours differing from the standard as deviant and requiring adjustment. Cultural standard did not need, and in some psychological circles still does not, a justification to be considered equivalent with good mental health. Rather than a synonym of good health, deviation from standard

¹⁵ The chapter title is a paraphrase of the German film entitled *Nicht der Homosexuelle ist pervers, sondern die Situation, in der er lebt* (eng. *It Is not The Homosexual Who Is Perverse, But the Society in Which He Lives*, dir. Rosa von Praunheim, 1971) which shows a gay protagonist searching for his place in the society and trying different lifestyles in order to find his identity. In the last scene, the protagonist arrives at the conclusion that the only way for him is to act for social change.

or defiance against it becomes a pathological symptom that is the individual's disposition are requires therapy. American clinician Bruce Levine notices that DSM-III included many mental disorders and diagnoses that pathologized antiauthoritarianism, defiance and resistance¹⁶. In some cases, defiance is subtly pathologized and diagnosed, in others it is directly called a disorder – such as “oppositional defiant disorder” concerning children and teenagers. The characteristic of behavioural disorders of this type is to be the presence of intensified defiant behaviour, disobedience, and absence of more serious anti-social activities that violate the law or rights of other persons. Mental health specialists may accidentally, without knowledge of social context, diagnose depression, anxiety and anger as a result of mental disorder, which they are competent to cure when these reactions may largely stem from pain and non-compliance to live in a dignity-depriving environment. A similar observation was made by Erich Fromm when analysing the American society in which emotional issues and alienation of people were redeveloped by psychoanalysts and therapists in such a way as to adjust patients to realities of the society without reflection on realities' depriving and subjugating nature.

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One should take a look at public opinion towards gays and lesbians in order to, at least partially, gain insight into attitudes which they have to face in daily life. For this purpose, we shall use the research conducted by the Centre for Public Opinion Research (CBOS) which does not consider attitudes towards neither transgender nor bisexual persons. According to the most recent CBOS research (February 2013)¹⁷, 83% of the society believes that homosexuality is not normal and is a deviation from standard. According to the majority of society, persons of the same sex should not have the right to enter into a marriage (68% against), to enter into a partnership (65%), to adopt a child (87%), or to publically

16 Levine, Bruce E. (2013). The Systemic Crushing of Young Nonconformists and Anti-Authoritarians, http://www.huffingtonpost.com/bruce-e-levine/the-systemic-crushing-of-_b_2840316.html.

17 Centre for Public Opinion Research (2013). Komunikat z badań: Stosunek do praw gejów i lesbijek oraz związków partnerskich [Communication on Research: Attitude to Rights of Gays, Lesbians and Partnerships]. Warsaw: Fundacja Centrum Badania Opinii Społecznej.

show their way of life (63%). Researches from July 2010¹⁸ concerning attitudes towards gays and lesbians are alarming in two ways. It turns out that 64% of the society believes that gays/lesbians should be prohibited from organizing public manifestations, and 37% would forbid gays and lesbians to have sex. Not only the fact that part of the society would like to deprive gays and lesbians of constitutional rights and rights resulting from the Universal Declaration of Human Rights, and the Universal Declaration of Sexual Rights¹⁹ is alarming, but also that the respected research centre considers such possibility in the survey (despite the fact that researches on attitudes towards other minorities do not pose similar questions). CBOS researches also show nuances in people's attitudes towards particular gay and lesbian rights, as well as their admissibility to work in specific professions. The rights non-heterosexual persons to daily life (considering the fact that they live in single-sex relationships, raise children, work in various professions, have sex) are subject to public debate and negotiations, where decisive voice on granting them belongs to the majority of the society who is already covered by these rights. Hostile attitudes towards LGBTQ persons find their place in public discourse; it may be assumed that they are also present in the life of LGBTQ persons. Therefore, a client who asks a therapist for assistance does not come "with his problem" but with unequal relations which connect them with the majority of society, with strategies of coping with oppression, and with aftermath of disciplining and disheartening messages which they have encountered thorough their life.

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18 Centre for Public Opinion Research (2010). Komunikat z badań: Postawy wobec gejów i lesbijek [Communication on Research: Attitudes Towards Gays and Lesbians]. Warsaw: Fundacja Centrum Badania Opinii Społecznej.

19 World Health Organization (2002). Universal Declaration of Sexual Rights.

THE WORLD OF LIVING

32

In Poland, there has not yet been coordinated research works that could demonstrate the realities of life, difficulties and determinants of welfare of LGBTQ persons. When university research conducted by psychology departments and institutes at larger academic centres touch upon LGBTQ-related subjects, most often it is done in a fragmented way that does not constitute a part of greater initiative, results of which would be available and recognizable in community broader than the group of involved researchers²⁰. At the same time, the subject of sexual orientation is popular among psychology students who, due to lack of access to world literature and ignorance of academic supervisors, in their annual works and master's theses frequently verify hypotheses that have been absent in psychological discourse for decades. For Polish psychology, the difficulty seems to lie in finding non-stereotypical research problems and reaching non-heterosexual examined persons of varied demographic characteristics (not to mention transgender persons who are not clinical patients). Poor quality of research in this field may be exemplified by a study recently realized by a research worker of a renowned academic centre, which examined "relationship patterns of homosexual men" on the basis of psychoanalytical hypotheses on broken bond with father. The research group consisted of non-heterosexual men who did not accept their own orientation and participated in religious support group. Results of similar researches give rise to great doubts connected with the possibility of their generalisation and interpretation. Simultaneously, they bring little applications to the state of knowledge on LGBTQ persons in Poland, their needs and welfare.

20 The only such study of non-heterosexual persons' situation is the report edited by Ireneusz Krzemiński (2009). *Naznaczeni. Mniejszości seksualne w Polsce , Raport 2008* [Stigmatized: Sexual Minorities in Poland. 2008 Report], composed in the Institute of Sociology of the University of Warsaw. In this publication we do not refer to its results, for the subsequent report of Campaign Against Homophobia, Lambda Warsaw and Trans-Fuzja Foundation contains more up-to-date results received in examination of larger and more representative population sample.

In this area, more happens at the junction of activities of non-governmental organisation and institutions interested in sociological image of LGBTQ person's population in Poland. Since 2001, non-governmental organisations working for LGBTQ persons have been trying to show the situation of these persons, realizing increasingly ambitious research projects. At the same time, pan-European analyses are prepared (e.g. the Agency for Fundamental Rights' report²¹) and, in 2012, the first government-ordered analysis prepared by the research team from Jagiellonian University²². The aim of similar research is to analyse areas where government public institution's policy could be changed to better and fairer respond to the specificity of LGBTQ persons as a social group. Simultaneously, the results of these analyses reveal consequences of authority's lack of recognition of LGBTQ persons as citizens equal to heterosexual persons in the individual areas of social life. Together with visibility of LGBTQ persons in public space and the increase in audibility of demands articulated by human rights communities, there is a rise in number of public opinion surveys examining social attitudes towards these demands and LGBTQ persons in general.

33

Presentation of LGBTQ persons' situation in Poland is possible only thanks to detailed studies of non-governmental organisation working with and for LGBTQ persons. Closeness to their persons of interest, and trust enjoyed by non-governmental organisations allows them to achieve an impressive size and variety of research group. Such a close relation and insight is often not possible for academic centres and researchers who have neither knowledge nor contact with LGBTQ persons, but who treat them instrumentally as a researched social group.

All data provided below are taken from the report prepared jointly by Campaign Against Homophobia association, Lambda Warsaw association, and Trans-Fuzja Foundation in 2012²³. With over 11.000 participants, it is the largest study of LGBT person's lives in Poland so far.

21 EU Agency for Fundamental Rights, 17 May 2013 EU Research report, LGBT survey.

22 Research realized on request of the Office of the Government Plenipotentiary for Equal Treatment's under the "Equal Treatment as a Standard for Good Governance" programme, 2012.

23 Makuchowska, Mirosława, Pawłęga, Michał (eds.) (2012). Situation of LGBT Persons in Poland. 2010 and 2011 Report, Warsaw: Campaign Against Homophobia.

Non-heterosexual persons are afraid to publically display their feelings towards their partner of the same sex. When asked if they would feel comfortable holding hands or kissing in public spaces, the majority (63%) of the respondents answered, that such behaviour is less comfortable for them than it would be if it involved a person of the opposite sex. Results of men and women are significantly different. It turns out that, in public spaces, it is much more difficult for men than women to be comfortable in romantic relations with partner. This phenomenon may be explained by standards connected with expression of masculinity that stigmatize men who display warm behaviour towards each other, and the fact that women holding hands or hugging are not always socially perceived as being in a romantic relationship, making them less exposed to homophobic reactions of the environment. Three quarters (74%) of the examined gays, lesbians and bisexual persons believes that in general, gays/lesbians in Poland are not accepted and respected.

34

Gays, lesbians, and bisexual persons most often do not disclose their sexual orientation in public spaces. Only 17% of the examined persons stated that they do not hide this fact in public institutions (e.g. commune offices, courts), or in other public spaces (e.g. bars, clubs, shops, public transport, taxis, beaches). Among these persons, 18% experienced worse treatment, most often consisting in rude behaviour or refusal of service.

In a taxi, when I was holding hands with my partner. The taxi driver threw us out²⁴ (man, 43 years old).

The majority (71%) of gays, lesbians and bisexual persons feels the need to hide their identity at work. It means that they do not reveal any information which may indicate that they are non-heterosexual to their colleagues. It often results in not only concealing facts from one's own life, but also active hiding the truth or lying during informal worker small talks regarding family life or leisure time, or during company parties.

24 All quotations have been taken from research published in reports: Makuchowska, Mirosława (ed.) (2011). *Violence Motivated by Homophobia*, Warsaw; Makuchowska, Mirosława, Pawłega, Michał (eds.) (2012). *Situation of LGBT persons in Poland. 2010 and 2011 Report*, Warsaw: Campaign Against Homophobia.

Some research respondents argued that their sexual orientation is their intimate matter and work is not a place to disclose it. Assuming such attitude complies with social expectation of “not flaunting” their non-heterosexuality, but it is worth to remember that revealing one’s marital and parental status does not rise controversies at work and, according to the above reasoning, it may be considered as revealing intimate matters. For 6.4% of the respondents, homosexual or bisexual sexual orientation resulted in being treated worse than their heterosexual colleagues, and the discrimination most often consisted in greater labour input requirements or dismissal on the grounds of sexual orientation.

I want to have complete peace of mind, that is, no harassment, malicious comments, hints, smirks, malice, or other activities aimed to humiliate me to the point I would have to quit to not go crazy (man, 42 years old).

In contacts with health care, over 11% of persons encountered worse treatment as a result of disclosing their homo- or bisexual orientation to the health care worker, most often involving mockery, ridicule, contempt, humiliation or refusal to provide aid.

Nearly half (45%) of the examined are believers. Every fifth non-heterosexual person considers oneself to be a religious person, and over half of them participate at least several times in a year in some religious practices (e.g. worship, religious meetings, masses). Some believers and practitioners revealed their orientation in contact with representatives of the church. In such situations, every second person reported experiencing worse treatment from representatives of the church. Most often it consisted of abuse and insults; such events took place during confession. In some cases, the person was refused a possibility of active participation in religious practices.

Nearly all examined persons (98%) believe that they should have the right to formalise a relationship with a person of the same sex, and nearly half of them (44%) currently is in such a relationship. 6% of the examined raise or have children. Often, they are children from previous, heterosexual relationship and are raised together with the person of the opposite sex (i.e. with the former partner), or the same sex (with the current partner).

Among family members, non-heterosexual persons most willingly start to disclose (coming out) their non-heterosexuality to their siblings, and only then to their parents. When coming out occurs of their own, free will, these persons receive more acceptance from their families and friends. It could be assumed that persons who come out on their own are mainly those, who presume that it will not significantly worsen their relations with parents. Persons who display most acceptance are siblings (sister, then brother), and mother. Among all family members who know about sexual orientation, it is the father who provides the least support, for only in half of the cases (52%) he was specified to be accepting. 27% of respondents actively hide their sexual orientation from any family member, with most persons hiding this fact in small towns and villages.

The situation of LGB persons in school deserves a particular attention, for it concerns mainly teenagers who are just becoming aware of sexual orientation, and are connected with networks of dependencies which limit their autonomy and self-determination possibilities (e.g. teachers, parents). At the same time, this period is vital in formation of positive identity and building satisfactory relations with the world. Young non-heterosexual persons rather do not reveal their orientation to their closest school environment. 58% admits that in school either only their closest person knows about their orientation, or nobody does²⁵. Data from Irish examination of LGB teenagers²⁶ indicate that the period between becoming aware of non-heterosexual sexual orientation, which takes place around 12 years of age, and first coming out is usually 5 years of living in hiding. Over the course of education in Polish schools, gays, lesbians and bisexual persons are not provided with expected knowledge about their sexual orientation; when this subject is discussed during lessons, it is done in a way that is humiliating and inconsistent with the state of scientific knowledge²⁷.

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25 Data concerning situation in school are taken from the Świerszcz, Jan (ed.) (2012). Equality Lesson. Attitudes and Needs of School Staff and Youth Towards Homophobia in School report, Warsaw: Campaign Against Homophobia.

26 Mayock, P., Bryan, A., Carr, N., Kitching, K. (2012). Supporting LGBT Lives: A Study of the Mental Health and Well-Being of Lesbian, Gay, Bisexual and Transgender People, Dublin: BeLonG To Youth Services.

27 Świerszcz, Jan (ed.) (2012). Equality Lesson. Attitudes and Needs of School Staff and Youth Towards Homophobia in School, Warsaw: Campaign Against Homophobia.

OPPRESSION AND VIOLENCE

A term often encountered in anti-discrimination, police and legal literature is “hate crimes”, derived from a definition adopted by the Office of Democratic Institutions and Human Rights (ODIHR) of the Organization for Security and Co-operation in Europe (OSCE). According to this definition, a **hate crime** denotes “any crime of criminal nature, aimed at people or their property, which includes choosing the victim or other targets because of their actual or alleged affiliation with or support of a group distinguished by characteristics common to its members, such as actual or assumed race, nationality or ethnic origin, language, skin colour, religion, sex, age, physical or mental disability, sexual orientation or other similar characteristics”²⁸. In the context of this publication, this definition may give rise to doubt for two reasons. First, calling an act of violence motivated by prejudice a “crime”, and stating that it should be of “criminal nature”, places the event in certain country and international legal frameworks. However, law changes and is interpreted differently, and in current case, the Penal Code treats crimes motivated by various kinds of prejudices unequally (e.g. incidents of violence motivated by racism are prosecuted *ex officio*, and incidents of violence motivated by homophobia are not). The term “violence” grants a possibility to take a look at broader spectrum of incidents without the need to search for their legal connotation. In literature, sometimes one can find a term “**oppression**” which is used in this publication as well; however, in the majority of cases, oppression refers to even broader spectrum and manifestations of violence, especially when it involves more than personal, relational character and concerns social and cultural influences on the individual or social group. The second doubt created by the term „**hate crime**” is indicating hatred as main violence-inducing factor. However, in Polish language, hatred is a very strongly valued emotion and

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28 Ryłko, Ewa (2007). *Jak mówić o przestępstwach z nienawiści* [How to Speak About Hate Crimes], in: *Przemoc motywowana uprzedzeniami. Przestępstwa z nienawiści* [Violence Motivated by Prejudice. Hate Crimes], Lipowska-Teutsch, A., Ryłko, E. (eds.), Kraków: Towarzystwo Interwencji Kryzysowej.

is associated with high agitation, sometimes even a passion preventing from evaluation of one's own actions. **Violence motivated by prejudice** is not always (and even in minority of cases) an action of passion. Therefore, harmful actions towards perceived (i.e. actual or alleged) members of some social group resulting from negative emotions and emotionally charged stereotypical beliefs are considered violence motivated by prejudices. When a prejudice results from homophobia, then we talk about violence motivated by homophobia.

Researches on occurrence of violence motivated by homophobia strictly define and categorize this phenomenon in a way necessary for empirical studies. Such approach is connected with specificity of quantitative researches and requires clear definition of violence in order to state if it occurred and if its motive was homophobic. However, before we take a look at results of researches describing violence motivated by homophobia, it is worth to check discourse understandings of the violence motivated by prejudices.

38 Quantitative analyses often miss the subjective experience and way of feeling of persons who encountered oppression resulting from prejudice. Simultaneously, a part of influences affecting the person that may be successfully regarded as an element of homophobic violence conditioning the person's welfare is absent from the research.

SYMBOLIC VIOLENCE

The analysis of symbolic violence present in daily environments of LGBTQ persons thorough their lives is the one most avoided in Polish research. Quantitative researcher's reluctance towards the idea of symbolic violence is not surprising at all. Despite the fact that some consider it one of sociology's current key categories of social reality description, in psychological discourse it does not appear probably due to difficulties in its operationalization. Pierre Bourdieu, French sociologist and philosopher, derived a concept of symbolic violence from analyses of tools and observations how privileged social layers exert pressure on non-privileged social groups²⁹. He calls symbolic violence a "soft" form of violence,

29 Bourdieu, P., Passeron, J. C. (1990). *Reproduction in Education, Society and Culture*, London: Sage.

one that camouflages its oppressive inclinations and takes place when the dominating group operates through its culture, so that other groups acknowledge and accept their inferior role in the society. The strongest tool of symbolic violence towards LGBTQ and non-heteronormative persons is heteronormativity. An assumption that everyone is heterosexual, making heterosexual relations and persons entering into them a default subject of social life is connected with organisation of society's symbolic capital (that is standards, law, history, rituals, values, networks of connections, scientific and cultural texts) around heterosexual persons. Symbolic area in which LGBTQ persons socialize tells them that they are less valuable in such a way that they perceive this message as obvious and natural. Oppression and violence they encounter becomes easier to endure and more difficult to deny, for it is habituated (people get accustomed to it) and becomes a part of acceptable status quo.

It is virtually impossible to indicate perpetrators of symbolic violence because the influence of symbolic violence may be independent from individual persons' intentions. However, consequences for groups subjected to such form of violence are visible. In the case of non-heterosexual persons, they consist in self-refusal of equal, compared to heterosexual persons, participation in society, acceptance of dominant (often stereotypical) messages about gays and lesbians and conforming to them (e.g. assuming that sexual orientation is an intimate matter and hiding it from people, displaying no feelings towards the partner in public spaces).

39

MICROINEQUALITIES

Another form of oppression and pressure being in a spectrum of LGBTQ person's daily experiences but not clear enough and sufficiently elusive to avoid description are microinequalities. Microinequalities are ephemeral behaviours and situations encountered in the society by the representatives of a minority group (socially non-privileged), and which reinforce and confirm their inferior position or role compared to the majority. Manifestations of microinequalities may appear in jokes, manner of speaking, facial expressions and social standards. Usually, persons

from majority groups do not perceive inadequacy or harmful nature of their behaviours; still, persons from the non-privileged group notice and are particularly sensitive to them. However, noticing and drawing attention to the occurrence of microinequalities meets with lack of understanding and accusation of oversensitivity, exaggeration, lack of distance or „sense of humour“. For example, a joke about gays or lesbians told in a company, while not being explicitly homophobic, contains elements of the stereotype and causes discomfort for gays/lesbians. However, other persons may think that “it’s just a joke” and “relax, we aren’t speaking about you”. Another example of microinequalities may be a set of non-verbal (e.g. laughing under one’s breath, not looking in the eyes, keeping or crossing physical distance), or paraverbal (voice tone, grunting) reactions on the part of the police, encountered by a person reporting a homophobic crime. This last example may lead to secondary victimisation – repeated harming of a person who experienced violence – by the system and persons responsible for providing support to that person.

INTERNALISED HOMOPHOBIA

The last group of experiences and feelings not defined directly as homophobic violence but recognized as such by authors of this publication are various forms of homophobic oppression directed towards oneself. Self-hatred and lack of self-acceptance are not individual’s issues that can be diagnosed and treated individually as a phenomena separate from the social context. Precisely this context and cultural demands create a rule of non-acceptance and self-disciplining, internalised on the level of thoughts about oneself, feelings towards oneself and behaviours. A person who receives messages that with their current identity there is no place for them in the society feels forced to withdraw from it. The clearest and ultimate manifestation of homophobic violence towards “self” is committing suicide. In some cases, motives for suicides which result from sense of inferiority, worthlessness and self-hatred are revealed to the environment, for the person committing suicide either communicates their intentions to family and friends, or leaves a suicide note. However, in many situations breaking shame is too difficult from them, making it

difficult to clearly indicate reasons for the suicide. Polish research shows that non-heterosexual persons, in comparison with general population, are more prone to suicide thoughts. In the 15-18 age group, the difference in frequency of suicide thoughts occurrence is nearly fivefold. Lack of self-acceptance may also display in a range of other self-destructive behaviours, intermediate between creating a positive image of oneself, and taking one's own life. They consist of involvement of hazardous behaviours, addictions, self-harming, mood disorders, anxiety³⁰.

PHYSICAL AND MENTAL VIOLENCE

In this chapter, data on violence in its classic and undisputed sense, i.e. a situation in which a person or persons employ violence and a person experiences it, shall be presented in detail. In such approach to the subject, a person experiencing violence may consciously recall events and specific, easily categorized oppressive behaviours they have encountered. At the same time, an intention or motive of persons employing violence unambiguously results from homophobic reasons – they recognize the attacked person as non-heterosexual. However, it should be remembered that this approach narrows the spectrum of LGBTQ persons' homophobic experiences and does not provide full insight into them as a result of omitting the influence of symbolic violence, microinequalities, and internalised homophobia.

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Mental violence, sometimes called psychological violence, is operationalized in researches³¹ as verbal aggression (verbal taunts, abuse, humiliation, ridicule), dissemination of negative opinions on a person, threats (including menaces and blackmailing), hateful letters (including e-mails, SMS messages to the person or their loved ones), vandalism and destroying property of the person, graffiti, leaflets, and other

30 Williamson, Ian R. (2000). *Internalized homophobia and health issues affecting lesbians and gay men*, "Health Educational Research", no 15 (1), pp. 97-107.

31 We mainly use statistics from researches realized by the Campaign Against Homophobia Association together with Lambda Warsaw and Trans-Fuzja Foundation, results of which have been presented in the following reports: Makuchowska, Mirosława (ed.) (2011). *Violence Motivated by Homophobia*, Warsaw; Makuchowska, Mirosława, Pawłega, Michał (eds.) (2012). *Situation of LGBT Persons in Poland. 2010 and 2011 Report*, Warsaw. Data taken from other publications shall be indicated in the text.

forms of public defamation referring to the person and resulting from their perceived sexual orientation. 44% of the LGB persons experienced such forms of violence, and among them the majority experienced them more than three times during two years covered by the research. Most often they consist of verbal aggression and taunts. The most widespread words used when employing verbal violence are fag, queer, dyke, whore, or common vulgar expressions (e.g. dick, bitch, loser, cunt), and derivatives from insults and words related to the LGBTQ community (e.g. faggot, homo, lesbo, poof). A separate category of frequent insults consists of word-formation connected with sexual activities (e.g. cocksucker, fudgerpacker, cum dumpster) or referring to health and mental disorders (e.g. sick, abnormal, perverted, deviant).

As it most often happens in public spaces, persons employing mental violence most frequently (in 59% of the cases) are unknown. However, it is disturbing that in as many as 37% of the cases, mental violence occurs on the part of school or college peers. Researches conducted with participation of LGB school pupils show that as many as 76% of young persons notice homophobic verbal violence in their schools. It is most often encountered by boys, regardless of their actual sexual orientation, who behave differently from cultural standards connected with their sex (e.g. if they prefer to be friends with girls than play football, if they take care of their look), and persons deemed LGBTQ by the school society.

42

I am constantly being attacked, I'm afraid of walking around the school, I don't even go to the school shop alone because I'm afraid that those who bully me. Sometimes even in town some strange blokes say something about me among themselves. In school, a few students from another class constantly accost me with some remarks, they even made a rhyme about me (man, 15 years old).

Among persons who experienced homophobic mental violence, 48% encountered dissemination of negative opinions on them, and 11% threats. Dissemination of negative opinions most frequently consists of gossiping, backbiting, revealing unfavourable and/or false opinions about some person in order to belittle them in the eyes of others.

My supervisor informed all the workers in my department that she engages me to check whether I really am homosexual. She spread gossip about my personal life (of which she had no knowledge). She asked other female workers whether "I fancy any of

them". I reported this case to the director, but nothing happened. I was informed that before the election nobody would touch such a case. I was forced to quit my job at that place because my supervisor spread gossip about me in different departments – even among people who didn't know me (woman, 30 years old).

Another form of mental violence is outing, i.e. disclosing information about somebody's non-heterosexual orientation to expose that person, or their family and friends, to homophobic reactions. **Outing** is something different than **coming out** where revealing oneself is an autonomous decision of the LGBT person. In an outing situation, a person doing it is aware that another person does not wish to reveal their orientation, for it may result in worsening their situation, discrimination, escalation of violence, or rejection by the family and friends. Outing is often an object of threats and blackmailing, with the blackmailer forcing the person to provide services (e.g. performing unpaid work, sexual services), or goods (e.g. money) under the threat of disclosing that they are gay, lesbian or bisexual.

The worst was when somebody copied posts from my private website and sent them to a public email box at the school where my mother worked. One by one, the secretaries, headmistress and probably half of teaching staff found out about my sexual orientation, all emotions and happy love. My mother (who already knew) was terrified that she would lose her job, because she heard that if she couldn't raise her own child, how dare she raise other's children. It ended with erasing myself from the net. Completely. All websites, profiles on social networks, changes of addresses and numbers. Plus, of course, humiliating shouting in home. Other incidents like ridicule and the diminishing value of my relationships are standard and not even worth mentioning (woman, 22 years old).

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Physical violence is understood as invasive infringement of physical inviolability of a person due to their attributed non-heterosexual orientation. This form of violence is indicated by physical provocation (pushing, hitting, pulling, kicking), beating, armed assault, sexual harassment (e.g. touching against will, patting), sexual violence (rape or attempted rape). Such form of violence is experienced by at least one out of ten examined LGB persons (12%), with 39% three or more times over two years. The most common forms of physical violence are physical provocation (65%), sexual harassment (42%), beatings (17%), and sexual violence (8%). In all cases, perpetrators are nearly always men.

I was on a bus, which three young, drunk men boarded. They put a sticker with a Celtic cross and the slogan "No faggoting" on the window pane. I protested and began tearing off the homophobic label. The perpetrators called me very offensive names (e.g. "dyke", the perpetrators were convinced that I am homosexual), one of them spat at me, the other pushed me around (woman).

Identically as in the case of mental violence, most often perpetrators are unknown (68% of the cases); if known, most frequently they are school or college peers (36%). According to every fourth (26%) young LGB person, homophobic physical violence (kicking, pulling, or spitting) is present in their school.

It is important to notice significant differences between forms of violence directed towards men and women. Men most often encounter beatings and physical provocations, women – sexual harassment and violence. Such differentiation of violence in relation to sex is consistent with the stereotype and gender roles. Masculinity is demonstrated and enforced by physical strength. Common stereotypes and beliefs about women's sexuality deprive them of their power in the sexual field and change them into objects of male fulfilment and satisfaction. Men's sexual violence towards lesbians and bisexual women rises from a myth that a woman needs a penetrative sexual intercourse with a man and only such intercourse is able to wake her „healthy" sexuality. This myth results in so-called corrective rapes aimed at "curing", i.e. changing the sexual orientation by experiencing a sexual intercourse with man.

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While in a gay club, I went outside with a man I met there. I was sure he was gay. Unfortunately, when we had walked a few meters away from the club he raped me, claiming that I didn't know how it is to be with a man and that he would show me. Despite my attempts to free myself, he wouldn't stop... (woman, 21 years old).

Mental violence is nearly never reported to the Police, only 3% of the affected persons decide to inform law enforcement authorities about such situation. It is noteworthy that, according to Polish law, threats and intimidation are forms of crime which may be, if reported by the affected person, prosecuted under penal law. Slightly more – every tenth affected person (10%) – reports physical violence to the Police.

The reason for non-reporting to the Police is not so much ignorance of the law, but rather disbelief in efficiency of law enforcement author-

ities (42%), and fear of incompetence (26%) and homophobia (19%) on the part of police officers. It is alarming that majority of persons who experience violence (57%) state that they “don’t feel the need” to report it to the police. For a psychologist, this percentage is particularly worrisome, for it means that in over half of the cases, oppressed persons may not act to change their situation, and accept it or treat passively, which may be connected with their internalised homophobia that allows for worse treatment.

WELFARE OF LGBTQ PERSONS

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Specificity of the experienced oppression, discrimination and violence is not just a part of the context and social atmosphere disfavoured for LGBTQ persons. From the perspective of threats to mental welfare, one should mention greater, compared to general population, susceptibility of non-heterosexual persons to feeling loneliness, depression, suicide thoughts, and increased involvement in hazardous behaviours, alcohol abuse and proneness to addictions. In the area of mental welfare, the comparison of results of demographically similar populations from “Social Diagnosis 2011³²” and “Situation of LGBT Persons in Poland. 2010 and 2011 Report” yields highly unsettling results. It turns out that gays, lesbians and bisexual persons aged 19-50 rate their life worse than general population. Also, there is a difference in life evaluations done by non-heterosexual persons from smaller towns and larger cities. Persons from larger cities rate their life better. It may explain the trend observable in sociological analyses of LGBTQ societies – LGBTQ persons migrate from smaller to larger towns. Migrating persons choose a new environment for themselves, often adjusting it to their needs; compared to their place of origin, it is better at providing them with possibilities of development and sense of security. Following Pierre Bourdieu’s thought about mechanisms of symbolic violence, it could be assumed that non-heterosexual persons, being a non-privileged group, will have a limited social capital that allows them to cope with difficult situations and efficiently live in the society. Social capital is understood as a network of connections and trustworthy social relations, as well as acknowledgement from others. Actually, every second non-heterosexual person (49%) responded that they “feel lonely, despite that they do not want it” (compared to 18% of persons from general population). Loneliness is connected with

32 Czapiński, J., Panka, T. (eds.) Social Diagnosis 2011, www.diagnoza.com; qtd. in Makuchowska, Mirosława, Pawłęga, Michał (eds.) (2012). Situation of LGBT Persons in Poland. 2010 and 2011 Report. Warsaw: Campaign Against Homophobia.

significant differences in ways of coping with troubles and difficult life situations. Compared to general population, non-heterosexual persons in such situations more often resort to alcohol (3% vs. 13%) and use sedatives (3% vs. 6%).

At the same time, when they find it impossible to deal with the problem, they twice as often attempt to divert their own attention from it and either engage in activities that improve their mood (26% vs. 49%), or give up (2% vs. 12%). Non-heterosexual women resort to alcohol more often than men. More frequently than women, men motivate themselves to act, or seek consolation in prayer, even though the LGB group much less often seek God's support than the general population (12% vs. 23%). Among various behaviours occurring as a reaction for breakdown, suicide thoughts also appear in non-heterosexual persons more frequently. According to Social Diagnosis 2010, as much as 13% of LGB persons aged 19-50 admitted that in recent months they had been thinking about suicide "quite often" or "very often", in comparison with 2% of persons having suicide thoughts at this age.

MINORITY STRESS

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Decades of research have shown that members of socially marginalised and oppressed minority groups more often engage in hazardous, health threatening behaviours (e.g. addictions, risky sexual behaviours), have lower, compared to the rest of population, psychophysiological welfare, and are more often diagnosed with symptoms of mental disorders. The infamous tradition of research on LGBTQ persons sought for explanation of disorders and decreased welfare of this social group in personal dispositions and traits acquired as a result of childhood and adolescence relations specified as pathological. Contemporary researchers and practitioners have greater understanding for social context which leads to occurrence of such symptoms in some minority groups. The concept of minority stress³³ describes the complex process of long-term influence of socio-cultural-economic stressors on psychophysical welfare of mem-

33 Meyer, Ilan H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence, "Psychological Bulletin", no 129, pp. 674-697.

bers of socially stigmatized groups, and explains phenomena previously attributed to personal traits. Relatively fresh theory of minority stress, developed and verified mainly by American psychologists, has an application and confirmation in research of discriminated and oppressed social groups, such as LGBTQ persons and African Americans. According to its proposed approach, being an object of prejudices from the dominant side and majority group which constructs social life standards and principles results in feeling of chronic stress (with symptoms such as anxiety and increased blood pressure) and, in effect, worse mental and physical health condition.

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There are several aspects that distinguish minority stress from previously known stressors and factors determining general welfare. First, it is a unique phenomenon that concerns only persons whose identity or recognizable traits (such as skin colour or gender expression) categorize them to minority and socially disfavoured groups³⁴. Non-stigmatized social groups do not experience such type of stress. The second characteristic is the chronic nature of minority stress. The minority stress is connected with permanent social and cultural structures which position the chosen social group, e.g. LGBTQ persons in a specified, less privileged (compared to the majority) place. Therefore, this stress is not a reaction to the situation, but to socio-cultural status. The third aspect distinguishing this kind of stress refers precisely to its social sources, as opposed to biological or intrapsychical ones. Minority stress is determined by processes, hierarchy, acts of social standards and institutions which are beyond the person experiencing it. LGBTQ persons are objects of prejudices, they function in an environment saturated in stereotypes about them, face heteronormative customs and threat of discrimination – all these factors make them experience daily life differently.

The theory of minority stress is not particularly unique or surprising for the researchers. It is an effective model that organizes previously known phenomena and shows how social world may have vital impact on individual world and even basic health issues of members of the minority.

34 Groups specified as minority and socially disfavoured not necessarily constitute a statistical minority in the society. These terms refer to groups which, on the grounds of social system structure, have less access to power and privileges. Therefore, e.g. it is often stated that women are a minority despite the fact that they do not constitute a statistical minority.

It should be noted that minority stress not as much as explains how experiencing incidents affects the person, but rather how is living in a world where incidents have a long-term place, affected by experiencing stress and health deficiencies.

In the theory of minority stress, two kinds of stressors are distinguished: **distal stressors** and **proximal stressors**. Distal stressors are placed outside of the individual and consist of such factors as experience of rejection, discrimination, violence caused by belonging to the group of LGBTQ persons.

Previously mentioned researches concerning discrimination and violence towards non-heterosexual persons and social attitudes towards this group visibly confirm the presence of distal stressors in the living environment of LGBTQ persons in Poland. It is noteworthy that verbal violence is the most common form of violence, and various aggressive, provocative, defamatory, hatred-inciting opinions on LGBTQ persons appeared in mainstream media as an equal element of discourse³⁵.

The second type of stressors, proximal stressors, is derived from distal stressors and makes an impact from person's inside. They include such phenomena as hiding one's orientation, expecting rejection, continuous fear of prejudices, and negative perception of one's group (e.g. non-heterosexual persons). Persons who observe prejudices and negative attitude towards LGBTQ persons in their environment often decide to hide their non-heterosexual orientation and not to disclose it to their family and friends. Several forms of hiding one's gay, lesbian or bisexual nature can be distinguished³⁶. Some persons decide to pretend to be heterosexual and mislead others by deliberately making it appear that they are heterosexual. The second strategy is connected with avoiding any situations or discussions which involve revealing one's sexual orientation or preferred sex of a partner. At the same time, persons using this strategy precisely control what information they disclose about themselves to others, and filter out information referring to their sexual orientation. The next strategy which may precede coming out is revealing information which may indicate one's non-heterosexual orientation to

35 See Czarnecki, G. (ed.) (2009). Raport o homofobicznej mowie nienawiści w Polsce [Report on Homophobic Hate Speech in Poland], Warsaw.

36 Meyer, Ilan H. op. cit., pp. 674-697.

others, but not communicating it directly and avoiding explicit declarations. Hiding of non-heterosexual sexual orientation often results in significant stress connected with continuous focus on pretending and creating guises of heterosexuality, recurrent anxiety thoughts regarding threat of exposure, feeling of guilt, shame and reduced self-esteem, and choice to live in isolation from other LGBTQ persons³⁷.

One of the key proximal stressors for LGBTQ persons is the internalised homophobia understood as internalisation of negative social perception of homosexuality which leads to reduced self-esteem and self-hatred. According to assumptions of the minority stress concept, internalised homophobia as a proximal stressor appears when distal stressors, i.e. prejudices, unfavourable stereotypical opinions and negative beliefs about LGBTQ persons generally available and disseminated in the public space, occur.

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Persons experiencing minority stress also expect to be harmed and function in a state of chronic anxiety of being rejected on the grounds of their socially stigmatized identity trait. Rejection may be felt as deprivation of certain rights, attribution of specific traits, or expression of non-acceptance by a group significant for them. Expectation of rejection and non-acceptance as a proximal stressor is often connected with internalised homophobia, depression, and anxiety.

Another characteristic phenomenon connected with experiencing of minority stress are ruminations, i.e. obsessive and ceaseless directing one's thoughts towards threatening situations, including repetitive contemplating of past events related to experiencing discrimination or violence motivated by homophobia. In particular, persons who encountered violence incidents will be prone to recall them, possibly resulting in reduced mood and anxieties.

In conclusion, there are three basic theses of the minority stress theory:

1) Minority status in the society leads to increased exposition to distal stressors.

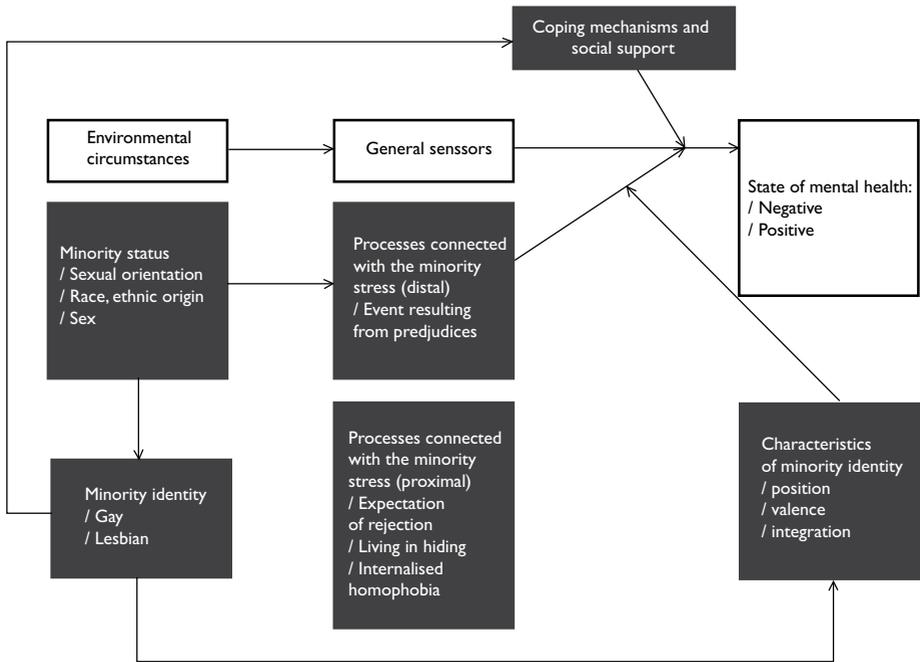
37 This phenomenon is visible in language of men looking for sexual contacts with other men via the Internet. They write that they are "discrete", "do not evoke associations", "hetero type", and that they seek for persons "from outside the environment". Similar phrases may be interpreted also in the context of experiencing internalized homophobia and being threatened by the stereotype.

2) Minority status in the society leads to increased exposition to proximal stressors mediated by distal stressors.

3) Persons of minority status suffer from health issues resulting from experiencing proximal and distal stressors.

Figure 1. Processes connected with the minority stress

Source: Meyer, 2003, qtd. in Grabski et al, 2012³⁸.



38 Grabski, B., Iniewicz, G., Mijas, M. (2012). Mental health of homosexual and bisexual people – review of research and presentation of phenomenon, "Psychiatria Polska", XLVI, 4, pp. 649-663.

EMANCIPATION AND LIBERATION

52

Having recognised that non-heterosexual persons are subjected to social oppression, experience discrimination and various forms of violence that impact their psychophysical condition, it is difficult to acknowledge this situation as encountered and acceptable *status quo*. A dilemma faced by persons providing psychological support to those who experienced homophobic violence is connected with the aim of a therapeutic meeting. Such deliberations may and should focus more extensively on the mission and ethos of psychologist's profession, and on the role of persons providing psychological aid to members of groups experiencing minority stress. Many practiced ways and employed methods of therapy aim at changing client's internal world so that it would correspond to the experienced reality in a way that is rational and acknowledged as socially adequate. Such work with a person focuses on developing behaviours, as well as thinking and interpreting the world in a socially expected way; it accepts social standards as a framework of person's functioning. Therapeutic influences aimed at going beyond the issue, coping with its effects and finding a solution which does not undermine the injustice and groundlessness of the sustained harm may lead only to developing a strategy of coping with the issue (violence), but will not contribute to preventing and changing it. A supporting person working with such an attitude, adjusting clients to fit into the framework of social standards and acceptable behaviours, may become a supporter of the oppressive system of prejudices affecting the client. Therefore, conscious identification of one's role and mission, as well as specifying the aim of actions, is extremely important. Currently, therapists more often (as Levine argues³⁹) aim to bring persons experiencing difficulties into line by the means of pharmacological therapy or short-term psychotherapies, so that they would be able to return to their environment, regardless of how pointless (e.g. consumer), devastating (e.g. oppressive), or exploiting (e.g. in a production sense) is its influence on the individual. In the approach

39 Levine, Bruce E. (2012, 20 Oct). How Psychologists Subvert Democratic Movements, „ZMagazine“.

proposing restoration of the “sick and suffering patient” to the society, the ideology plays an enormous yet behind-the-scenes role. According to this ideology, moderate conformism is the most healthy reaction towards current social standards, roles and world’s structure with its unjust privileges towards some groups and violence towards other ones. The principle argues that members of minority groups disfavoured because of that fact should either learn to cope with psychological intricacies related to experienced oppression, or seek aid of specialists who will bring them into line. As a consequence, this ideology serves to maintain affairs of privileged groups and cultivate unjust social environment.

The concept that being adjusted to the surrounding social world is always a symptom of an individual’s healthy and good functioning style, has been undermined half a century ago by the prominent Polish psychiatrist, creator of the “psychical hygiene” concept, Kazimierz Dąbrowski: “(...) until now, in psychology, pedagogy and psychopathology it was thought that adaptation is generally something correct, positively developmental, that it constitutes a criterion of mental health. And non-adaptation is something incorrect, negative, indicating lack of mental health.

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Taking a closer look at this issue, it turns out that adaptation in all circumstances and on every level indicates emotional and moral underdevelopment, expresses a lack of hierarchy of values, is connected with conformist attitude, contains neither essential elements of positive development nor creative elements. (...) One cannot adapt to crime, harm and humiliation, lies, deceit, betrayal and numerous other such phenomena”⁴⁰. Dąbrowski indicated that non-adaptation and experiencing of seemingly psychopathological symptoms may constitute one of ways of development of a disintegrating identity.

Such an approach to the concept of adaptation contains many elements common with the development of emancipation competences proposed by critical pedagogues. These competences include development of proficiency in noticing and understanding subjective limitations, expression of non-compliance to oppression, defiance towards encountered reality, and selection of responsible way to extend the field of freedom in order to perfect oneself and the environment. Figure 2 presents the

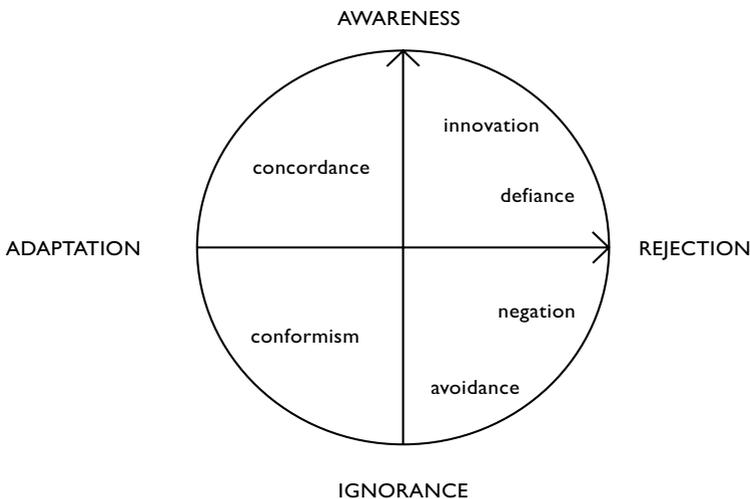
40 Dąbrowski, Kazimierz (1986). *Trud istnienia* [The Hardship of Existence]. Warszawa, pp. 49-50.

concept of the “emancipation rose” which shows the development of the emancipation competence that may be useful to understand processes taking place in the attitude of LGBTQ persons experiencing oppression.

In experiencing violence, the process of liberation from oppression and of subjective emancipation may be presented on two axes: adaptation and awareness. On the adaptation axis, the person experiencing harm may adapt to it, comply with it, or assume defiant attitude against unjust reality and reject the oppressive environment. At the same time, a person may not understand the experienced violence and have little insight into it, or have high socio-political self-awareness connected with the ability of rational ordering their experience in the oppressive social structure.

Figure 2. The emancipation rose

Source: Leirman, W. (1981). *Vormingswerle en Vormingswetenschap*, qtd. in Czerpaniak-Walczak, Maria (2006). *Pedagogika emancypacyjna [Pedagogy of Emancipation]*.



The situation of low awareness of dependency on the environment, depriving social situation, and regime of freedom-limiting standards may result in assuming a conformist attitude. A person without broader

insight into factors connected with the experienced oppression tries to adapt to and be submissive towards them. At this stage, oppressive regulations of homophobic and heterosexist nature may be thoughtlessly internalised and even passed on (e.g. aversion and disgust of a gay/lesbian towards single-sex couples who publically walk holding hands). Non-compliance to experienced harming reality connected with non-understanding of this reality and its oppressive mechanisms may result in withdrawal, isolation, clamming up, or escape behaviours, and, in societal dimension, voluntary ghettoization of the minority. Non-compliance may also display in manifesting one's dissatisfaction, criticising violent persons, even aggressive defiance; however, without increase in awareness, it will not employ exposing actions aimed at actual sources of oppression.

In the concept illustrated by the emancipation rose's matrix, the process of self-liberation from limitations takes place in dialog relation between the attitude evoking innovative behaviours and the concordance. Concordance is understood as conscious participation in the system of dependencies and limitations, also these which create oppression, and its acceptance. Therefore, the awareness of this system's existence, insight into one's role in it, and non-compliance to objectivisation and constructed limitations is a potential for critical search for new innovative solutions liberating from experienced oppression. Not only the harming status quo is rejected, but also conventional and inefficient methods of coping with harm are negated and replaced with the one's personal solutions corresponding to their individual needs.

According to previously mentioned in this chapter Martin Baró, a clinician and Jesuit working daily with the most marginalised group of the poor in Salvador, the aim of therapeutic meeting with the representatives of oppressed groups should consist in "deideologisation of the reality"⁴¹. Therefore, instead of leaving it transparent, the psychologist should assist people to better understand the nature of their relationship with social world. Such deideologisation via better insight into one's

41 Burton, M., Kagan, C. (2005). Liberation social psychology: learning from Latin America. "Journal of Community and Applied Social Psychology", 15, pp. 63-78.

role in the structure of social privileges, regulations and expectations prompt persons from marginalised groups to develop their own ideologies which may take care of their own affairs and have a chance to break the hegemony of the privileged groups. Only when suffering, pain and self-destructive behaviours of a person experiencing violence have been explained and justified by social relation, a place for understanding and sense of security in striving to change one's situation shall appear. Therefore, it is not about bringing a person into line so that they would cope in the society, but rather about taming and directing their defiance, reinforcing their natural desire for emancipation, and teaching them how to change their environment⁴².

56

The **liberation psychology** proposed by Baró, perceiving the psychologist as an important actor in the process of emancipation of oppressed groups, is not the first social science placing emancipation in the centre of the individual's development. The significance of inner representation of connection between personal experience and socio-political structure, i.e. basic element of liberation psychology, has been indicated by Brazilian pedagogue and thinker Paulo Freire. The aim of his educational actions is to "help people so that they could help themselves to critically perceive and interpret reality that oppresses them"⁴³ by increasing socio-political awareness (*concientización*). In the *concientización* process, persons become empowered and become activists for their own case thanks to improved understanding of their life in the context of social inequalities and oppression. When they start to influence their environment, a change takes place in them as well. In this approach, an insight into interrelation of the environment of violence, power distribution and relations in the society, with behaviours and psychopathological symptoms of the individuals, is essential to understand experiences of persons encountering oppression.

42 Put into practice, this idea becomes extremely dangerous to all authoritarian systems of power and destabilizes societies built on injustice and inequalities. Martin Baró had been working according to his method with the poorest layers of Salvador society, at the same time waking their political awareness and desire to change their economic situation by greater social participation. Being a threat for dictatorship of that time, he and his closest colleagues, university workers and Jesuits, were brutally murdered in his house by a military division.

43 Freire, P. (1970). *Pedagogy of Oppressed*, New York, p. 166.

Therapeutic work with LGBTQ persons experiencing violence due to their identity may draw from the approach proposing emancipation and liberation. It would mean shaking off the discourse focused on suffering, psychopathology and experiencing homophobia. Except for intrapsychical searches, the client and the therapist have a chance to understand the place of client's experience in broader socio-political, cultural and historical contexts. Such analysis should result not only in greater insight into one's situation, but also in liberation from sense of guilt and shame related to unconscious internalisation of heteronormative beliefs about oneself.

An increase of *concientización* results in being aware of one's participation in the social system, and of possibility to assume responsibility for one's position. What is more, according to assumptions of dialectic relations between personal and social change, LGBTQ persons making personal and environmental changes may consciously observe changes in these two areas. And it is precisely the recovery of agency and control that is essential for the sense of pride and empowerment.

CHAPTER II

PSYCHOLOGICAL SUPPORT FOR LGBTQ PERSONS

In order to competently work with non-heterosexual and transgender persons, one should first learn about socio-cultural circumstances influencing the specificity of experiences of members of disfavoured groups; the whole first chapter of this publication is devoted to it. In this part we shall concentrate on competences (knowledge, skills, awareness, and attitude) of specialists working with persons whose gender or sexuality eludes heteronormative assumptions. This chapter contains practical prescriptions and recommendations useful in the work of persons providing psychological support to LGBTQ persons who are exposed to violence in much greater degree than heterosexual or traditionally gendered persons (fulfilling cultural expectations regarding gender). A specific form of violence is mentioned here – the violence motivated by homophobic hatred. Persons visibly eluding stereotypical expectations about their behaviours, appearance, interests, or traits traditionally ascribed to women or men are particularly exposed to this kind of violence. One of these expectations is alleged heterosexuality, accompanied by an assumption of gender binary which does not accept that biological sex, gender identity and/or expression may be vastly different than opposing and separate categories of woman and man.

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This part begins with a search for guidelines which could constitute beacons for standards of working with LGBTQ persons, supported by guidelines of global and national organizations concerned with sexuality and mental health such as, among others, Polish Sexological Society, American Psychological Association, American Psychiatric Association, and World Health Organization. In order to stronger place this publication in Polish context, we shall refer to Polish realities, as well as standards and guidelines indicated by the Polish Psychological Association.

PSYCHOLOGICAL ETHICS AT WORK WITH LGBTQ PERSONS

Psychological support is a critical field connected with great responsibility of the persons providing it. In order to maintain high work standard and take care of ethics and safety in psychological contact, the psychological and medical communities establish ethical codes aimed at setting standards which are to provide safety, respect for dignity, and optimal working conditions both for the person providing support, and for persons receiving it.

60 In Poland, currently there is no law on the psychologist profession and, consequently, there is no official ethical code common to all specialists either. Persons engaged in providing psychological support employ various guidelines, starting with Hippocratic *primum non nocere* (from Latin, “First, do no harm”), through the Ethical Code of the Polish Psychological Association, ending with ethical codes of various therapeutic schools (e.g. the Ethical Code of the Polish Association for Integrative Psychotherapy, the Ethical Code of the Cognitive-Behavioral Therapist of the Polish Association for Behavioral and Cognitive Therapies⁴⁴). These codes have certain common parts resulting from general ethical standards – the respect for human rights. The variety of codes facilitates ambiguity, also in relation to issues of prejudices and discrimination experienced by LGBTQ persons, as described in the first chapter.

How do guidelines included in these codes refer to working with the LGBTQ persons? Let us begin from the Code of Ethics of the Polish Psychological Association (PTP), last point of which states that: “Principles of the Code of Professional Ethics apply to all Polish psychologists.” Although formally these principles apply only to members of the Polish Psychological Association, usually it is acknowledged as guidelines in the psychologist community regardless of PTP membership.

44 <http://www.pttpb.pl/pl/pttpb-info/kodeks-etyczny-pttpb>.

The mentioned code has been approved by the General Meeting of Representatives of the Polish Psychological Association in 1991. It should be noted that the code has been approved 22 years ago; therefore, it may not consider technological and cultural changes which have occurred since then. In that document there are no direct mentions of the issue of respecting sexual and gender identity; however, there are passages particularly important in working with LGBTQ persons:

Art. 4. The psychologist is obliged to constantly develop professionally and to strive to continuously develop personally. Psychologist's qualifications should reflect the current level of knowledge and psychological techniques. The psychologist uses the achievements of world science⁴⁵.

This passage clearly indicated the need of updating knowledge and techniques applied at work with LGBTQ clients as well, considering the achievements of world science. It is particularly significant in the case of sexuality issue, knowledge of which has been dynamically developing in recent years. As indicated by results of researches analysing contents of publications in Polish language, Polish literature often presents contents incompatible with the most recent standards. For example, it is clearly seen in "Raport o homo-, biseksualności i transpłciowości w polskich podręcznikach akademickich" [Report on homo-, bisexuality and transgender in Polish academic textbooks] (Loewe, 2010). In that report, Katarzyna Bojarska divided publications into three main approaches, starting with the least up-to-date initial concept – "pathologizing", through the middle concept – "subconsciously evaluative", ending with the most up-to-date contemporary concept – "egalitarian"⁴⁶. As a result of qualitative analysis, the researcher states that, among textbooks received for analysis, "all but one contemporary scientific publications by Polish authors have presented the concept B (middle one)." Similarly, in the case of transgender persons, as indicated by Wiktor Dynarski, pre-

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45 Emphasis added by authors, aimed at highlighting particularly vital passages in the context of working with LGBTQ persons.

46 Bojarska, Katarzyna. Analiza merytoryczna wybranych pozycji piśmiennictwa poświęconego problematyce homoseksualności [Substantial Analysis of Selected Literature Devoted to the Issue of Homosexuality], in: Loewe, A. (ed.) Raport o homo-, biseksualności i transpłciowości w polskich podręcznikach akademickich [Report on Homo-, Bisexuality, and Transgender in Polish Academic Textbooks], Warsaw: Campaign Against Homophobia, pp. 20-21.

sented contents have been significantly different from contemporary standards. According to him, the main issues are:

- false (in relation to current state of medical knowledge) information about the classification of “gender identity disorders” categories or other issues connected with sexuality;
- excessive stereotypization and/or stigmatization of sexuality,
- false information regarding medical actions leading to gender correction⁴⁷.

Although more and more Polish publications presenting standards compliant with current guidelines (see: subchapter with proposed literature in this publication) appear, they still consist a minority. Obtained results display a need to update one’s knowledge on the basis of world literature compatible with the most recent achievements, as obliged by the Code of Professional Ethics of the Polish Psychological Association. It reads as follows:

Application of statements and methods developed in other social and cultural conditions should be preceded by critical analysis of possibilities of employing them in our circumstances.

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It is an extremely important point and it may evoke valid associations with culture understood as ancestry or ethnicity; however, “social and cultural conditions” may be also related to the cultural difference which characterizes every minority in the society, including sexual and gender ones. Undoubtedly, social conditions of LGBTQ persons are significantly different from social conditions of heteronormative persons who possess privileges unknown to LGBTQ persons, e.g. a possibility to legally formalize relationships. Discrimination, both on individual and system levels, results in LGBTQ persons living in social conditions different from heteronormative persons and having certain common experiences, e.g. the experience of coming out (revealing of the non-heterosexual psychosexual identity), most often very stressful. Knowledge of these experi-

⁴⁷ Dynarski, Wiktor (2010). Tematyka transpłciowości w wybranych publikacjach oraz jej usytuowanie we współczesnych dyskursach akademickich [The Topic of Transgender in Selected Publications, and Its Placement in Contemporary Academic Discourse], in: Raport o homo-, biseksualności i transpłciowości w polskich podręcznikach akademickich, [Report on Homo-, Bisexuality, and Transgender in Polish Academic Textbooks], Warsaw: Campaign Against Homophobia.

ences and culture constitutes one of conditions essential for competent work with LGBTQ persons. This knowledge can be acquired through participation in workshops and trainings touching on the issue of sexuality (one should pay attention to competences of the trainers), individual reading of current literature, watching films (both documentary and feature), participation in thematic events organized by non-governmental organisations, as well as contacts (both private and professional) with non-heterosexual and transgender persons.

Going back to guidelines binding Polish specialists engaged in therapy and counselling, the PTP Code of Professional Ethics states as follows:

Art. 15. The psychologist should perform his professional activities striving to achieve possibly highest level of his work, regardless who is the receiver of his activity, and what is their personal attitude towards this person or persons. In particular, psychologist's intention of providing assistance and careful performance of professional activities does not depend of such properties of the clients: social position, material situation, political views, beliefs and system of values, race, nationality and age, as well as nature of issues requiring psychological intervention.

As can be seen, there are no direct references to LGBTQ persons; however, the issue of sensitivity to diversity of traits and properties of our clients arises. The code indicates that one should try to perform their professional activities at the highest possible level regardless of traits of persons approaching us. To make this possible, specialists need to be able to verify their own attitudes and the influence of social stereotypes and prejudices on personal approach to members of disfavoured groups. It is extremely important for persons providing psychological support to be conscious of their values, beliefs and social context that shapes them; such characteristics can be acquired during an antidiscrimination training. Besides current knowledge and psychological skills, the anti-discrimination training is the basic recommendation for persons working with persons experiencing violence motivated by hatred. It allows for critical analysis of personal attitude towards LGBTQ persons; considering the heterosexism and homophobia present in the society and internalised in the socialization process, such training is essential. Lack of critical analysis of one's beliefs – stereotypes and prejudices, may result in unaware behaviours or interventions harming non-heterosexual and/or transgender clients.

An example of abuse in the scope of aiding LGBTQ persons is an attempt to change the sexual orientation towards heterosexuality, so-called correction therapy, also known as reparative or conversion therapy. If we are approached by a person who does not accept their sexual orientation, what is often stated to be the first stage of sexual identity development⁴⁸, therapist may, acting according to the client's wishes, make such attempts. In an extreme case, lack of knowledge about modern guidelines and researches on effects of such therapy, connected with one's own unawareness of mechanisms related to internalised homophobia, displayed by the person providing (as they believe) support, leads to intensification of client's self-hatred, increase in risk of mood disorders occurrence, and deterioration of mental condition⁴⁹.

Except the mentioned Code of Polish Psychological Association, persons studying under various therapeutic schools assume ethical codes established within frameworks of these schools. Here, direct mentions regarding sex and sexual orientation often appear. For example: the second part of the Ethical Code of the Polish Association for Integrative Psychotherapy⁵⁰ entitled "Respect for others and non-discrimination" states directly that:

The psychotherapist does not discriminate on the ground of age, sex, race, nationality, religion, sexual orientation, disability, beliefs, education, language, or socio-economic status.

Similarly, chapter II of the Ethical Code of the Cognitive-Behavioral Therapist of the Polish Association for Behavioral and Cognitive Therapies⁵¹ entitled "Cognitive or behavioural psychotherapist's ethical responsibility towards the patient" states that:

Cognitive or behavioural psychotherapist is obliged to treat patients equally, regardless of age, sex, marital status, sexual orientation, nationality, religion, political beliefs, material situation, health status, race, skin colour, and other preferences and personal traits.

48 see Długołęcka, Alicja 2012, Williams, Savin 2011, Reynolds and Hanjorgins 1999.

49 APA 2009, Iniewicz 2012.

50 The Ethical Code of the Polish Association for Integrative Psychotherapy, <http://www.integrative.pl/index.php?page=kodeks>.

51 The Ethical Code of the Cognitive-Behavioral Therapist of the Polish Association for Behavioral and Cognitive Therapies, <http://www.pttpb.pl/pl/pttpb-info/kodeks-etyczny-pttpb>

However, there are also schools which avoid or not touch upon this issue directly, such as the Ethical Code of the Psychotherapist of the Polish Association for Psychodynamic Psychotherapy⁵².

As can be seen in provided examples, although wording and degree of literariness of attitudes to sexual orientation in different codes vary, common elements include: respect for human rights and dignity, care and respect for the client's well-being, competence, honesty, as well as professional and social responsibility⁵³. The article 2 of human rights set out in the Universal Declaration of Human Rights (United Nations, 1948) states that:

Art. 2: Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (...).

"The Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity"⁵⁴ (Remin 2009), developed in 2006 by a group of experts on human rights, deserve particular attention. It is a set of 29 principles constituting a reconstruction of international standards of human rights in reference to sexual orientation and gender identity.

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It is also worth to cite the passage from the Universal Declaration of Sexual Rights⁵⁵ adopted by the World Health Organization in 2002, directly emphasizing the right to equal sexuality which:

Refers to freedom from all forms of discrimination, regardless of sex, sexual orientation, age, race, social class, religion, and physical or emotional disability.

In its official statement from 2006, the Polish Association of Sexology emphasizes the concern about harmful influence of social prejudices on mental and social functioning of homosexual and bisexual persons. At the same time, it calls for "health scientific organizations and all individual psychologists, psychiatrists and other specialists in mental health"

52 <http://psychodynamika.pl/index.php/page/witamy/l-kodeks-etyczny.html>.

53 Leach, Harbin 1997, qtd. in Iniewicz 2012, p. 29.

54 Can be downloaded at: http://www.kph.org.pl/publikacje/b-y_zasady.pdf.

55 The Declaration of Sexual Rights has been established during XIII World Congress of Sexology in 1997 (cf. XIII World Congress of Sexology Valencia Declaration on Sexual Rights, in: The Kinsey Institute Advancing Sexual Health and Knowledge Worldwide, <http://www.iub.edu/~kinsey/resources/valencia.html>). In May 2002, the declaration has been adopted and recommended by the World Health Organization.

to undertake actions consisting in denying stereotypes and prejudices towards homosexuality.

We also invite you to familiarize yourself with “Recommendations for Polish scientific societies regarding treatment and therapeutic assistance for homo- and bisexual persons” (2013) included in the attachment to this publication.

In the next part we shall compare various approaches to therapeutic and assistance work with LGBTQ persons in the context of their ethicality and compatibility with current guidelines and standards.

SOCIO-CULTURAL ASSUMPTIONS REGARDING SEXUALITY

One of the factors influencing the philosophy of work and choice of tools employed in psychological work is therapeutic school. However, this part shall focus not on various therapeutic schools but on another, extremely important perspective that influences the way of working with LGBTQ persons, regardless of the therapeutic trend. Besides therapeutic school, one of the significant factors vital in the context of working with members of socially stigmatized groups is the (un)awareness of one's own internalised beliefs about sex and sexuality. Critical analysis of these beliefs is essential for competent therapeutic work. Persons providing psychological support are tools in their work and, in the same way as other persons rooted in the heteronormative and homophobic society, they internalise scripts and schemes prevailing in the society – stereotypes and prejudices towards LGBTQ persons. Growing in heteronormative society, we learn offensive vocabulary describing LGBTQ persons already in childhood; we adopt not only stereotypic beliefs (stereotypes), but also very strong emotions connected with them (prejudices). Often we assimilate negative emotions connected with terms describing LGBTQ persons (e.g. "fag") before we learn their actual meaning. For example, a child may learn (at pre-school, school, on a playground) that to insult someone it is enough to utter the word "fag" – it heard somebody angrily calling another person like this. Now, the child knows that this word means something terrible (it does not have to know its meaning – in Polish language the same word is used to denote bicycle pedals, so it may wonder why this exact part of a bicycle is so insulting), and if it wants to insult or ridicule someone, then it knows how to do it. With the passage of time and accumulation of similar experiences, negative associations perpetuate. With time, a child may learn that this word, except denoting bicycle parts, is also used to define boys and men interested in, or establishing, close, intimate relationships with persons of

the same sex. Learned patterns of emotional reactions perpetuate and aversion occurs automatically. Then, learned, automatically evoked feelings (aversion, contempt, disgust, pity etc.) are reinforced by common stereotypes and prejudices (e.g. that gays molest children, lesbians hate men, bisexual persons do not know what they want and are untrustworthy, and transgender persons are whimsy in relation to their sex), which are present both in private sphere, as well as, what is particularly concerning, public sphere. For example, homophobic slogans in public spaces (on walls, buildings), hate speech in the media (e.g. statements of the Nobel Peace Prize Laureate – Lech Wałęsa⁵⁶ who spoke about partner relationships. In his view: "They must know that they are a minority and must adapt to minor things. (...) I do not wish for this minority, with which I do not agree (...) to go out into the streets and lead my children and my grandchildren astray with some minorities." According to him, in Polish Sejm (Lower House of Parliament), "homosexuals should sit in the last bench of the plenary chamber, and not somewhere in front (...) And even behind the wall"), in utterances of religious institutions representatives (e.g. clergyman – Ireneusz Wołoszczuk's statement⁵⁷: „homosexual adoption of children is a premeditated crime on defenceless psyche of a child, on its vision of social roles, and even on the foundations of society existence!"). Such behaviours appears even in persons who should constitute a role model of ethics in assistance professions such as, e.g. psychologists recommended by organizations undertaking "treatment" of homosexuality⁵⁸. There are many such examples. While the clergyman's statement is easier to understand in the context of religious doctrine which imposes certain guidelines on its representatives (however, religion's attitude in reference to sexual orientation is not so unambiguous; more information can be found in lit-

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56 The statement appeared in the Fakty po faktach [Facts After Facts] programme on TVN24, see Wałęsa ostro o homoseksualistach: Oni muszą wiedzieć, że są mniejszością [Wałęsa's Sharp Talk on Homosexuals: They Must Know That They Are A Minority], available on: <http://www.tvn24.pl/wiadomosci-ze-swiatea,2/lech-walesa-dzialacz-elektryk-prezydent-laureat-nobla-homofob,309769.html>. See also the continuation of the debate on TVP Polonia on: <http://www.youtube.com/watch?v=u8SIKzeXs4Q>.

57 Fr Ireneusz Wołoszczuk's text entitled Przywileje za homoseksualizm? [Privileges for Homosexuality?] has been published in the "Idziemy" Catholic weekly, no 30 (359), 22 July 2012. Available at: <http://www.idziemy.com.pl/polityka/przywileje-za-homoseksualizm/1/>.

58 See Podgórska, Joanna (2013). Zawracanie geja [Turning Back a Gay]. Polityka. Paper available at <http://www.polityka.pl/spoleczenstwo/artykuly/1546771,1,jak-leczyc-homoseksualistow.read>.

erature⁵⁹), statements coming from psychologists bounds by professional ethics are particularly scandalous. Such statements are not only incompatible with the Code of Ethics of the Polish Psychological Association, but they are an expression of deeply ingrained stereotypes and prejudices, as well as of lack of elementary knowledge about sexuality and gender. Impunity, silent agreement to hate speech and blatant breaking of the ethical code are appalling as well. It is one of the examples of systemic homophobia that remains unpunished in communities which should be at the forefront of depathologization and respect of human rights, including rights of LGBTQ persons.

Changing of homophobic or heterosexist attitude is not an easy task and does not come effortlessly – it requires conscious work, knowledge updates, verification of deeply rooted convictions, and perception of a mechanism behind them – social acquisition and perpetuation of prejudices (MacRae, Stangor and Hewstone 1999, Nelson 2003). Additionally, once gained stereotypes and prejudices are poorly susceptible to change⁶⁰. It can be said that the natural effect of socialization in homophobic and transphobic society is internalisation of negative beliefs and emotions. „Stereotypes seem to be a part of the common heritage of the society. They are passed down for generations as a part of knowledge amassed by the society. (...) Nobody can grow in the society without learning stereotypes.”⁶¹

It is worth to ask oneself – how may lack of knowledge and awareness displayed by specialists on heteronormativity, heterosexism and homophobia influence working with LGBTQ persons?

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59 E.g. in: Boswell, John (2005). *Christianity, Social Tolerance, and Homosexuality*, Chicago: University of Chicago Press; Helmniak, Daniel A. (2000). *What the Bible Really Says about Homosexuality*. Sacramento: Alamo Square Press. See also Gene Robinson – Homosexual Bishop, e.g. Gay Episcopal Bishop Gene Robinson Talks About Jesus, “Alternative Lifestyle”, <http://www.christianpost.com/news/first-gay-episcopalbishop-gene-robinson-talks-about-jesus-alternative-lifestyle-96790/>.

60 Allport, Gordon W. (1958). *The Nature of Prejudice*; Bojarska-Nowaczyk, Katarzyna (2005). *Psychospołeczne korelaty homofobii [Psycho-social Correlates of Homophobia]*; Cieślakowska, Dominika (2010). *Postrzeganie społeczne, Dyskryminacja [Social Perception, Discrimination]*; Dułak, Katarzyna (2008). *Tendencyjność spostrzegania a stereotypizacja gejów i lesbijek [Biased Perception And Stereotypisation of Gays and Lesbians]*; Macrae, C.N., Stangor, Ch., Hewstone, M. (1996). *Stereotypes and Stereotyping*; Nelson, Todd N. (2006). *The Psychology of Prejudice*.

61 Ehrlich (1973), p. 35; qtd. in Dułak (2008). *Tendencyjność spostrzegania a stereotypizacja gejów i lesbijek [Biased Perception And Stereotypisation of Gays and Lesbians]*, p. 58.

In order to better understand the influence of heteronormativity on perception of the world, we propose you to familiarize yourself with the *Heterosexual Questionnaire*.

HETEROSEXUAL QUESTIONNAIRE

Regardless of your actual sexual identity, try to assume a role of a heterosexual person and answer the following questions:

1. What do you think caused your heterosexuality?
2. When and how did you first decide you were a heterosexual?
3. Is it possible that your heterosexuality is just a phase you may grow out of?
4. Could it be that your heterosexuality stems from a neurotic fear of others of the same sex? Maybe you just need a positive homosexual experience?
5. Sometimes, heterosexuals have homosexual “adventures”. Do you think that you may have turned to heterosexuality out of fear of rejection?
6. If you have never slept with a person of the same sex, how do you know that you would not prefer that?
7. If heterosexuality is normal, why heterosexuals constitute a disproportionate large number of patients with mental disorders?
8. To whom have you disclosed your heterosexual preferences? How did they react?
9. Your heterosexual orientation does not bother me as long as you do not try to impose it on me: but why so many heterosexuals attempt to induce others to assume their sexual orientation?
10. If you decide to have children, would you want them to be heterosexual, knowing the issues they would face in life?
11. The majority of child molesters are heterosexuals. Do you believe that it is safe to expose your children to contacts with heterosexuals (especially heterosexual teachers)?

12. Why the majority of heterosexuals flaunt their sexual orientation in public spaces in such an ostentatious way? Can't you be together and keep it secret?

13. Heterosexuals always assign themselves strictly defined, stereotypical schemes of gender roles. Why do you stick to such unhealthy principles such as role-playing?

14. How is it possible to have a fully satisfying, deep emotional or sexual experiences with a person of the opposite sex since the obvious physical, biological, and character differences between you are so vast? How can a man understand what pleases a woman sexually, or vice versa?

15. Despite heterosexual marriages enjoying enormous societal support, the divorce rate still grows. Why are there so few stable heterosexual relationships?

16. Since only few heterosexuals are happy, techniques aimed at aiding people have been developed. Have you considered a possibility of therapy changing your sexual orientation?

17. Why heterosexuals are often promiscuous, constantly have romances, and other "adventures"?

18. A disproportionate amount of persons using social aid, criminals, and racists, is heterosexual. Who would seriously consider a possibility to offer them a responsible job?

The quoted questionnaire is constructed as a reflection of questions often asked to gays, lesbians and other non-heterosexual persons by some therapists (especially questions 1-6, 8-10, 16-17). Some questions (12, 15, 18) consist of two parts: the first one considers realities of the „heterosexual world”, while the second one cites (replacing the word “homosexual” with “heterosexual”) questions asked to persons of homosexual orientation. The remaining questions of the Questionnaire (7, 11, 13, 14) attempt to show what issues usually do not rise our objections despite the fact that are not obvious at all, and their apparent obviousness is only a result of a cultural training: accepting certain specified principles as “natural”.

How does it feel to answer these questions?

Do answers come easily?

Does it feel nice?

The provided exercise contains a lot of questions which may occur in effect of specialists' lack of knowledge and awareness about heteronormativity, heterosexism and socio-cultural factors which construct and maintain them. One can sense a negative, pathologizing attitude in the questions, resulting in appearance of questions which are harming and unpleasant for many persons. As one might guess, hearing such questions from a person who was supposed to provide assistance does not facilitate establishing a safe, trust-based relation.

One of the most common examples of heteronormativity appearing in therapeutic work is a question about the husband or male partner asked a to woman and, likewise, question about wife, female partner asked to a man. This means that if a woman says that she is in a relationship, the therapist may automatically, heteronormatively assume that she is in a relationship with a man. As a result, they may ask further questions connected with the relationship, emphasizing (often deliberately) the person's sex, e.g. „Does your (male) partner know about it?⁶²”. Another example is a standard interview question: “Do you have a (female) partner?”, “Do you have a (male) partner?” instead of a question about a relationship or loved ones. An example of heteronormativity outside of the office may be offering (e.g. on a website) of a “marriage advice” instead of “partnership advice” or “relationships advice”. The phrase “marriage advice” itself narrows the group of persons to whom the assistance offer is directed, for not only it excludes non-heterosexual persons who most often are not married (at least in Poland where there is no such legal possibility), but also heterosexual persons in so-called “informal relationships”. It is also worth to consider that both heterosexual and non-heterosexual persons may want to form, or do form, various kinds of more or less open relationships, with more persons involved in them. A desire or acceptance of involvement in love or sexual relationship with more than one person at the same time, with agreement and knowledge

62 Translator's note: this phenomenon is less noticeable in English due to differences in grammar.

of all persons forming given relationship, is called polyamory⁶³. Disclosing one's non-heterosexuality is an enormous challenge for LGBTQ persons, and asking questions that suggest heterosexuality by the therapist additionally complicates this process, possibly inhibiting authentic relation and competent support for LGBTQ persons.

Heterosexism assumes that the only proper, correct or healthy persons are heterosexuals fulfilling and adapting to the traditional gender roles. As one can easily guess, such assumption from the side of the therapist may cause great damage to non-heterosexual and transgender persons.

This approach pathologizes non-heterosexuality and transgender; it may manifest in seeking reasons, possibly accompanied by hope that finding a reason may help to remove it, repair it, or restore its desired direction, i.e. heterosexuality and unambiguous gender.

As a result of lack of reflection on the listed phenomena, assistance profession specialists may, in good faith, attempt to change sexual orientation (Iniewicz 2012, see also Ardweg 2006 – an example of such approach) or, more rarely, gender expression (Zucker 1999). These therapies are called **reparative**, **correction**, or **conversion** therapies. Persons or groups undertaking reparative therapy are often motivated by religious ideology (Iniewicz, Bąk 2012). An attempt to change the direction of emotional and/or sexual needs suggests at the outset that the initial, non-heterosexual direction of these needs is improper and requires correction. Proposing such solution by specialists is a display of heterosexism which may lead to negative psychological consequences: from low self-esteem and non-acceptance of one's sexuality, up to self-hatred⁶⁴. A desire to change one's sexual or gender identity itself should not be surprising, for LGBTQ persons, growing in homophobic society, are subject to, similarly to the rest of the society, socialization in which they internalise negative beliefs about sexual or gender non-normativity.

63 Easton, Dossie, Hardy, Janet (2009). *The Ethical Slut: A Practical Guide to Polyamory, Open Relationship & Other Adventures*, Emeryville, California: Greenery Press.

64 APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009). *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Washington, DC: American Psychological Association, <http://www.apa.org/pi/lgbcc/publications/therapeutic-response.pdf>.

Such internalised convictions are called internalised oppression (homophobia, biphobia, transphobia etc.).

Organizations researching the efficiency of these therapies (American Psychological Association and American Psychiatric Association, among others) for many years have been stating that there is no evidence of their effectiveness, and there are tests indicating harmfulness of these therapies for mental health of affected persons. Numerous psychological and medical organizations, such as American Psychiatric Association, International Federation of Social Workers, American Academy of Pediatrics and American Psychological Association among others, on the basis of research results analysis, have stated that there is no scientific evidence of effectiveness of this kind of therapy; however, potential hazards such as mood disorders, anxiety and self-aggressive behaviours are enormous⁶⁵. Official positions of medical and scientific communities are as follows:

American Psychological Association:

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Homosexuality in itself does not imply weakening of neither judgement, balance, reliability nor social and profession abilities. (...) The American Psychological Association [APA] calls for all mental health specialists to make efforts do remove the stigma of mental disorder which has been associated with homosexual orientation for a long time. Moreover, APA supports and calls for the implementation of provisions of law protecting citizen's rights [of these persons] (...). (1975).

American Psychiatric Association:

Considering the fact that homosexuality in itself does not imply weakening of neither judgement, balance, reliability nor social and profession abilities, the American Psychiatric Association calls for all international health organizations and individual psychiatrists in

65 APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009). Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Washington, DC: American Psychological Association, <http://www.apa.org/pi/lgbt/publications/therapeutic-response.pdf>; Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (2010). Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients. In: American Psychologist Association Vol. 55, No. 12, 1440-1451 Iniewicz, Grzegorz, Grabski, Bartosz, Mijas, Magdalena (2012a). Mental health of homosexual and bisexual people – review of research and presentation of phenomenon. „Psychiatria Polska”, vol. XLVI, no 4; American Psychological Association (2006). Statement of the American Psychological Association on conversion therapies. 10 August 2006, available at <http://www.apa.org/pi/lgbt/resources/policy/ex-gay.pdf>.

other countries (...) to do everything possible to reduce the stigma of homosexuality, wherever and whenever it appears (December 1992).

American Psychoanalytic Association:

Homosexual orientation may not be recognized as an expression of incomplete development of personality, or psychopathology. 2. As in every social prejudice, prejudice towards homosexuality negatively influences mental health, contributing to permanent sense of stigmatization and deep self-criticism through internalisation of this prejudice in homosexually oriented persons.

Source: The official position of the Polish Sexological Society dated 30 June 2006.

Therefore, in accordance with aforementioned presumptions and principles, proposing reparative therapies to LGBTQ persons does not comply with professional ethics. Unfortunately, such practice is still sound in Poland where books (e.g. Aardweg's book series, m.in. *Homosexuality and Hope* from 1999 [translated into Polish in 2000], among others), web portals (e.g. www.homoseksualizm.edu.pl), or correction groups (e.g. Grupa Pascha from Lublin) aimed at changing the sexual orientation to heterosexual are easily accessible. It is disturbing that the mentioned author's book is easily available in popular bookstores (e.g. Empik), and the web portal is one of the first that appear on the list of proposals when typing "homoseksualizm" ["homosexuality"] into a web search engine (as of June 2013). One tab (entitled "Terapia jest możliwa" ["Therapy is possible"]⁶⁶) contains "Świadectwa ex-gejów" and "Świadectwa ex-lesbierek" ["Testimonies of ex-gays" and "Testimonies of ex-lesbians"]. In this way, quite a lot of persons searching for knowledge on homosexuality on their own (also parents or specialists) come across this website and strengthen heterosexist prejudices. Small amount of alternative sources of knowledge exerts enormous influence on perpetuation of harmful stereotypes, prejudices, as well as on formation of public opinion, affecting the maintenance of stereotypes and prejudices, and translating into statistics on homophobic violence. In order to see how such a group may

66 See <http://www.homoseksualizm.edu.pl/index.php/terapia/sukcesy-terapii/swiadectwa-exgejow?Name=Value>.

function, it is worth to watch an exemplary report about “Pomoc 2002” group, broadcast during Tomasz Sekielski’s programme “Po prostu” on TVP, 22.01.2013⁶⁷.

Also, a passage of a letter dated 27.06.2007 should be quoted – an apology from Darlene Bogle, Michael Bussee and Jeremy Marks, leaders of a *former gays and lesbians*⁶⁸ ministry: „As former leaders of *ex-gay ministries*, we apologize to those individuals and families who believed our message that there is something inherently wrong with being gay, lesbian, bisexual, or transgender. Some who heard our message were compelled to try to change an integral part of themselves, bringing harm to themselves and their families. Although we acted in good faith, we have since witnessed the isolation, shame, fear, and loss of faith that this message creates. We apologize for our part in the message of

broken truth we spoke on behalf of Exodus⁶⁹ and other organizations (...). We encourage current leaders of *ex-gay programs* to have the courage to evaluate the fruit of their programs. We ask them to consider the long-term effects of their ministry.”

Another situation is homophobia in the attitudes of specialists which may result in conscious actions against LGBTQ persons, a glaring violation of professional ethics. At this point, the question arises: can a homophobic therapist, despite homophobic or heterosexist beliefs, leave their homophobia “at home” and work with LGBTQ persons in professional life? What about persons working in crisis intervention centres or other agencies which are obliged to provide assistance to those who need it?

67 See also an article on this subject: Hołowczyc, Radosław (2013). Heretycy z odczuciami homo [Heretics with Homosexual Feelings], in: “Replika – dwumiesięcznik społeczno-kulturalny LGBTQ” [Replika – LGBTQ Socio-Cultural Bimonthly] no 42, March-April 2013, <http://homiki.pl/index.php/2013/04/heretycy-z-odczuciami-homo/>.

68 Available at: <http://www.beyondexgay.com/article/apology.html>

69 Exodus International was a Christian ministry offering the reparative therapy for gays and lesbians. This ministry, the largest of such type (120 branches in USA and 150 around the world), was founded in 1976, and ceased to exist on 19 June 2013. The management of this ministry has published an apology directed to gays and lesbians. Alan Chambers, President of Exodus stated: „For quite some time we’ve been imprisoned in a worldview that’s neither honoring toward our fellow human beings, nor biblical. (...) I am sorry for the pain and hurt many of you have experienced. I am sorry that some of you spent years working through the shame and guilt you felt when your attractions didn’t change.”: <http://www.polskieradio.pl/5/3/Artykul/870645,Exodus-przeprasza-za-leczenie-gejow-i-lesbijek.html>

Recalling the mechanism of prejudice formation, the emotional component should be emphasized; emotions, such as antipathy and loathing which, if unconscious and not reworked (e.g. during an antidiscrimination workshop), are evoked automatically. Taking these mechanisms into consideration, it seems impossible to provide support when such feelings occur. What is more, it is most probably visible for a LGBTQ person who may notice so-called microinequalities like adverse gaze or grimace present in therapist's behaviour, possibly with the therapist unaware of them. Due to constant experience of oppression, some members of socially disfavoured groups (LGBTQ persons, among others) may be sensitive even to the slightest signs indicating aversion or disapproval⁷⁰. Therapeutic contact should constitute a space in which the recurring scheme of oppression is broken and replaced with full respect and kindness underpinning the affirmative therapy.

70 Allport 1958, Iniewicz, Grabski and Mijas 2012b

SOCIO-CULTURAL ASSUMPTIONS REGARDING SEX

The dominating assumption in the Western culture is that there are two separable sex categories – woman or man. The majority of people in the Judeo-Christian culture are subject to socialization aimed at adapting of this assumption. In social sciences it is called “an assumption about dichotomy/binary of genders.” This assumption constitutes a traditional way of understanding sexes and it is reflected in the legal system (sex registered at birth – woman or man⁷¹), in medicine (disease entities pathologizing every sexual “difference”⁷²), in the system of formal education (infinitesimal education on transgender in schools, or lack thereof), etc.

It is assumed that sex may occur in two variants – male and female, and that every human has an internally “programmed” sex – his “real” sex which determines the appearance of the body (biological sex), gender identity (sense of gender), cultural gender (interests, clothing, behaviour, personality traits)⁷³. It is one of the main approaches encountered in contemporary sexologist, medical and psychological literature, so-called essentialist approach. It assumes gender binary (woman vs. man) and cohesion of all dimensions of sex (woman body = woman identity = feminine appearance, behaviour, traits = sex registered at birth “woman”), perceived as a “natural” and “obvious” gender expression⁷⁴. This approach is characteristic for biological and medical sciences. In the society and (Western) medicine, persons not fitting into this assumption are given a label of abnormality, deviation from norm, disorder, or “abomination”.

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71 This assumption is grounded in the Polish legal system so strongly that the only possibility of changing sex registered at birth is a procedure consisting in suing one's parents for wrong identification of sex at birth. State as of June 2013.

72 Difference from cisnormative assumption, e.g. that biological sex reflects the gender identity of a given person.

73 Lev (2004). Transgender emergence: Therapeutic guidelines for working with gendervariant people and their families.; Bojarska, Katarzyna, Dułak, Katarzyna (2012). Specjaliści zawodów pomocowych wobec ludzkiej różnorodności płciowej [Assistance Profession Specialists Towards Human Gender Diversity], in: Kłonkowska, Anna (ed.) Transpłciowość – Androgynia. Studia o przekraczaniu płci [Transgender – Androgyny. Studies on Transgression of Gender], Gdańsk: Wydawnictwo Uniwersytetu Gdańskiego.

74 Ibidem.

Another approach, social constructionism, undermines the traditional way of thinking about sex and sexuality. This approach takes the achievements of social sciences into consideration – socio-cultural, historical, biographical, and psychological factors that influence shaping and expression of gender identity, as well as roles fulfilled in the society. The way of social construction of sex and sexuality is a subject of interest of the queer theory⁷⁵.

Such approaches result in specific consequences and ways of interpreting reality. According to the essentialist approach, gender expressions and/or identities are divided into “proper” and “improper”, “better” and “worse”, “healthy” and “pathological” etc. Social

constructivism, refraining from evaluative judgements, at most perceives “more” and “less widespread” gender expressions⁷⁶.

Also, each approach sets a different perspective on the role of physicians and psychologists in the system of assistance provided to transgender persons – the essentialist approach places strong emphasis on proper diagnosis (pathologization) that will allow to „cure”, while social constructivism approach, dominating in the current, global specialist literature, separates itself from pathologization and focuses on the affirmative approach which acknowledges feelings and identity of transgender persons, reinforcing the right of self-determination. One element of such approach may be discovering of cultural gender entanglement, and of the oppressive social system.

In order to facilitate understanding of the subject matter, basic definitions connected with sex shall be provided:

Biological sex refers to corporeality. It is a set of diverse physical/anatomical traits which make people different. Biological sex is a multi-aspect, largely unknown phenomenon; however, what is currently known, denies the assumption that there are two kinds of human bodies – male and female. Persons whose sex undermines this assumption are medi-

75 Butler; Judith (1990). *Gender Trouble: Feminism and the Subversion of Identity*. London; Foucault, Michael (1978). *The History of Sexuality*. Mizielńska, Joanna (2007). *Płeć/ciało/seksualność* [Gender/body/sexuality], Kraków.

76 Bojarska, Katarzyna, Dułak, Katarzyna (2012). *Specjaliści zawodów pomocowych wobec ludzkiej różnorodności płciowej* [Assistance Profession Specialists Towards Human Gender Diversity], in: Kłonkowska, Anna (ed.) *Transpłciowość – Androgynia. Studia o przekraczaniu płci* [Transgender – Androgyny. Studies on Transgression of Gender], Gdańsk, pp. 32-57.

cally referred to as **intersexual persons** (there is no coherence between different dimensions of biological sex).

Intersexuality denotes a state when one person has such physical traits (genetic, biological, anatomical, or physiological), that do not allow identifying their biological sex as unambiguously male or female. Sometimes, intersexuality is visible at birth (the new-born's genitals are neither unambiguously female nor male), and sometimes during adolescence, e.g. persons recognized as girls and having female external genital organs in whom, during adolescence, secondary male sexual traits start to appear – testes descend (appear), voice changes etc.⁷⁷. In Western medicine, these persons are said to have a 5-ARD deficiency. In 1974, a village in Dominican Republic where “girls become boys” has been described. In this village, 5-ARD has been observed in 1 out of 90 men (46XY). They are called guevedoces, an abbreviation of colloquial “huevo a las doce”, i.e. “balls at twelve”⁷⁸. In such situations “normalizing” operations are sometimes conducted; they are aimed at making genitals more similar to standard ones in order for them to be more unambiguous and compliant with expectations about the appearance of such organs⁷⁹. Such “normalization” of reality to social assumptions is heavily criticized by the affected persons and organizations acting for intersexual persons. These organizations call for depathologization of intersexuality and refraining from medical interventions, decision about which should be left to the affected person⁸⁰.

Cultural sex/ Gender – is different from biological sex. Gender is a way of understanding, perceiving, and attributing certain traits and behaviours to woman and man by the society and culture⁸¹. These traits

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77 Zucker, Kenneth J. (1999). *Intersexuality and gender identity differentiation*, Review of Sex Research, 10, pp. 1-69.

78 Imperato-McGinley, Guerrero, Gautier, Peterson (1974). Steroid 5alpha-reductase deficiency in man: an inherited form of male pseudohermaphroditism.

79 Dreger, Alice (1998). „*Ambiguous sex*” or *ambivalent medicine*? *Ethical issues in the treatment of intersexuality*, The Hastings Center Report, 28(3), s. 24-35; Zucker, Kenneth J. (1999). *Intersexuality and gender identity differentiation*, „Annual Review of Sex Research”, 10, pp. 1-69.

80 Dreger, Alice (1998). „*Ambiguous sex*” or *ambivalent medicine*? *Ethical issues in the treatment of intersexuality*, The Hastings Center Report, 28(3), pp. 24-35; Dreger, Alice (2012). *Shifting the Paradigm of Intersex Treatment*, Intersex Society of North America. Downloaded from <http://www.isna.org/compare>, 31.12.2012.

81 *Gender – kulturowa tożsamość płci. Podręcznik dla trenerów*. [Gender – Cultural Identity of Sex. Trainer Handbook] (2005). Warsaw: Amnesty International, p. 21.

are acquired during socialization, e.g. “men do not cry” is a cultural expectation towards men reinforced during socialization (e.g. when a boy cries because someone hurt him, he is told “not to blubber”). Additionally, pop culture strengthens the images of a “tough guy”, e.g. Rambo, Superman etc.⁸²). Gender includes expectations established by the society and culture in which it functions; therefore, its contents will be different, depending on both culture which creates it, and on the moment in history. Therefore, expectations towards women shall be different for a female Muslim in Western culture (e.g. in Canada), and yet different in Iran where cultural and historical context is different. In the majority of cultures, gender includes two options corresponding to dichotomic division of sex into female and male. Sex corresponds to gender, that is cultural patterns of traits, behaviours, and roles ascribed to woman and man. In the case of persons biologically recognized as women, the society requires, or considers desirable, certain traits (gentleness, sensitivity, care about beauty etc.); in the case of men, the set of desired and reinforced traits is different (strength, decisiveness, interest in football or vehicles, provision of financial stability etc.).

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However, such division is neither the only one nor universal. There are cultures in which more gender categories have been noticed or established to choose from, such as, apart from woman and man, kathoey in Thailand and hijra in India. Just like femininity and masculinity, the mentioned categories of further genders each have full sets of expectations about specified traits, behaviours and fulfilled roles⁸³. For example, hijra perform sacred rites during marriages and after the birth of a child.

According to cultural assumption, gender is connected with sex, i.e. persons with biological traits recognized as masculine have male gender (traits, behaviours, interests), and persons with biological traits recognized as feminine have female gender. Although sex may be coherent with gender (feminine woman, masculine man), most often people have a mix of traits ascribed to different genders (some traits culturally deemed feminine, and some traits culturally deemed masculine).

82 More in: Katz, Jackson (2006). *The Macho Paradox*, Naperville; see also the textbook and attached film: Earp, Jeremy, Katz, Jackson (1999). *Tough Guise. Violence, Media & the Crisis in Masculinity*.

83 See Kenneth, J. (1999). *Intersexuality and gender identity differentiation*, „Review of Sex Research”, 10, pp. 1-69.

Gender identity – another aspect of gender that may be defined as internal, subjective sense of one’s own gender; how a person describes themselves, how they sense, name, or do not name themselves. Identity may be either compatible or incompatible with social expectations which equate specified biological traits of a given person with identity ascribed to them. For example, a biologically female person identifying as male is not compatible with social expectations. Persons breaking from social expectations regarding coherence of different dimensions of sex are called transgender.

Transgender includes all named and unnamed identities in which there is no socially expected compatibility between sex and its ascribed biological sex registered at birth, gender identity or gender role fulfilled in the society, gender. Transgender is an umbrella term, including the whole human gender variety incompatible with cultural assumptions about gender. The drawing presents examples of identities breaking cultural assumptions about sex. The opposite of transgender is cisgender.

Transsexuality is a medical category (narrower than transgender) established in order to name the feeling of divergence between physical

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sex and felt gender (gender identity). Such divergence is often connected with deep emotional discomfort. A given person may seek for a possibility to change sex registered at birth, and to undergo surgeries and/or hormonal therapy aimed at adjusting the legal status and/or appearance of one's body to their gender identity. Sex reassignment surgeries (SRS) are aimed at adjusting appearance of the body to gender identity (felt gender). What is changed is not sex, but the body. Gender identity is something different than body itself.

Cisgender is a category introduced by persons acting for transgender persons in order to name a compatibility between possessed sex, felt gender (gender identity), gender, and other dimensions of sex. Such compatibility is evaluated as „normal” in the culture that assumes dichotomy and internal coherence of all dimensions of sex.

Cisnormativity is a culturally dominating presumption about gender binary and cohesion of all these dimensions, i.e. that people come in two versions: woman (default female sex – female gender identity – female gender – ...), or man (default male sex – male gender identity etc.).

Polish language does not facilitate the critical analysis of gender entanglement. In Polish, there is one word to denote sex, encompassing sex, gender, sex registered at birth, gender identity, and other elements of which we are more or less conscious.

Diversity, also sexual one, is a fundamental feature of life, from the most primitive biological organisms, to the most complex social systems⁸⁴. Despite that, two standards for human sex are assumed – woman or man. Vast amount of researches on gender in the fields of sexology, anthropology, psychology, and sociology, as well as personal experiences from working with transgender persons, indicate that the cultural assumption

84 Compare with Rubin, Gayle (1994), *Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality*, in: Ablove, H., Barale, M.A., Halperin, D. M. *The Lesbian and Gay Studies Reader*. New York: Routledge.

about gender binary is artificial and incompatible with reality⁸⁵. In a way, every person breaking cultural assumptions about sex is transgender. With their behaviour, body, fulfilled roles, or internally sensed identity, a large number of people deny cultural assumptions about sex. Socio-cultural image of sex (woman vs. man) is simplified – it does not perceive the whole actually appearing sexual complexity and diversity. There is an infinite number of the most diverse expressions and combinations of gender in its different dimensions (sex – gender identity – gender role – legal sex – ... etc.) and every persons may feel their sex in a singular, unique way, and may decide to express their feelings, and how they want to be named, what roles they want to fulfil.

A question should be asked – how lack of knowledge and awareness of social assumptions about binary, consistency and coherence of various dimensions of sex may affect the work of therapists with transgender persons?

An effect of cultural cisnormativity (an assumption about binary and coherence of various dimensions of gender) may be an automatic assumption that:

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- A person coming to us is either a woman or man (assumption about gender binary).
- Appearance (gender, i.e. traits stereotypically recognized as feminine or masculine, e.g. jewellery, dress; and sex – visible physical traits, anatomically recognized as feminine or masculine) indicates gender identity of a given person.

85 See Blumenfeld, W.J. (1992). Squeezed into gender envelopes. in: Homophobia: How we all pay the price. ed. Blumenfeld, Boston: Beacon Press; Bieńkowska-Ptasznik, Małgorzata, Kochanowski, Jacek (eds.) (2008). Teatr płci. Eseje z socjologii gender [Gender Theatre. Essays on Gender Sociology], Łódź: Bojarska, Katarzyna, Dułak, Katarzyna (2012). Specjaliści zawodów pomocowych wobec ludzkiej różnorodności płciowej [Assistance Profession Specialists Towards Human Gender Diversity], in: Anna Kłonkowska (ed.), Transpłciowość – Androgynia. Studia o przekraczaniu płci [Transgender – Androgyny. Studies on Transgression of Gender], Gdańsk; Dreger, Alice (1998). "Ambiguous sex" or ambivalent medicine? Ethical issues in the treatment of intersexuality, *The Hastings Center Report*, 28(3), pp. 24-35; Dreger, Alice Shifting the Paradigm of Intersex Treatment, *Intersex Society of North America*. Downloaded from <http://www.isna.org/compare> on 31.12.2012; Factor, Rhonda J., Rothblum, Esther (2008). Exploring gender identity and community among three groups of transgender individuals in the United States: MTFs, FTMs, and genderqueers. *Health Sociology Review*, 17(3), pp. 235-253; Zucker, Kenneth J. (1999). Intersexuality and gender identity differentiation, *Annual Review of Sex Research*, 10, pp. 1-69; Konarzewska, Marta, Pacewicz, Piotr (2010). Zakazane miłości. Seksualność i inne tabu [Forbidden Loves. Sexuality and Other Taboo], Warsaw.

Actually, a person “looking” (according to cultural patterns dictating what we call masculine, and what feminine) like a man may feel like a woman, part woman and part man, neither woman nor man, etc. The amount of possibilities is endless. A decision on revealing one’s transgender status is often connected with high stress and fear of being not understood or being rejected. Transgender persons themselves may feel lost and not understand their feelings (e.g. it can be seen in the client’s statement: “I don’t feel like a woman, but also not like a man... I don’t even know if I’m a human”⁸⁶). It should be remembered that all persons living in a given culture are subject to similar socialization – they learn what sex is and how many types of it there are. Over time, it turns out that learned patterns do not reflect authentic feelings of transgender persons towards their own sex, and a conflict between what I know and what I feel arises. It may lead to undermining one’s feelings and attempting to “convert” to the “proper”, desired and valued way in a given society, e.g. a person born in a biologically female body and feeling like a man may deny these feelings and try to play the role of a woman as faithfully as possible, despite the feeling of inconsistency and suffering it evokes. Another way may be undermining of “what I know” about sex and its coherence, and an attempt to find, or construct, an alternative identity. One of elements of competent, respect-based professional practice is acknowledgement of identity of the person asking for assistance. The easiest way is to avoid cisnormative assumptions about sex and checking how does the person refer to themselves (by introducing) and what is their preferred way of referring to them – this question may be asked directly at the beginning of therapeutic cooperation, or whenever it is necessary (e.g. “I need to establish how are we going to call each other.”).

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The analysis of gender binary constitutes one of the factors necessary for competent work with transgender persons. As a result of unawareness of cultural context influencing our thinking about sex, when working with transgender persons we may underestimate feelings of our clients, transgender persons who are not gendered in a traditional way. It is an extremely important area which should be subject to careful reflection of specialists who want to work with transgender persons

86 An example from the author’s own professional practice.

in a competent way. Therapists should be able to rework their approach to issues connected with traditional perception of both sex and gender, so that they do not to reproduce the oppressive social system in which transgender or sexual unambiguity are given a label of aberration, deviation, or something abnormal, therefore intensifying the suffering of persons asking for assistance.

RECOMMENDATIONS FOR INSTITUTIONS AND INDIVIDUALS PROVIDING PSYCHOLOGICAL SUPPORT TO LGBTQ PERSONS

It is no measure of health to be well adjusted to a profoundly sick society.

JIDDU KRISHNAMURTI

In the first chapter we have presented the specificity of LGBTQ person's situation. Due to socio-cultural context, stereotypes and prejudices, LGBTQ persons experience various forms of violence, from symbolic to hate crimes, in a greater degree than heterosexual and cisgender persons. The only possibility to change the worse situation of LGBTQ persons in the society is to change the social system which is oppressive both to non-heterosexual, and to transgender persons. The first and basic task for people and institutions working in the area of broadly understood social and psychological aid is to become aware of mechanisms contributing to such situation, and their effects on health and life of LGBTQ persons, as well as to express clear opposition towards discriminating practices. A number of non-governmental organisations acting for human rights⁸⁷, as well as scientific and assistance institutions (these mentioned in this publication, among others), is actively working for changing harmful prejudices. It may assume highly diverse forms, from affirmative approach to LGBTQ persons, through active opposition to discriminating practices in the workplace or private life, up to activism and involvement in antidiscrimination actions aimed at changing the harmful social system. It is not an easy task, for heterosexism and homophobia widespread in the society may result in negative attitude of institutions towards this subject. Persons running an individual assistance practice

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87 AKCEPTACJA Association for Parents and Friends of Homosexual, Bisexual and Transgender Persons, Lambda, Campaign Against Homophobia, and Trans-Fuzja, among others.

are in much easier situation; however, such aid is most often payable and not available to everyone. Therefore, persons working in public centres and clinics, especially these providing crisis interventions, are greatly needed. Ultimately, every person decides for themselves whether to react and try to change this system, or to refrain from reaction. However, it should be remembered that lack of reaction is a reaction as well. Reaction which gives consent to the encountered situation.

This part of the publication provides persons giving psychological support with guidelines about directions of self-development and acquisition of knowledge, experiences and skills essential in order to competently work with LGBTQ persons. Every person concerned with therapy or psychological counselling has their own set of competences and skills which may be used in this work, and which provide them with insight into what is important and how to develop in this field.

AFFIRMATIVE APPROACH AND EMANCIPATION

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Affirmative therapies are based on complete acceptance and respect for sexual and gender identity of a person asking for psychological aid, whether their identity belongs to the majority (heterosexual), or minority⁸⁸. It consists in providing support, among others by acknowledgement of client's sexual and/or gender identity without undermining ("You don't look like..."), questioning ("Are you sure about that?"), or attempting to change it ("We'll try to cure you"). Respectful acknowledgement of this identity in itself is the first step allowing breaking the harmful scheme of automatic reactions of the environment and rejection, which may be experienced by

88 The term "majority-minority" does not refer to size of groups or their proportions in the society, but to their social position, amount of rights and privileges (heterosexuality and sexual normativity are privileged). Therefore, in social sciences, women are described as a minority group – despite greater numbers, they are in less privileged position in patriarchal societies (e.g. analyses of economic situation revealed a number of mechanisms discriminating women on the labour market, resulting in women earning less than men on the same posts), have lesser share of powers (cf. distribution of sexes in management positions, or in politics). Non-heterosexual and transgender persons are deprived of a number of privileges and rights possessed by heterosexual persons (e.g. being able to freely and comfortably hold partner's hands in a public space, without being afraid of negative reactions of the environment).

LGBTQ persons when revealing their non-normative identity⁸⁹. Interestingly, such an affirmative approach is something completely obvious in the approach towards heterosexual persons, where the therapist displays upfront support, acceptance of reality and feelings, and acknowledgement of the client's identity; however, when a LGBTQ person appears in the office, cultural assumptions about gender (binary, coherence of different dimensions) and sexuality (heteronormativity, heterosexism, homophobia) are automatically activated, introducing ambiguity about proper proceeding. Because of that, the analysis of one's own knowledge and beliefs (stereotypes and prejudices) about gender and sexuality is so important, for it allows verifying common and scientific, yet no longer valid, knowledge and prejudices.

The affirmative approach is not a separate school or therapeutic trend; it does not propose specialist tools and techniques. It is an approach that takes the achievements of social sciences into consideration, noting the role of social context in life and situation of LGBTQ persons. It employs positive attitude towards the identity and relations of LGBTQ persons, and discusses issues of homophobia, transphobia and heterosexism influence on situation and life of LGBTQ clients⁹⁰. This approach considers the role of mechanisms contributing to the situation and feelings of the person. It is about noticing the influence of heteronormativity, heterosexism, homophobia, widespread assumptions about binary and coherence of genders, transphobia, with particular consideration of internalised oppression – homophobia or transphobia which may result in assumption of role of a victim, compliance with experienced violence, or self-hatred, leading to worsening of mental condition. This approach is consistent with current guidelines of world psychological, psychiatric, and sexological organizations. Working with a LGBTQ person who

⁸⁹ Affirmative psychotherapy and counselling for lesbians and gay men. Chernin & Johnson 2002, Does affirmative training matter? Assessing CFT student's beliefs about sexual orientation and their level of affirmative training. Journal of Marital and Family Therapy. Rock & Carlson & McGeorge 2010.

⁹⁰ Handbook of Counseling and Psychotherapy with Lesbian, Gay, and Bisexual Clients. Perex, DeBord, Kurt, Bieschke (1999). Does affirmative training matter? Assessing CFT student's beliefs about sexual orientation and their level of affirmative training. Journal of Marital and Family Therapy. Rock & Carlson & McGeorge (2010)., Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients (2010). Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients (2010).

reports with an issue regarding violence, either experienced or feared, one should be aware that the problem or its symptoms are closely linked to the broader social context which most often creates these difficulties.

90 The affirmative approach may draw from the liberation psychology and the concept of emancipation. These ideas propose moving away from work focused on suffering (effects of homophobia), psychopathological and intrapsychic influences, and turning towards a broader perspective which considers social, political, economic, historical and cultural contexts. Interpretation of behaviours of persons experiencing social oppression through their intrapsychic process, instead of life in adverse, stigmatizing environment, creates a threat of reinforcing the message that the issue lies in the person, and not in the circumstances they happen to live in. The perspective of emancipation is aimed at reinforcement, or empowerment of a person by paying attention to harming social context and recognizing that reactions experienced as a result of violence are natural reactions to abnormal social situation. It allows freeing oneself of guilt and shame which accompany an internalised oppression (homophobia, transphobia, etc.). As a result, it leads to becoming aware that social injustice stigmatizing selected persons, who break from expectations about gender or sexuality, deprives of personal freedom and strips away the feeling of power and self-determination, possibly contributing to worse condition of LGBTQ person's mental health. Understanding of mechanisms contributing to social inequality may facilitate emancipation understood as conscious and responsible liberation of the subject from felt limitations. Emancipation is a process of conscious rejection of stereotypes and myths, overcoming difficulties, and "conscious and lasting over time recognition of one's limitations and sources of oppression, undertaking actions aimed at rejecting them, achieving new areas of freedom and new rights, as well as responsible and consistent using them."⁹¹ In order to reject myths and stereotypes, they must be identified, possibly in company of a conscious and affirmative supporting person (e.g. a therapist). Correct recognition of sources of oppression is essential to undertake proper actions aimed at changing

91 Czerepaniak-Walczak, Maria (2006). *Pedagogika emancypacyjna [Pedagogy of Emancipation]*, Gdańsk, pp. 32-33.

the oppressive social system. It contributes to regaining sense of control, authorship and influence, which are crucial for regaining the sense of pride and empowerment. It is a way allowing for improvement of mental condition of socially disfavoured persons.

The affirmative approach focuses on positive formation of one's identity. An indispensable element of work with LGBTQ persons is knowledge not only about social situation of their community, but also about culture (see queer culture) and possible support systems, such as self-help groups and non-governmental organizations acting for LGBTQ persons.

GUIDELINES FOR AFFIRMATIVE THERAPISTS⁹²:

1/ Speak openly about your affirmative approach towards LGBTQ persons in the professional community, among potential clients, and also in private life (to family and friends, acquaintances).

2/ Be aware of your own heteronormativity and assumptions about gender. Undermine oppressive standards.

3/ Become acquainted with the LGBTQ community and resources already existing in the local community (organizations, meeting places, Web portals, support groups, establishments friendly to LGBTQ persons).

4/ Be aware that every persons has their own, unique history related to discovering/constructing of their sexual or gender identity, do not presume any schemes (e.g. that coming out in the family was painful and connected with rejection by the loved ones).

5/ Know the difference between sexual orientation and gender identity.

6/ When you address someone, make sure to use proper vocabulary and grammatical gender. If in doubt – ask!

7/ Take care about constant education, update your knowledge, and practice according to the latest scientific achievements. Participate in workshops, trainings, antidiscrimination trainings, also in these concerning the affirmative therapy.

92 Rock, M. Carlson, T. S. McGeorge, C.R. (2010). Does affirmative training matter? Assessing CFT student's beliefs about sexual orientation and their level of affirmative training. „Journal of Marital and Family Therapy“, 36 (2), pp. 171-184. https://education.uoregon.edu/sites/default/files/affirmative_therapy_handout.pdf.

8/ Assume responsibility for your own self-education – use library resources or web pages.

9/ Get involved in events and activities directed at the LGBTQ community.

ANTIDISCRIMINATION TRAINING AND ITS SIGNIFICANCE IN THERAPEUTIC DEVELOPMENT

One of the key elements of a diligent preparation to work with LGBTQ persons is participation in an antidiscrimination workshop, or training, allowing for verification of one's knowledge and attitude which are of enormous significance in therapeutic relation, as well as increase of awareness of stereotyping and discrimination mechanisms. According to the definition of the Anti-discrimination Education Association⁹³, antidiscrimination education is a "conscious activity raising knowledge and skills, and influencing attitudes, aimed at working against discrimination and violence motivated by prejudices, as well as supporting equality and diversity."

Accurate antidiscrimination education:

- develops knowledge about mechanisms of discrimination, exclusion, and consequences of discrimination (social exclusion, stigmatization, isolation, marginalization, among others);
- shows how stereotypes, prejudices, and unequal treatment may lead to violence, including hate speech and hate crime;
- develops the awareness of one's stereotypes and prejudices, and teaches how to counter them;
- constructs competences of working against discrimination by, among others, increasing knowledge about instruments for countering discrimination, developing skills for countering, and reacting to expressions of discrimination;
- develops knowledge about discriminated groups and emancipation movements;
- strengthens groups and discriminated persons on principles of inclusion and empowerment;

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93 Edukacja antydyskryminacyjna i jej standardy jakościowe [Antidiscrimination Education and Its Quality Standards] (2011). Anti-discrimination Education Association, Warsaw.

- develops an equality attitude, based on recognition of dignity, freedom and equality of all persons, as well as respect to diversity of persons and social groups⁹⁴.

Antidiscrimination education is a response, or reaction, to actual social inequality. This education is based on assumption that discrimination and violence are issues of the whole society, regardless whether these phenomena are our personal experience, or not. Moreover, it is assumed that diversity of persons on the basis of various traits is a fact and, what is more, it should be respected and appreciated. Other important assumption is a belief that a person growing in a society full of stereotypes and prejudices cannot be free of them, but only, at best, can become aware of and “unlearn” them through verification and change of behaviour resulting from them.

Antidiscrimination education can assume various forms; an example of division is provided below⁹⁵:

Course – a form of education based mainly on transferring knowledge using various methods, also active ones. Working on attitudes or developing skills (e.g. recognizing heteronormativity, working against discrimination) is not the main objective of a course, although it may become its effect.

Workshop – the main objective of a workshop is a reflection and change in the area of awareness and knowledge, identification of stereotypes and prejudices, and formation of skills and social competences related to reacting to discrimination. This form of education employs mainly active methods. „Workshop should be clearly structured and consist of specific experiences (exercises).” During a workshop, the instructor may take group processes and phenomena into account, but he or she does not base on them.

Training – similarly to a workshop – is realized by active methods and has awareness-skills objectives; however, contrary to workshop, it focuses more on “psychological and individual insight, life experience

94 Edukacja antydyskryminacyjna i jej standardy jakościowe [Antidiscrimination Education and Its Quality Standards] (2011); Teutsch, Grzymała-Moszczyńska (2012). Trening antydyskryminacyjny jako narzędzie przeciwdziałania homofobii [Antidiscrimination Training as a Tool Against Homophobia].

95 Branka, Cieslikowska (2010). Edukacja antydyskryminacyjna. Podręcznik trenerski [Antidiscrimination Education. Trainer Handbook].

and personal feelings, as well as deepened reflection” regarding one’s social identity. Structure of training should be clearly planned but also adjusted to group phenomena and current needs of the participants. Training is based on a group process and depends mainly on it.

According to definitions above, workshops and trainings which allow reworking one’s attitude and its significance in therapeutic contact are particularly recommended. Antidiscrimination education covers a broad range of topics and various premises, e.g. sex, ethnic origin, skin colour, sexual identity, gender identity, socio-economic status, religion, lack of religious beliefs, age, etc. In particular, gender and antidiscrimination trainings as well as workshops touching upon the issue of sex, including transgender⁹⁶ and sexuality, are recommended. Training or workshop allows for verification of one’s beliefs and acquisition of knowledge about mechanisms of stereotyping and discrimination which play a major role in the reality of LGBTQ persons. When deciding to participate in such workshop or training, it is important to verify the competences of the person proposing such form of education. Not all persons who have finished a trainer school are competent to hold this type of workshops! Training skills do not guarantee antidiscrimination awareness and sensitivity. In addition to trainer preparation and experience, one should pay particular attention to trainer’s professional experience in antidiscrimination subjects. Preferably, the person holding such classes should complete a minimum 16-hour antidiscrimination workshop or training, and minimum 16-hour gender training (concerning tackling discrimination on the grounds of sex) themselves. In addition, one should consider scientific or social activities (e.g. in non-governmental organizations) related to this issue, as well as all out-of-work activities or interests lending credibility to competences and equality attitude of the trainer⁹⁷. Due to the specificity of education, it is essential for the

96 The issue of transgender does not always appear during antidiscrimination or gender workshops. One should learn the workshop or training objectives and programme to verify its contents.

97 See also guidelines of the Anti-discrimination Education Association “Rekomendowane kompetencje trenera/trenerki prowadzących zajęcia z zakresu edukacji antydyskryminacyjnej dla organizacji pozarządowych i instytucji publicznych” [Recommended Competences of a Trainer Holding a Course on Antidiscrimination Education for Non-governmental Organizations and Public Institutions], in: Edukacja antydyskryminacyjna i jej standardy jakościowe [Antidiscrimination Education and Its Quality Standards] (2011), pp. 20-22. Available at www.tea.org.pl/publikacje.

person undertaking this task to possess not only necessary knowledge, but also to become aware of their own stereotypes and prejudices, and to acknowledge values related to equality and fighting against discrimination: inherent dignity, freedom and equality, as well as respect for diversity.

Antidiscrimination education not only facilitates ethical and competent work of therapists in the office, but also answers the question how to contribute to change of harming practices in one's own workplace or private life. For example, how to react when we hear a homophobic joke in the workplace. During trainings and workshops one can learn how to react to discrimination in the workplace, and how to reinforce equality behaviours, both in professional and in private life.

SUPERVISION AND ITS SIGNIFICANCE IN DEVELOPMENT

Another element allowing for ethical professional practice of persons working with LGBTQ persons in the field of psychological support is supervision, that is meeting of the therapist with another specialist or a group of persons (group supervision) in order to consult work and other issues connected with performing of professional obligations (e.g. verification whether one's knowledge is up to date and accurate, in compliance with professional obligation to update one's practice according to the latest worldwide achievements⁹⁸). Supervision aims at assistance to take a look at one's own experiences in therapeutic work, and at possible obstacles in this contact attributable both to the person providing psychological support, and to the client. An essential objective of the supervision is to ensure high quality of provided therapeutic services. Art. 28 of the Polish Psychological Association's Code of Professional Ethics for the Psychologist states that: „As a psychotherapist, a psychologist is aware of dangers resulting from his ability to influence others persons; therefore, he subjects himself to supervision or consultation.”

When working with LGBTQ persons, it is extremely important to consult one's work with persons who possess knowledge and awareness of the issue of stereotyping and discrimination mechanisms that condition the society's attitude towards LGBTQ persons. In work with clients, lack

98 Art. 15 of the Polish Psychological Association's Code of Professional Ethics for the Psychologist.

of such knowledge may result in failure to notice the heteronormativity, heterosexism or simplified assumptions about sex. When working with a transgender person, e.g. one who does not identify themselves with any gender, we may persistently follow an assumption that the person has to choose once and for all whether they want to be a woman or a man. In this way, we deprive a person of a possibility to independently construct their identity outside of cultural standards assuming gender binary. Thereby, we reproduce an oppressive social system which orders to adjust to either one or the other category. In order to perceive such dependencies, it is essential to possess knowledge about social situation of LGBTQ persons, and of cultural determinants of genders and sexualities.

When choosing a supervisor, one should consider his or her competences consisting of: knowledge, antidiscrimination awareness, experience and specialisations, as well as therapeutic approach which may be more or less favourable towards non-normative persons. Should one be supervised by a person who does not update their knowledge or display homophobia or heteronormativity in their statements or behaviours, there is a great risk of overlooking factors vital for competent and ethical work.

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Peer supervision should be mentioned as well – often, it can be organised without incurring financial costs, therefore it is more available to persons involved in providing advice or therapy. This form allows one to establish interdisciplinary teams on their own, inviting variously educated and experienced persons, resulting in increased number of perspectives so valuable for supervision.

Sometimes, supervision is recommended as a countermeasure of so-called “professional burnout”, described in literature as a result of stress and overwork, especially in professions requiring intense contact with people. Working with members of disfavoured groups may seem particularly challenging. In a test verifying the attitude to work with LGB persons⁹⁹, one of concerns declared by psychotherapists has been the feeling of powerlessness towards social situation of gays, lesbians, and bisexual persons. Indeed, such perception may give rise to concerns or reluctance to work with non-heteronormative persons. One of the ways of coping

99 Authors of the test: Grzegorz Iniewicz and Bartosz Grabski, 2012.

with this discomfort is recognising one's role in the social system and undertaking actions aimed at countering the unjust social situation. It may consist in various levels of social or human rights activism: from openly declaring one's equality views, e.g. at the workplace, through participation in cultural, educational, antidiscrimination events for the LGBTQ society, up to active initiation of actions aimed at changing the oppressive social system (e.g. introduction of changes at the workplace, at one's institution, organisation of educational events etc.).

SENSITIVE LANGUAGE AS A WORKING TOOL

The language we use provides framework for interpretation of reality; therefore, one should carefully use the language employed at work with LGBTQ persons who ask us for assistance. Below, I present several options for consideration:

- In contact with persons asking us for help, we should avoid phrases which may elicit wrong associations of sexual or gender identity with a disease. Popular usage of a term "patient" for a person using psychotherapeutic assistance predefines the developed relation – a patient and a person who will cure them. This term may imply disease or a psychopathology.
- In different languages that are various, although often overlapping, terms used to name elements of reality. In English, when talking about sex, people employ two words – sex, denoting biological sex, and gender, referring to cultural sex. In Polish there is one word for sex, what may suggest that biological sex and cultural sex is one and the same. Using language, they should be distinguished to show that they are not the same.
- Another aspect connected with language in the context of transgender persons – one should not assume that if a person comes to us and externally appears in a way culturally called masculine or feminine, then it is coherent with who they feel like, how they define themselves, and how do they want to be addressed. When a person with bodily features indicating male sex and wearing a suit and a tie enters the office, then we may automatically start to refer to that person as if they were male

(e.g. “What brings you here, Mr ...”), while they may be a transgender person struggling with their female sexual identity. Such question may automatically reduce the sense of safety and make coming out more difficult. One should check, by asking directly at the beginning or, if any doubt arises, even further on during the therapy or consultation – how does a given person want to be referred to.

- In order to facilitate contact with a LGBTQ person, as well as potential coming out in the office, one should ensure that employed language is not heteronormative, e.g. avoid presumptions about the partner’s gender, as in the following example: “You said that you are in a relationship, please say something more about your partner.” It can be easily replaced with a proposal to tell about the person with whom a given person is in a relationship.
- In order to establish a comfortable space for persons who do not specify their gender in a traditional way, one should avoid introducing a binary gender system in favour of acceptance of a given person’s concept about gender, e.g. if somebody does not feel that they are woman or man and specifies their gender differently – they have a right to do so. Questions suggesting a necessity to choose woman, man or transgender identity should be avoided if a given person thinks of themselves otherwise.
- When speaking about LGBTQ persons, one should emphasize their “personhood”, e.g. instead of homosexual, say gay/lesbian, instead of transsexual – transsexual person. A word homosexual or transsexual may suggest that sexuality or gender is the only or main trait defining a given person. In the case of gays/lesbians, when referring to their sexuality, it is best to use words which use they describe themselves. Moreover, homosexual is a term used in the past and it has negative and medical connotations. It should be remembered that many members of the LGBTQ community do not use this term to refer to themselves due to pejorative historical connotations related to it (e.g. usage of the term homosexuality in DSM and other clinical researches which classified it as a mental disorder). Therefore, we do not use that term in this publication. Some homosexual persons accept or like terms gay and lesbian (adapted from English into Polish as “gej” and “lesbijka”),

as well as bisexual person. Another, broader phrase, is non-heterosexual person which encompasses all LGBTQ persons. Instead of „homosexuality” (ending “-ism” may be wrongly associated with medicine), term “homosexuality” should be used.

- Sexual, psychosexual or affectional orientation? In some texts¹⁰⁰, authors employ the term affectional orientation instead of sexual or psychosexual orientation. Affectional orientation is a synonym of these terms. Using the term affectional orientation instead of sexual orientation is aimed at emphasis of multiple relationships layers (emotional, sexual, spiritual, and psychical) as well as reduction of emphasis placed on “sexual” behaviours as the only way of understanding one’s identity. Due to the fact that identity of many persons is not exactly coherent with their sexual behaviours and desires (as exemplified in Kinsey’s famous research), using the term affectional orientation better reflects the multi-layered nature of identity. In this publication we employ the phrase sexual orientation as a synonym for affectional orientation.
- Gender identity refers to the internal sense of being a man, a woman, both man and woman at the same time, or none of the above (describing one’s gender outside of the binary gender system). Gender identity usually complies with biological sex (registered at birth) of a given person (cisgender persons), but it also happens otherwise (transgender persons). Gender identity of a person may be specified only by a given person and nobody else.

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In this publication, when talking about gender and sexuality, we also employ phrases sexual identity and gender identity. Identity refers to how a person describes and names (or does not name) their gender and/or sexuality. Presently, within the queer theory, the term sexual orientation is being replaced by sexual identity, aimed at emphasizing self-description and subjectivity in defining one’s sexuality. Similarly, gender

100 See ALGBTIC LGBQQIA Competencies Taskforce, Amney Harper, Pete Finnerty, Margarita Martinez, Amanda Brace, Hugh C. Crethar, Bob Loos, Brandon Harper, Stephanie Graham, Anneliese Singh, Michael Kocet, Linda Travis, Serena Lambert, Theodore Burnes, Lore M. Dickey & Tonya R. Hammer (2013): Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals, *Journal of LGBT Issues in Counseling*, 7:1, pp. 2-43; <http://dx.doi.org/10.1080/15538605.2013.755444>.

identity concerns the internal sense of gender. Gender identity of a person may be specified only by a given person and nobody else. Approaches in which the “specialist” tells a person what is their “real” gender should be avoided.

SELF-DEVELOPMENT

Currently, in the majority of Polish universities educating psychologists, and during therapeutic courses training in psychotherapy, the topics of gender and sexual non-normativity, as well as issues of socio-cultural factors influence on their formation and perception, are touched upon in a very limited extent. Therefore, there is an enormous need to undertake the effort of self-updating the knowledge about issues connected with LGBTQ society and culture, as well as with adequate actions at work with this group and possible support systems. Below, you will find examples of sources which may constitute a basis for further education. We encourage persons interested in further education to acquaint themselves with references listed in the bibliography, included in the last part of this chapter.

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WORTH WATCHING:

Aimée & Jaguar (1999), Germany, directed by Max Färberböck

But I’m a Cheerleader (1999), USA, directed by Jamie Babbit

If These Walls Could Talk 2 (2000), USA, directed by Anne Heche, Jane Anderson, Martha Coolidge

For 80 Days (2010), Spain, directed by Jon Garaño, José María Goenaga

Lost and Delirious (2001), Canada, directed by Lea Pool

Floating Skyscrapers (2013), Poland, directed by Tomasz Wasilewski

Beginners (2011), USA, directed by Mike Mills

Prayers for Bobby (2009), USA, directed by Russell Mulcahy

The Kids Are All Right (2009), USA, directed by Lisa Cholodenko
A Single Man (2009), USA, directed by Tom Ford
Milk (2008), USA, directed by Gus Van Sant
Sennosc (2008), Poland, directed by Magdalena Piekorz [no official English title, approx. meaning “Drowsiness”]
XXY (2007), Argentina, directed by Lucía Puenzo
The Bubble (2006), Israel, directed by Eytan Fox
Shortbus (2006), USA, directed by John Cameron Mitchell
Breakfast on Pluto (2005), USA, directed by Neil Jordan
C.R.A.Z.Y. (2005), Canada, directed by Jean-Marc Vallée
Transamerica (2005), USA, directed by Duncan Tucker
Brokeback Mountain (2005), USA, directed by Ang Lee
Angels in America (miniseries) (2003), USA, directed by Mike Nichols
The Hours (2002), USA, directed by Stephen Daldry
Venus boyz (documentary) (2002), Germany, Switzerland, USA, directed by Gabrielle Baur
All About My Mother (1999), Spain, directed by Pedro Almodóvar
Boys Don’t Cry (1999), USA, directed by Kimberly Peirce
Total Eclipse (1995), Belgium, France, Italy, England, directed by Agnieszka Holland
Wilde (1997), England, directed by Brian Gilbert
The Color Purple (1985), USA, directed by Steven Spielberg

WORTH VISITING

CAMPAIGN AGAINST HOMOPHOBIA – www.kph.org.pl

Website of the Poland-wide organization concerned with education, research, advocacy, as well as psychological and legal support for LGBTQ persons experiencing discrimination. On the www.kph.org.pl website you can find information about realized projects, publications to download, and details regarding providing psychological and legal assistance.

LAMBDA WARSAW – www.lambdawarszawa.org

Website of the oldest Polish assistance organisation for LGBT persons, conducting psychological consultations, running help groups and a helpline.

TRANS-FUZJA – www.transfuzja.org

Website of the largest, until recently the only one, organisation associating transgender persons. Currently, the Foundation works in four areas - advocacy, support, education, and culture.

REPLIKA-ONLINE.PL – Website of a socio-cultural bimonthly about LGBT.

QUEER.PL – The largest Polish community portal containing up-to-date information and articles related to LGBTQ.

HOMIKI.PL – Website containing information, articles and opinions regarding LGBTQ.

KOBIETY-KOBIETOM.COM – Community portal dedicated to non-heterosexual women.

TRANSOPTYMISTA.PL – Private webpage with interesting information and opinions regarding transgender topics.

WWW.TRANSSEKSUALIZM.PL – Webpage for transgender persons, contains information on sex reassignment surgery.

ROWNOSC.INFO – The online database of articles and books on diversity and working against discrimination.

BEZUPRZEDZEN.ORG – Web portal devoted to antidiscrimination education, contains material and information resources.

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¹⁰¹ All publications by Campaign Against Homophobia are available in electronic form on www.kph.org.pl. To order them in printed form, send a request at: info@kph.org.pl.

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CHAPTER III

THE PATIENT NEVER HAS SYMPTOMS – A CONVERSATION WITH DANIEL BĄK

Daniel Bąk – MD, PhD; psychotherapist, psychologist, and biologist. He has been aiding persons representing non-normative gender and sexual identities (LGBTQIA) for eight years – first as an educator in the area of sexual health, then as a psychologist and therapist (psychological consultations, as well as individual, group and couple therapy). Creator and manager of psychological aid and personal development programme for LGBTQIA persons. Collaborator with non-governmental institutions working for LGBTQIA persons. Author of scientific and popular science publications, conference reports, and trainings concerning psychotherapy for LGBTQIA persons. He has trained in the field of providing psychological assistance to LGBTQIA persons in Poland and Great Britain.

Jan Świerszcz: What do you do?

Daniel Bąk: I am a psychologist and psychotherapist. My activities include, among others, psychological assistance in form of individual, couple and group therapy. I also organize courses and workshops for therapists, pedagogues, social workers etc. in providing psychological aid to LGBTQIA persons. I also participate in conferences by holding workshops and lectures presenting the affirmative model of psychotherapy and psychological aid for LGBTQIA persons; here, “affirmative” means „based on respect and acceptance”. Additionally, I am the originator of peer supervision group for psychotherapists working with persons presenting various sexual and gender identities. The first edition of this group has already taken place. Education is a very important part of my activities; it is at least as important as that dozen or more hours a week which I work as a psychotherapist. I am also an author, writing texts about psychological assistance for LGBTQIA persons, both for scientific and popular science publications.

What does LGBTQIA stand for? Why so many letters?

I feel that, when using the LGBT abbreviation in conversation about homophobia, sexual orientation, and heteronormativity, we constantly omit persons representing some sexual and gender identities. If you do not add that QIA (*Queer/Questioning, Intersexual, Asexual*) to LGBT, then you do not consider persons who identify themselves as intersexual, that is those who, according to old, currently not recommended, nomenclature, were called hermaphrodites; it omits asexual persons as well. In literature, the LGBTQIA abbreviation sometimes “stretches” even further. Once, I have heard an anecdote that one day there will be not enough alphabet letters to denote the diversity characterising human sexuality and gender. I am using the LGBTQIA abbreviation because it is relatively broadly recognized. However, I think that there is an abbreviation which is an even better solution. I brought it from London, from Dominic Davies, at whom I have trained. Dominic proposes to use the GSD abbreviation, meaning *Gender & Sexual Diversities*. These three letters are very capacious, for they refer to existence of an infinite number of very different sexual and gender identities. In addition, the word diversities, sends various issues pathologizing sexuality and gender to discard pile. Besides: there is no danger of running out of letters.

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Does the GSD abbreviation also include heteronormative identities and heterosexual persons?

I would imagine so. I do not remember if I ever discussed it with Dominic Davies, but: diversity is diversity. Therefore, GSD would include heterosexuality together with other sexual identities. In turn, LGBTQIA is unique because it includes minority groups, unprivileged and more often subjected to social oppression. The choice of abbreviation to use in a given situation could depend on what we want to emphasize.

What constitutes the subject of psychotherapy of LGBTQIA persons?

The reason for further therapy may be, for example, difficulties related to some kind of oppression sustained by the LGBTQIA person due to their sexual orientation or gender, resulting in experiencing mental suffering and/or functioning disorders. From the assistance perspective, it is a clear situation: therapy is where the subject of treatment is.

Simultaneously, your question reminds me of the controversial issue of employing so-called conversion therapy (often called also reparative, reparation, reorientation) aimed at changing the sexual orientation of homo- and bisexual persons to heterosexual. The term “conversion therapy” is often encountered in literature. I think that applying the term “therapy” to attempts to convert homosexual orientation is unfounded; it has no substance for justification. The definition of therapy mentions healing, its curative nature. How can we speak of treatment if there is no object to be treated? In particular, one should consider the fact that persons involved in the so-called conversion therapy try to influence homo- and bisexuality themselves, recognizing them as mental disorders and their symptoms. It is inconsistent with current knowledge of human sexuality and incoherent with statements of such organisations as World Health Organization. Persons trying to convert sexual orientation often refer to diagnosis present in ICD-10: *egodystonic* (unwanted) sexual orientation, and deem the sexual orientation itself to be the source of such problems. In relation to this, they inform that precisely it is the orientation what should be changed. Nothing could be more wrong, there is nothing like that resulting from criteria of that diagnosis in the ICD-10! Difficulties reported by the homosexual client in this situation (I always speak of client and not patient, for I am a therapist working within the humanistic approach) are connected with his homosexuality; however, saying that homosexuality is the source of these difficulties – it is an abuse. One could as well look for sources of psychological difficulties of homo- and bisexual persons in the minority stress, something that a person trying conversion will rather not do. To sum up, in the light of current knowledge and according to the statements of the world’s scientific associations most important for psychiatry and psychotherapy, homo- and bisexual orientations do not constitute disorders or their symptoms. Therefore, it is clear that they cannot constitute a subject of treatment. As a result, there are no foundations to define these so-called conversion therapies as therapies. In connection with that, I never speak of conversion therapy. I use the term conversion influence, emphasizing their actual status in the background of psychological assistance of psychotherapy character. These are not only theoretical deliberations.

Language creates reality. Using the term “therapy” without substance justification may create wrong impression that homo- and bisexuality as such should be treated.

You point to various institutions and standards. Can a psychotherapist have their own world-view? Does he has to suspend his attitudes and cannot follow his own values?

Let us begin with that a psychologist or therapist also has some world-view. Therefore, I think that one should not ask if they should have it. They do. I would rather ask to what degree the therapist’s world-view should influence his undertaken actions, interventions. When attempting to answer a question asked in such a way, for myself, I have two guidelines: benefit of the client and therapist’s being in harmony with himself. For example, I think that it is alarming when therapist’s world-view, even resulting from being faithful to truths of a specific religion, has a chance to negatively influence the client’s mental condition; however, it happens in some cases of attempting conversion influences. Therapists, often motivated by religion, strengthen clients’ conviction that their homosexuality is a disorder or a symptom of a disorder. At the same time, homosexuality has been long depathologized, and, in addition, there is no evidence to support the claim that orientation other than heterosexuality is – as such – a source of pathology. I do not enter into contracts to change sexual orientation; however, in my professional career, I have met persons ready to attempt sexual orientation conversion, following their own world-view. In turn, refusing to attempt to change client’s homosexual orientation is a situation when my world-view “defends” my internal harmony. I do not have religious motivation to negatively evaluate homo- or bisexuality, I do not call influences aimed at human traits which do not constitute a disease or disorder, a therapy, I respect my clients’ world of subjective feelings, I do not assume that I understand them better than they understand themselves. These are elements of my world-view. I do not resign from it as a therapist. For me, it is a guideline not to harm a person whom I aid, and not to abuse myself in assistance contact with another person.

You mentioned that, in your professional career, you have met persons who attempted to conduct sexual orientation conversion following their own world-view – is this fine?

Is this OK? No, for me it is not OK. It is outrageous for me because I consider myself obliged to comply with ethical principles regulating my profession. Ethical codes, e.g. that of the Polish Psychiatric Association prohibit discrimination on the grounds of sexual orientation. For me, entering into a contract for conversion, offering conversion of homo- and bisexuality into heterosexuality, is a discrimination of a client on the basis of sexual orientation. Please consider: if a client came to the therapist and said – I am heterosexual, I would like you to help me change the orientation to homosexual, then that therapist would not think of conversion into homosexuality, he would convince the client that they are fine, that there is no need to do anything with heterosexual orientation. However, if a homosexual client came asking for conversion, then some practitioners, these involved in conversion influences, would consider the request to change the sexual orientation. For me, it is discriminating. Such actions fulfil definition criteria of direct discrimination.

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So, there exists a world-view more or less helpful for LGBTQ persons?

You can say so. However, I rather thought about how much the world-view should influence the contents of a session. I believe that the more I am more conscious of my own attitude to various issues, the less harm I will do as a psychotherapist. When I realise that my world-view may hurt someone, I try to withdraw from such job, just like that. I do not accept it.

You have just referred to ethical code of the Polish Psychiatric Association, but introduced yourself as a psychologist. Why did not you refer to the code of Polish Psychological Association?

I have referred to the psychotherapist code of the Polish Psychiatric Association – not medical one but one referring to psychotherapeutic aid. I take a view that a psychotherapist is a separate profession from psychologist. I think that one does not have to be a psychologist in order to be a good psychotherapist. I know great psychotherapist pedagogues,

excellent psychotherapist doctors; I would not fixate on that “psychologist”.

I have asked about that because the Code of Professional Ethics of the Polish Psychological Association does not include an entry about non-discrimination of gays/lesbians.

Yes, it does not. It is clear to me that in the matter of non-discrimination on the grounds of sexual orientation and gender, the ethical code of the Polish Psychological Association requires swift amendments. At the same time, it should be added here that a proper antidiscrimination entry is present in the Ethical Principles Code for Psychotherapist of the Psychotherapy Section of the Polish Psychological Association.

You are visited by persons experiencing violence motivated by homophobia, or minority stress. Reasons for this state are beyond them, in discrimination and oppression they experience. Their reactions to these experiences may be completely natural. Should therapist’s work be limited to work with client if there is no pathology in the client himself?

When a suffering person comes to me, they often present specific disorders from the perspective of some therapeutical narratives or medical narrative. My task is to support that person by working with them in an adequate way: a person in need of help reports – there is somebody who helps. At the same time, I agree with you – trouble starts at the previous level. The real difficulty is the socio-cultural situation of LGBTQIA persons which causes their oppression. LGBTQIA persons come to the psychotherapist’s office with effects of experiencing and inefficient coping with that oppression. Then, in the office they can “fall” into a specific “medical-psychotherapeutical-assistance” narrative, often connected with making a diagnosis (it depends on the theoretical approach of the therapist). Yes, I definitely see two levels here. The first is the pair working together: client – psychotherapist. The second one is the oppressive attitude of the society and culture to LGBTQIA persons – that is, an approach which is, *de facto*, the root cause of presence of at least some LGBTQIA persons in the psychologist or psychotherapist office.

You said that a person “falls” into a medical-psychotherapeutical-assistance narrative. “Falls”? Is this some trap? I have bad associations with this word...

Colloquial and, in the context we are speaking of, awful.

When a person “falls” into such narrative, then do they have a chance to work on something more than only symptoms of their own difficulties?

Here, “falling” into a narrative means attribution of some label. There are less and more labelling therapeutic approaches. Medical narrative, especially psychiatric, is something still different, far from some therapeutic narratives. When I was working in a psychiatric hospital, a fellow psychiatrist once educated me very wisely. When I said that a patient has symptoms I listed, he replied: Daniel, patient never has symptoms – a patient presents a way of feeling which someone once recognized as a symptom. True! For me, it was very valuable, corrective information and, *de facto*, the whole argument on labelling above comes down to it. We attribute clients with various diagnostic labels. There are specified threats connected with it. When a LGBTQIA person experiencing difficulties comes to us and receives a diagnostic label, from that moment onwards it will be a LGBTQIA person with a difficulties label. I think that in some practitioners such situation may relatively easily instil a way of thinking about LGBTQIA clients attributing them – by assumption – with struggle with mental difficulties. This type of reasoning is known from the history of pathologizing homo- and bisexuality: research of functioning of homo- and bisexual persons had been conducted in, among others, psychiatric hospitals. It turned out that these patients had sizeable psychological difficulties. All in all: no wonder. Patients of psychiatric hospitals form a group by definition presenting difficulties that require specialist psychiatric and psychological assistance. To sum up, one has to be careful with labels, also with diagnostic ones, ascribed in good faith. One should be sensitive not to, by labelling, make LGBTQIA equal to presence of psychological difficulties. Such equation, treated as a kind of justified generalization, is not true. At the same time, we should not lose sight of possible benefits resulting from labelling. By receiving a diagnosis, a person may benefit from a specified, often earlier developed, medical model of treatment. From the moment of receiving a diagnosis, there is a chance that they find a specialised algorithm of treatment, that they obtain efficient aid. The approach described above

applies to, among others, using medical and psychotherapeutic assistance under insurance scheme. Receiving insurance aid requires making a diagnosis; an object of treatment present in the register of disorders and diseases of the World Health Organization must emerge. Also, labelling may be beneficial in the context of the psychotherapeutic narrative. In some therapeutic attitudes, a specific diagnostic label is connected with a precise concept for origins, emergence of a given difficulty. Often, it is invaluable help for a client and a therapist – theoretical systems explaining the creation of various difficulties had been established as a result of accumulation of therapists' experiences over decades. However, it should be remembered that the result in form of a specific psychological difficulty may often arise through several different means. I think that psychotherapy is negatively influenced by attempts to explain some psychological difficulty only in one, "correct" way.

Then, what is the aim of therapy with a person experiencing violence motivated by prejudices? They come because they cannot cope with that violence, resulting in specific psychological difficulties, anxieties they would like to take care of.

120 First, presence of a client in the office is a chance to take care of direct effects of experiencing violence, e.g. anxiety, stress, anger, which appear in such circumstances. It should be remembered that experiencing homophobic, biphobic or transphobic violence may result in the LGBT-QIA client creating such an image of himself, and a way of self-experiencing, which may start to be difficult as such. The one best known is the model of internalised homophobia where the gay/lesbian starts to recognize homophobic attitudes of the environment as their own. However, we should not forget that biphobia and transphobia may also be internalized. It brings suffering. Then, it is invaluable to work with a client in order to show them, colloquially speaking, what are culture and society doing with them. I think that is an essential part of the assistance process: aiding the client to become aware that they are not suspended in a socio-cultural void. Our socio-cultural order is heteronormative, heterosexist and cissexist, and sexuality and gender are construction products under the mentioned order. In my opinion, an assisting person should be aware that so-called non-normative sexualities and genders

are subject to oppression, and be able to convey this awareness to the client. I think that this is an absolutely necessary part of working with an abused person. Lack of client's reflection on the nature of socio-cultural conditions in which they happen to live may only make it more difficult to cope with psychological effects of homo-, bi-, and transphobia. If a client understands what we are talking about, they will increase their own chances to possibly distance themselves from the fact of experiencing oppression, stand back, and see "what is really happening". Only then the client would be able to recognize that there are no objective reasons for which, e.g. homo- or bisexuality should be deemed improper, unhealthy, disordered, or sick; that there is a long tradition of pathologizing homo- and bisexuality but there is no objective reason for such pathologizing. Where, if not from their therapist, the client would learn that sexual orientation is a concept from the end of 19th century, that terms "homosexuality" and "heterosexuality" did not exist before. For some clients, that will be a very opening, intellectually and emotionally, tale.

So, during that therapeutic meeting, let me paraphrase, it is a very important factor for a person experiencing violence to realize that they are an object of many cultural, social, and historical oppressions?

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Yes.

It is probably a horrible thing, to realize something like that?

Indeed, for many clients such awareness is very difficult to experience. However, I think that, as time passes, it turns out to be really healing, useful. It may be also curing to become aware that sexual and gender identities, while partially biologically conditioned, are also socially and culturally constructed. In order not to omit socio-cultural construction of sexuality and gender, in the therapy I conduct I employ the perspective of queer theory. It is an invaluable theory in the matter of emphasizing cultural and social determinants of sexuality and gender; it is priceless when a person whose sexuality and/or gender are not included in constructions made available by the heteronorm comes to the office. It may be a person who says, e.g.: I have a sexual orientation but I am neither hetero-, nor bi-, nor homosexual. If they "make it", if there are no identity difficulties around them, and it is not a reason for their discomfort

in any way, then I just accept it. I say: Mhm, and I keep working. This person's experience is not described by categories of human sexuality listed in specialist books. Therefore, does it mean that such client has an issue with their sexual orientation?

This does not have to be the case! Human sexuality and gender are more unique and diverse than many sexologists and psychotherapists would want. However, that is their problem, not the client's.

So, one of the aiding, curing factors is becoming aware of being an object of oppression. A person begins to better understand their circumstances, their environment, but becomes conscious of being a victim. How can this be curing?

Coming to the office, they are aware of experiencing oppression. By working with a therapist or psychologist, they have a chance to see that it is groundless and unjust. And yet, the client not always, from the very beginning, knows about it. For me, the issue of injustice is something separate from groundlessness here. Really, there are no foundations for sexual and/or gender orientation to constitute a reason or motivation for someone to use violence.

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And how does it help them since the session ends, they leave the office and return to the social context which harms them?

My experience is that it helps. Experiencing violence may destructively influence the way in which they experience themselves. Therefore, we talk about sexuality, gender and, in particular, about how they experience their sexuality, their own gender. Being aware that a way in which one experiences their own sexual orientation and/or gender is fine, despite that it is different from the way which characterizes the majority of the society, may be curing. Such conversation does not reinforce negative self-image which may be "acquired" by experiencing homo-, trans-, or biphobic violence. The therapist-client dialogue has a chance to prevent inadequate process of searching for guilt in oneself. The fact that a client does not internalise homo-, trans-, or biphobic beliefs may vastly change their situation and strengthen them. Such person would change the way they see themselves, and recognize that they are unreasonably subjected to violence. Is that a little?

I have a soul of an activist and I wonder if you think that is enough for a psychologist: is such objective and result enough in a therapeutic relation?

I cannot affect a possibility of a person meeting somebody who would try to harm them again. However, as a psychotherapist, I can work in such a way as to help them experience further, possible confrontation in a completely different way. I can do this in the office when providing psychological assistance. Is the change in client, appearing during work with a therapist, a sufficient therapy result for me? When I think about an isolated, in a sense, client-therapist pair working together, then my answer is: yes; when I realize the force of oppressive socio-cultural context which "brought" the client to my office, then my answer: the change should have much broader range, it should also take place outside of the office – at our workplaces, homes, sejm, psychologist and therapist offices. I try to support that second type of change in a way possible for me. I consider myself to be a mini-activist in the issues of LGBTQIA psychology and psychotherapy. I hold lectures and workshops during conferences, I organize courses – in all these places I try to influence other psychologists' and therapists' way of thinking and proceeding.

I am not saying that linguistic, heteronormative "slip-ups" do not happen to me, because they do. However, I feel that I have done a great, personal work for myself, concerning my own heteronormative attitudes and beliefs, own heterosexism, own sexuality, own gender. Thinking about my psychotherapeutic work, I cannot imagine working at the office on a client's inwardness in relation to heteronorm, heterosexism, i.e. external socio-cultural oppression, and then leaving the office and consciously reinforcing that heteronorm. It is difficult for me to imagine that such one person could possess such two, opposite aspects.

At the same time, I have already experienced contact with psychologists who, declaring that they wanted to work with complete awareness of the way heteronormativity and heterosexism influence the functioning of LGBTQIA clients, after therapeutic session or supervision said something obviously indicating the usage of heteronormative stereotypes. However, these psychologists and therapists were not aware of this and I expect that they would have liked to know that they were using them. Simply, they probably did not realize that judgements, opinions,

and hypotheses they expressed were stereotypes. This example shows that there are persons who, working during sessions in a rather affirmative way, after meeting with a client may – without realizing it – speak or do something non-affirmative in regard to sexual and gender diversity, something heterosexist or supporting the heteromatrix in some other way, therefore strengthening negative attitudes towards homosexual, bisexual or trans persons.

For whom is this job then? Can every assisting person, every therapist be involved in psychological aid for LGBTQIA persons? I assume that awareness and readiness to rework, in the office, the issue of social relations' influence on the client, the ability to recognize this influence and name it, is an exceptional competence.

I have peers who do not understand “what is the deal with that sexuality and gender”, why do I emphasize the specificity of LGBTQIA clients so much. It happens that they present the following, simple way of perceiving the whole issue: possible specificity is not that essential, there is no need to focus too much; therefore, you sit in the armchair and work. I do not agree with this. On the one hand, indeed: a person who has completed a full course in professional psychotherapy should be prepared to conduct a psychotherapeutic session. They know how to do it, know psychotherapy as a kind of assistance institution – I would expect this. On the other hand, I cannot imagine them, deciding to work with LGBTQIA persons, to sit in an armchair without knowledge about sexuality and gender, and the way in which socio-cultural conditions influence welfare and functioning of this group of clients.

Second thing: if, as a psychologist or psychotherapist, you sit in an armchair without identifying issues connected with your own sexuality and gender then, at least in some situations, in some therapy processes, it leads straight to a therapeutic disaster. A particularly fitting example is a situation when a client disagreeing with their own homosexual orientation comes to a therapist, and the therapist has ... exactly the same issue. Please imagine that they would start cooperation. I do not think that anything good may come out of such contact. There is a chance that the therapist would pass all his fears, anxiety, and stereotypes connected with homosexual needs to the client. I also believe that, regardless of the

type of aided client, the therapist should go through the issues regarding their own sexuality and gender. After all, in therapy, sexuality and gender not always must mean homosexuality, bisexuality, transgender, etc. Sometimes, the psychologist or psychotherapist is visited by a client who completely, or in most aspects, found their way in the heteronorm. At the same time, they may have difficulties connected with gender stereotypes, for example with fulfilling specified social roles which are usually ascribed to only one sex. If a therapist is not aware how does the current socio-cultural situation of women and men look like, how does it change, how family models change, then I think that his possibilities of providing aid will be limited. He will not possess essential knowledge, as he has abilities, which would allow the client to see their own difficulties also through expectations of heteronormative society and culture.

Can you be a good therapist without this knowledge?

It is one of these more difficult questions... In my professional life, I have met such therapists who, unless they encountered directly expressed LGBTQIA issues, were excellent, very good therapists for a person they supported. Emphatic, technically efficient, and helpful. However, the same therapists, directly confronted with LGBTQIA issues, turned out to be essentially not ready for further work, for example: they did not possess knowledge about sexual orientation. They employed such methods of understanding sexual orientation, or concepts of its origins, which were discriminating, marginalising, or inconsistent with current scientific knowledge on this subject. However, I would not dare to say that they were bad, inappropriate therapists, because for some clients they probably had been hundred-percent successful. On the other hand, when an LGBTQIA client came to them, they turned out to be unprepared. I would expect that it could have been a double lack of preparation. First, insufficient knowledge about sexuality and gender. Second, lack of personal work resulting in lack of understanding regarding their own sexuality and gender.

Would you agree that every therapist may assume that: “OK, it is a part of specialization, I just do not deal with it, I am good at other things”?

When I think about it, then I have great doubts because it is the exact same story as the one we have discussed a second ago. Issues connected with sexuality and gender may not appear directly, but there is a chance that they would turn out to be important to some degree in every client, even in the topic of gender stereotypes. I would expect the therapist you speak about in the question to encounter a difficulty here. And, after all, they do not have to be LGBTQIA clients. The client may be heterosexual and cisgender but it does not change the fact that they may have troubles in regard to gender roles. Without earlier preparation, the mentioned therapist may feel discomfort at work with such client, all the greater because most probably they do not realize that social relations may be regulated differently than heteronormatively. Therefore, it is about acquisition of new knowledge, updating of one’s own attitudes and approaches – at all times I assume that such a therapist possesses assistance abilities. I believe that one must know there are things like heteronormativity, homophobia, biphobia, transphobia in order to begin to realize that maybe my behaviours and my experiences concern exactly these areas, in both aspects – therefore, e.g. both using heteronormative beliefs, and being subjected to heteronormative oppression. Therapists must first acquire knowledge which they may later use, trying to better understand their own experiences and the world of personal feelings connected with their sexuality and gender. Usually, university courses in Poland do not provide such professional preparation. It must be acquired somewhere outside the university curriculum, or one must try to prepare by oneself. However, I want to emphasize again that it is not only about knowledge. Another, vital stage is working on oneself, one’s sexuality, gender, and attitude towards them. Lack of such therapist’s involvement in their own development may result in later inability to empathise when the client will be sharing their experiences of being subjected to oppression. Simply, we will not know “what are they speaking about”. This whole oppressiveness coming from heteronormativity shall remain an empty, rather theoretical story read in a book that is, in the end, shelved.

Is it about work on the basics?

Yes, in my opinion work on the basics is crucial. When I work with therapists during courses, I do not inform them directly which attitudes should be deemed correct, ethical, etc., and which should not. Instead, I present my own standpoint, and then, together with participants, we examine their attitudes, check where they come from. I definitely try not to, in relation to participants, assume the role of the one who knows better and best, like: Now I will tell you how it (psychological aid to LGBTQIA persons) should look like. Instead, I say, for example: I believe that entering into a contract for conversion of a homosexual orientation is a form of discrimination on the basis of sexual orientation. Umm, ... Now, when I speak about this, about entering into a contract for conversion of a gay/lesbian into a heterosexual person, then I realize that, in fact, I clearly state that: In my opinion it is not an ethical attitude. Yes, I will not approve of such a contract. If another therapist came and told me that they are doing something like that – attempt conversion of sexual orientation, then my reaction would not be neutral. I would be touched, express this, and substantively justify my different stand. Therefore, I indicate what attitude is not OK for me. In fact, actually it is not the case that I am...

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...neutral?

At the moment, I assume precisely this attitude. As a psychologist functioning in my professional community, I am recognized as a non-neutral and involved person. I present my views very explicitly. When holding a lecture or a workshop, I describe specific, affirmative model of working with sexuality and gender – in this sense, I do not remain neutral. At the same time, it is not the case that, in my office, a gay, lesbian or transsexual person would not receive some better assistance of help only due to their non-normative sexual orientation and/or gender. I try to display the same degree of involvement and competency for all my clients. However, in relation to unfavourable socio-cultural situation of LGBTQIA persons, when I participate in a professional exchange forum of psychologists and psychotherapists, then I remain non-neutral in a sense mentioned earlier.

Then, neutrality is not the most important value for you?

I think that as long as socio-cultural situation of LGBTQIA persons is connected with oppression, remaining neutral in the professional exchange forum with other psychologists or psychotherapists is unjustified. Remaining neutral at any cost prevents possibilities of indicating that LGBTQIA clients are subject to strong oppression, also in some psychological and therapeutic offices. Experiencing social oppression has nothing in common with neutrality. At the same time, I would distinguish the lack of neutrality from the ideologization of a therapy process. For example, I would consider it my mistake if it happened that my involvement in LGBTQIA issues would affect my professional work in a way that I would make the emancipation of LGBTQIA persons into a framework organizing therapeutic practice.

Please wait... does it mean that emancipation may not be an objective in a therapeutic contact?

It may be an objective. At the same time, I would be troubled if, in contacts with all clients, I placed emancipation issues over all others. Indeed, social and cultural emancipation constitutes one of elements of reality of LGBTQIA persons; however, it is not essential and sole element for everyone. Even if one of more, or the most, important, still not the only one. I would fear a situation in which I lose sight of other issues and deal only and exclusively with oppressions affecting my client, only minority stress, and only internalised homo- or transphobia. Except that, that person may have a lot of other properties, possibly also psychological difficulties, which may not have that much in common with issues of sexuality or gender, such as matters of oppression and socio-cultural emancipation.

Is it possible to completely isolate psychological differences from connection with various identities simultaneously assumed by a person, and from social context creating oppression?

Not really. Sexuality and gender issues in a certain degree influence various properties of a client. Greater or lesser degree, but they do. For me, it is difficult to imagine a situation when, e.g. I identify myself as a man and my gender identity is male, and this does not affect, does not

constitute a framework for various situations I enter in life, for relations I build. This identification is a kind of a lens through which I see the world. If I live in a heteronorm and a society which deems patriarchy to be an essential value, then the fact that I am a man constitutes my very important property. It may be expected that, when I sit in the office, it may be possible for my first reactions, first ideas and first images which I see in my head to be passed through precisely this lens. I must take it into consideration. Only then, for example while working on a therapy with a woman, I will be able to notice how something which for me, a man, may seem obvious or easy in patriarchal social context, for her may be exceptionally difficult. In order to see it, I must be aware of my identity and realize what consequences in daily life, including therapeutic practice, result from it.

What good practices and guidelines can you pass to other specialists in the context of working with LGBTQ persons?

Important elements of good therapeutic practice, “happening” to a large extent outside of the office are acquisition of current knowledge, and work on oneself. We could also list specific components of treatment therapeutic relation with a LGBTQIA person, which are, among others: therapist’s awareness regarding their own heteronormativity, their heterosexism, gender stereotypes, their homo-, bi-, and transphobia, being attentive to deepened diagnosis of the client’s situation. However, please consider that all these “building blocks” may be reduced to two dimensions: extending one’s knowledge about sexuality and gender, and increasing therapist’s self-awareness in these areas. An example of key significance of the comprehensive diagnosis of client’s situation for further provision of psychological assistance may be a situation of homosexual man who, at the same time, is disabled, e.g. in mobility. If we do not identify the issues which come from having a homosexual identity and – at the same time – identity organised around the fact of being disabled, then we will not have a full image of that person’s situation. Please notice: homosexual identity is socially constructed as hypersexual, and for quite a large part of the society, disability still means lack of sex and sexuality. Our client will have to negotiate between these two identities.

Are we, providers of aid, aware of this conflict? I think that the degree in which we will be able to help that person may depend on the answer given a moment ago.

I also mentioned that, for me, good assistance practice in contact with LGBTQIA clients is identical to work on increasingly better understanding of one's own sexuality and gender. For example, in the process of providing psychological assistance to persons of orientation different than heterosexual, it would be about, among others, awareness of one's homosexual needs. Are they there, or not? Should the answer be affirmative, it would open a way to the next question – if they are realized. If it turned out that these needs are not realized, then – before sitting in an armchair in front of a homo- or bisexual client – I would suggest a therapist to ask themselves a question: why not? Should the provided answer indicate therapist's internalised, own homophobia, then maybe it would be better for them not to invite that client into cooperation. I am describing the elements of good assistance practice. As I mentioned, they can be reduced to two aspects: education and personal work on oneself. Acquisition of new knowledge about LGBTQIA persons and their life may take place in a variety of ways. One should consider participation in a course, reading fiction literature which, after all, is full of LGBTQIA characters, and watching movies touching upon LGBTQIA issues. If possible, I think it is worth to get to know LGBTQIA persons on professional and/or private basis. Usually, we are afraid and label those who we do not know. Therefore, I would not wait too long. I encourage to contrast notions, especially these built on the basis of low quality psychological literature, with reality.

What are the challenges (limitations) connected with functioning in psychological/assistance institutions within the area of LGBTQ? What benefits?

The basic benefit consists in many heads, each of them may have an idea connected with providing assistance in a specific situation. A limitation which I have encountered in group assistance work on LGBTQIA issues is the diversity of standpoints in regard to pathologization of LGBTQIA issues. One can try to state that it is another valuable pluralism, "we differ beautifully". However, for example, over twenty years after depathologization of homosexuality by the World Health Organization,

reconsidering if a homosexual client is disordered because they are homosexual is a waste of time – both of the assistance team, and of that client. Besides, such personal experiences gave “birth” to my realized idea of establishing a supervisory group for therapists working with LGBTQIA clients; an organizational restriction on joining the group consisted in non-pathologizing attitude towards human sexuality and gender. This group is already working. We do not waste time to consider if homo- and bisexuality are psychopathology. We are convinced that they are not. I think that it is a great comfort for our clients (I belong to the supervisory group). Affirmative work, that is based on respect and acceptance of diversity of sexual and gender identities, needs affirmative supervision. There is no other possibility. A “helper” may employ a perspective which looks at non-normative sexual orientations and genders as expressions of diversity, and work under the affirmative approach. However, if they encounter a supervisor closely related to repairing, treating, correcting non-normative sexual orientations and genders, then these two professionals rather will not come to an agreement. A particularly difficult situation is when beginning therapists get supervisors who teach their supervisees’ homo-, bi- or transphobic attitudes. It would be detrimental for a therapist, but above all – a client. By the way, please notice how little is spoken about supervision of therapeutic work with LGBTQIA clients. Quite a lot of time is devoted to reflection regarding therapists but, after all, a therapist assists under supervision. I think that the time has come not only to talk about therapy quality, but also about supervision quality, including LGBTQIA matters: a client, a therapist, and a supervisor (!).

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What is this attitude towards sexuality and gender from the perspective of diversity?

It is about looking into various sexual orientations, gender identity variants, gender roles, and biological sex as expressions of diversity which characterizes sexuality and gender. Usage of the word diversity denotes moving a focal point from the question: “What went wrong here?”, to curiosity accompanied by acceptance and respect. It would be a “starting point” of providing psychological assistance from a perspective that stresses diversity. Please remember that this sexual and gen-

der diversity refers not only to a client, but also their therapist (would be worth adding: also the supervisor of the mentioned therapist). It is a very important remark, awareness. If you reviewed the curriculums of complete courses for future psychotherapists, you would be able to count these including any thematic block concerning LGB on the fingers of one hand; T may be completely missing. During trainings in therapy, there are no classes which would directly concern sexuality and gender of the therapists. As a result, if a student does not take an interest in it by himself, does not need that, or if their therapist does not “catch” them during a training therapy, then there is a possibility that they will undergo the whole training process without touching upon issues connected with their own sexuality and gender at all. Then they sit in an armchair and begin to assist broadening of someone’s self-awareness regarding sexuality and gender. I do not think that it would be good if it was a first-time experience for both the therapist and the client...

Would it turn out that a therapist has neither gender nor sexuality? Therapist is neutral, has knowledge, interventions...

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Yes, it is remarkable that when you look at these courses, then there is little or nothing about the therapist, yet much attention is devoted to sexuality of the clients. There are numerous concepts about client’s sexuality; in some therapeutic approaches, precisely sexuality is to be the core deciding about psychological shaping of a client. About client: always and much. Therapist, however, is “clean and clear”.

Then maybe it would be good if the therapy of LGBTQ persons was done by therapists having just the same identity? Probably it would be easier for them to understand their clients.

It is a good moment to give an answer stereotypically recognised as the favourite among psychologists: “It depends.” Indeed, a therapist self-identifying as, for example, a homo- or bisexual, will have personal experience not possessed by a heterosexual therapist: socio-cultural experience of being in a society and culture as a non-heterosexual person. I am certain that it may be exceedingly helpful in better understanding of LGB clients. I also imagine that some clients will feel more freely, knowing that their therapist is a homo- or bisexual person. At the same time,

I would be afraid to announce such simple relationships in this matter. In my opinion, the fact of being homo- or bisexual person itself does not in itself constitute a sufficient preparation to provide psychological assistance to LGB persons. The fact that therapist's identity is homo- or bisexual, does not yet mean that they are prepared for such assistance work in the categories of necessary knowledge and awareness of their own sexuality and gender. And what about self-disclosure by a therapist? In my opinion, a situation in which a therapist or other assisting person does not decide to reveal their sexual orientation, is a repetition of what a homo- or bisexual person encounters on a daily basis. Please note that social regulation in this matter is as follows: you do not speak about sexual orientation, especially other than heterosexual. I would expect that repeating this in the office, in relation with a therapist, who, for their client, is often a model of behaviour in various social situations, may reinforce the earlier mentioned message in the client: Even my therapist does not speak about orientation. If my therapist does not speak, then it means that you really should not speak about it. I think that it would be detrimental for a client. If a client asks their therapist about sexual orientation, then it would be worthy to get interested in what way this is meaningful for them, and how this information may influence the therapeutic relation. However, ultimately I would not make a secret of the orientation itself. Of course, an important condition here is the readiness of a therapist to disclose their orientation. They are a party in the therapeutic relation and have a right to take care of their personal comfort, safety. However, it would be good if they were aware of relational consequences of withdrawing from answering various questions, not only the one concerning sexual orientation.

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Can one actually be a good therapist and help LGBTQ persons if one does not do it outside of the therapeutic relation as well?

When I hear this, I realize my own alertness: what could it be about, that in the office someone functions differently than outside? What could it indicate?

Have you been to the parade yesterday?

Sure, I have.

And what impressions did you get?

There has been a small counterdemonstration on the other side. The misters were holding a large banner with "WE WANT MEEN, NOT FAGS" written on it. We were very intensely waving at these misters.

REJECTION OF ASSUMPTIONS ABOUT EXISTENCE OF ANY OBVIOUSNESSES – A CONVERSATION WITH KATARZYNA BOJARSKA

Katarzyna Bojarska – PhD in Humanities, psychology graduate, sexologist, academic lecturer, trainer, sex educator, and social researcher. She works at the Institute of Psychology of the University of Gdańsk, and at the Centre for Psychosexual Health “BezTabu” [“NoTaboo”]. Since 2002, she has been giving lectures at the University of Gdańsk on subjects in the area of sexology and psychology of sex and sexuality. In 2002, at her home university, she has introduced the first academic course in Poland completely devoted to the issues of homosexuality and bisexuality, preparing students of psychology for future aid work with LGB persons. She has long-term experience in providing psychological aid – individual, partner, family, and group – to homosexual, bisexual, transgender and intersexual persons, and their heterosexual families and friends (parents, spouses, siblings, children). Since 2005, she has been teaching at postgraduate courses and sexology studies. So far, she has been giving lectures at, among others, the Postgraduate Medical Education Center in Warsaw, the Adam Mickiewicz University in Poznań, the University of Social Sciences and Humanities in Warsaw, the University of Social Sciences and Humanities in Sopot, the Medical University of Warsaw, the Queer Studies in Warsaw, and also at courses realized within the framework of the Centre for Psychosexual Health “NoTaboo”. Since 2002, she has conducted several thousand hours of courses, lectures, trainings, and workshops in the field of LGBTQIAF, sexology, psychology of gender, and sexuality.

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Katarzyna Dułak: You are a recognized specialist in counselling for LGBTQ persons – what does seem particularly important for you? What is your approach at work?

Katarzyna Bojarska: In my opinion, the foundation of assistance work with LGBTQ persons consists of affirmative, non-anxious and natural treatment of sexual identities, or orientations, and gender identities of the clients. The second issue is studying in the field of LGBTQ psychology, for knowledge on this subject exceeds common intuitions, even if therapists themselves are LGBTQ persons. Regardless of our own sexual

identity (orientation), heteronormative socialization makes it more difficult to get an insight into historical, socio-cultural, and psychological contexts in which LGBTQ persons function. Even if we know the realities of LGBTQ persons' daily life from experience, it does not automatically grant us insight into mechanisms governing these realities. In summary, it is important to have the meta-knowledge which explains daily experiences and mental conditions of LGBTQ persons. I think that it cannot be acquired without effort and intended education.

The way we speak is important as well. It should not be labelling, stereotyping, medicalising or discriminating, both towards LGB, and transgender persons. For example, if we arbitrarily "make a diagnosis" and state, even at the clients' request, what is their "true sexual orientation", then we may prematurely pigeonhole these persons with no easy way out (e.g. "since you have already had male partners, then you are not a lesbian, but a bisexual"), thereby disrupting their identity development. The external world labels people enough, and I think that it is worth not to contribute to that in the office. Then, if we specify the client's identity with medicalising language, associated with pathologization of sexual identities (e.g. "since you, Mr (!), feel like a woman, then I believe that you, Mr (sic!), have gender identity disorders"), then we establish a relation of superiority-inferiority with that person, which is, I think, dis-favourable for assistance. Words, beyond their dictionary meaning, also carry specific emotional charges and burden of associations, sometimes stereotyping or discriminating.

The language we use should not be heteronormative. It is a good practice to be careful how, for example, we talk about relationships. It is important not to presume heterosexuality of clients in our language. After all, when someone enters our office, we do not yet know with what they come.

Therefore, if we ask a women, whom we meet for the first time, about her relationship, using male grammatical gender in relation to her alleged partner, it may result in that person never returning to our office. Language should be open to diversity, and to the fact, that our clients may not necessarily be heterosexual. And – more generally – in therapeutic work in general, especially with LGBTQ persons, it is important

to reject assumptions about existence of any “obviousnesses”. Appearances can be very misleading.

And how about transgender persons? What should be considered?

For sure, we should follow the gender identity of a person coming to us – in a sense, to address them in a way corresponding to their identity. An expression of our respect towards transgender person is non-labelling and respecting the way in which they self-identify. During work, it may happen that the feeling of a gender identity of a given person changes; then it may be necessary to change the way in which we address them – I mean grammatical gender. And again, the principle of rejecting assumptions about “obviousnesses” proves to be true. Because there may exist any combination of somatic sex of a given person, their sex registered at birth, gender role, clothing, and gender identity, instead of making presumptions, it is worth to ask directly, in a completely natural tone (without anxiety or uncertainty), how should we address that person. It is about maintaining openness to any potential possibilities, including gender experiments, in persons with whom we work, and to display that openness by our manner. In a sense to... stop being surprised. If we express surprise about clients’ identity, then we can undermine their trust to us as psychologists. Of course, this is a more general principle, going beyond the work with LGB or transgender persons.

It is worth to stop being surprised about the world, and to look at it with open-minded attitude. One should restrain themselves from formulating immediate judgements or categorizations and instead – curiously explore situations in which our existing assumptions are undermined.

Do you have some recipe not to be surprised?

The first reaction of our mind is automatic and immediate. It cannot be restrained. However, we may practice the skill of separating automatic mind reaction from its effect on our behaviour – verbal and non-verbal. If we display surprise about client’s non-standard identity, then this person may feel uncertain and have doubts whether they can entrust us with their affairs.

Let us go back to mechanisms which you have talked about at the beginning. Can you say more about them?

Sure. Although we grow up in a single society regardless of sexual identity, and it socialized us in a similar way, the same world means something different for persons fitting into heteronorms, and something else for those breaking out of them. The Western world is organized in a way promoting the functioning of heterosexual and traditionally “gendered” persons. What constitutes a convenience for persons fitting in the heteronorm, is often a hindrance for those outside of it. For instance, pervasive heteronormative assumptions of the environment. Heterosexuality is treated as something so default and obvious that usually nobody asks about the sexual orientation. You just assume that it is heterosexual. A heterosexual person does not have to regularly correct wrong assumptions of their interlocutors concerning that person’s sexual identity. A LGBTQ person must choose between hiding and disclosing their sexual or gender identity. If they choose the first option, then they constantly need to be on the alert, resulting in psychological stresses, stress tension called “minority stress”. Should they choose the second option, that is revealing their identity, then stress tension partially drops, but some part of it remains. The world consists of countless people with heteronormative assumptions. If you reveal a LGBTQ identity to one person and in this way undermine their heteronormative perception of you, then after that one you will meet another ten, who will also make an incorrect assumption about your identity. And when you correct them as well, every one of them will be replaced by another ten. And this whole process endlessly repeats itself. Non-heterosexual coming out is a constant work, for you countless times have to confront situations in which someone measures you with heterosexual yardstick. It is one of elements maintaining the minority stress. This kind of stress concerns not only LGBTQ persons, but generally persons from socially disfavoured groups. Different daily stresses are also tinged with a certain layer of “stress noise” specific only for persons from oppressed groups. It results from constant mobilisation for action or making fast decisions. For example, you constantly anticipate that someone may treat you on the basis of mistaken assumptions about your identity. You also have to keep a high guard, ex-

pecting that someone may want to hurt you. If you are an LGBTQ person, they you constantly come into contact with somebody's assumptions which do not fit in your life. And due to this, even if you cope with your internalised homophobia or transphobia, or accomplish a coming out, your minority stress will persists, maybe just less severely. If you are an LGBTQ person, then in a greater degree you are burdened with certain tasks which you do not have to perform if you are heterosexual or "gendered" in a standard way.

Do you think that attitudes and world-view of the person providing support to LGBTQ persons are significant in this work?

Without a doubt, they are significant because the way in which we work, and therapeutic solutions which we propose, are determined by our internalised macro- and micro-cultural context – context which has shaped us. Our mentality in macroscale and microscale is a product of culture in which we grow. In connection with this, our way of perceiving the world will determine our limits of cognition and of what we can offer to others. Therefore, our way of perceiving the world, approach to reality, to social relations – our therapeutic orientation, or the way in which we studied for providing aid, undoubtedly influences what we have to offer to our clients.

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And, is an attitude towards homo- or bisexuality relevant?

Of course. It could be said that, simplifying, in relation to the degree of coping with one's prejudices, in assistance work one can have blatantly homophobic approach, "neutral" approach (or actually, apparently neutral, based on ignorance or not based on knowledge), or affirmative approach. One could be aware or unaware of their own homophobia, therefore I speak about "apparently neutral" approach.

If we have a knowingly homophobic approach, that is consciously deem homosexuality and bisexuality as worse than heterosexuality, then it is highly probable that we will be proponents of so-called "reparative therapies", that is "curing" LGB persons from homosexuality or bisexuality. Then, in the process of "curing", usually we will maintain a belief in our clients that homosexuality or bisexuality is an anomaly, or some kind of "impairment" which should be "fixed" and "straightened up". Thereby,

we will reinforce the non-acceptance of their sexuality in our clients. As long as our therapy will last, their reinforcing of self-hatred will continue.

In turn, the “neutral” (apparently neutral) approach is sometimes adapted by persons who, in good faith and will, want to work therapeutically with LGBT persons but are lacking earlier mentioned meta-knowledge in the field of LGBTQ issues because they did not study in this subject. If we lack meta-knowledge then we do not have tools to efficiently confront our own heterosexism, heterocentrism, and homophobia, and to keep them in check. As a result, we may be unable to, as therapists, facilitate our clients’ confrontation with their own internalised prejudices which lower the quality of their lives. It happens because, when we do not notice our own prejudices, we probably will not notice the same ones in others. Despite that our knowledge about realities of LGBTQ persons’ life may be greater or lesser, depending on whether we are LGBTQ ourselves or not, our internalised prejudices may enter the process of therapy and disrupt it. And the fact that, in the process of socialization, we have acquired homophobic prejudices, seems nearly unavoidable. Homophobia marks our life whether we want it or not, whether we know about it or not.

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If we lack knowledge and self-awareness, then our approach to the therapy of LGBTQ persons may turn out to be “blind to sexual orientation”. It happens when we draw assistance interventions we can offer, due to the lack of other points of view, from experiences of working with heterosexual persons, and they may be completely incompatible with realities which determine the experience and action possibilities of our LGBTQ clients. Thinking that we help, we may not do that, or even cause harm, because, with an improper intervention, we may just shoot off the mark.

Finally, there is the affirmative approach, that is honouring non-heteronormative identities. It should be noticed that, in psychotherapy, affirmative approach to the identity of heterosexual persons has always been accepted as obvious in principle. However, the formation of affirmative approach in the therapy of LGBT persons constituted a true breakthrough – a thought that client’s homosexuality or bisexuality may be

treated as naturally, as heterosexuality has been. The affirmative approach and therapist' freedom at work with LGBTQ persons generally go hand-in-hand with knowledge broader than only intuitive. I am thinking about that if someone actually works in the affirmative trend, it usually means that this person has studies in the field of LGBTQ.

“Honouring” an identity – could you explain what does it mean?

I am trying to use a possibly accurate Polish equivalent of English-language verb “to affirm” in order to properly express the essence of a therapy called affirmative, since Polish verb “afirmować” has different associations in Polish than in English, a different semantic tone. In Polish, “affirmation” is associated with idolisation, deification, and exaltation. Then, “to affirm” may be translated as “to acknowledge”, “to approve”, “to pat”, “to recognise”, “to allow”, and it is difficult for me to find a single word in Polish that would reflect this meaning well. For me, “honouring” the LGBTQ identity by therapists, that is acknowledging it, seems to be the closest in meaning. It means that LGBTQ clients may freely talk about their own identity in the office, without fear of being recognized as deficient or disordered due to it – as it happens in offices of therapists representing chronologically older approach to the issue of LGBTQ. The LGBTQ identity will be accepted as naturally as heterosexuality.

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In summary, if, as psychologists, we did not cope with our own homophobic or heterosexist attitude, then during a therapy we maintain analogical attitudes in clients because we are not able to lead neither ourselves nor them to confrontation with internalised prejudices. In this way, we can unintentionally reinforce self-hatred in our clients. It may also happen that, when coming to our office, some clients will have their own prejudices “reworked” more than we do. Then we may not understand their way of thinking, resulting in therapeutic relation suffering from it.

In the case of affirmative therapy, therapy time which reparative therapists would use to reinforce prejudices, we can use for empowerment – work which will grant clients a feeling of internal strength, allow to gather strength pumped out by social oppression.

Therefore, considering the chance for clients to achieve an improvement in mental health, the affirmative therapy is simply more beneficial for health. It is even difficult to compare its efficiency with reparative therapies which rather intensify clients' difficult mental state than improve it. The same therapy time used for work in the affirmative trend is more promising to improve mental health.

Another issue is ethics. To what extent are "reparative" influences ethical?

142 Already forty years ago, homosexuality ceased to be recognized as a disorder by the American Psychiatric Association, and twenty years ago – by the World Health Organization. Thereby, from the perspective of medicine, the grounds to conduct reparative therapies ceased to exist. We do not treat something that is not a disease. However, ethical standards of therapeutic work set up by professional or scientific organizations such as the American Psychiatric or Psychological Association are one thing, and therapists' beliefs drawn from an internalised system of values – another. If we work in the reparative trend, it means that we have internalised a conservative system of values. Then, our work may be compliant with our internal ethics, but not necessarily with professional ethics delineated by scientific or professional organizations.

It should be remembered that persons working in the reparative trends are convinced that in this way they actually aid clients. They believe that homosexuality as such is an anomaly which damages human psyche. Therefore, the only way to save that psyche is to remove the "cause", i.e. homosexuality, thus making that person heterosexual. In the understanding of persons conducting reparative therapies, their influences are ethical and, in contrast, conducting affirmative therapies may be unethical. They hope that they will actually mentally cure LGB clients by changing their sexual orientation.

Another matter is the ethical aspect of these therapies' influences on psyche of persons subjected to "treatment". In June 2013, as a result of "examination of conscience", the Exodus International, enormous coalition associating organizations, institutions, and individual therapists conducting reparative therapies, disbanded. For almost forty years of existence, it did not manage to achieve results in form of effective "cur-

ing of homosexuality” of its charges. Instead, its influences turned out to be mentally destructive for clients, for they reinforced both their self-hatred, and sense of failure. People remained homosexual and often, in despair, fell into self-destruction. From the point of view of health consequences of such therapies, conducting them, especially by therapists aware of their inefficiency, as well as therapists’ reluctance to confront their destructive consequences, may be deemed unethical.

And how do you evaluate the state of psychological counselling for LGBTQ persons in Poland?

Certainly, the supply of assistance services on the part of psychologists prepared sufficiently not to inadvertently reinforce prejudices of LGBTQ clients towards their own sexuality or identity is lower than the scale of needs. Preparation for affirmative work is not a standard element of education at psychological and medical university courses, and not even at the majority of schools of psychotherapy.

A handful of psychologists working within the consciously affirmative trend seems to be focused around several larger urban centres in the country, and on the majority of the territory of Poland there may be a great difficulty to access this type of aid.

Even if some part of psychologists prepared for affirmative work does work in smaller cities, the second vital issue arises – potential clients have to be able to find out about it. If a given person announces themselves as a “standard” psychologist, then LGBTQ persons may not know that it is a person with whom they can freely talk about their own identity and relationships. I often receive questions if I know where, in a given region of Poland, someone provides affirmative aid, for people seek it and often cannot find it. They do not find such information directly. Such prepared psychologists are in minority because it is a substantial knowledge, requiring separate education. Therefore, even if someone studied in the field of affirmative therapy, it is important to let clients know: “I am here and you can come to me”. It is about making it something more than word-of-mouth, for its reach is limited. It is crucial to create access routes, therapists should announce that they work ex-

actively in affirmative trend; otherwise, it may be difficult for clients to find a friendly psychologist.

Do you have any guidelines how to do it?

If we have a website of our psychological office or advertise it somewhere, then there we can directly provide information that we work with LGBTQ persons in affirmative trend (e.g. “office friendly to LGBTQ persons”). Providing such information significantly increases the probability that LGBTQ client chooses precisely our office from among the available ones. Second, it is worth to provide information about qualifications in one’s note about themselves. How and where did we study psychological assistance for LGBTQ persons, are we, and how are we, prepared to work with transgender persons, etc. This information may concern courses and trainings, but also all other forms of (self)education. We may self-educate by reading current literature. Thanks to providing such information, already at the early stage of looking for a therapist, clients decide if we are a person whom they want to visit. Affirmative psychologists are particularly needed in smaller cities, and non-capitals of provinces; also, there is a great need to disseminate information that someone like that sees clients.

And how can you establish an atmosphere friendly to LGBTQ persons in institutions at which we work?

We may create the working atmosphere on a greater or smaller scale. It may happen that we are a (co)decision making person, able to propose and introduce principles applicable to the whole team; this is the greatest freedom of action. But even if we work in an unfavourable environment and it seems to us that our voice will have little effect on co-workers’ behaviour, we can act in a microscale and create such a friendly atmosphere, even via the language we speak. We can use gender-inclusive non-heteronormative language, breaking assumptions of co-workers or clients about heterosexual “obviousnesses”.

When we dislike that someone talks about gender or sexually diversified persons in a disdainful, offensive or stigmatizing way, we can explicitly speak about it (e.g. “I would prefer if you did not speak in such way because you may hurt someone without knowing that among colleagues

there is someone personally concerned, or whose family members are.” or “I would prefer you to use different vocabulary because there may be someone among us hurt by such term. Instead, you may use such and such expression”). Besides, we may proceed in the same manner when in our presence someone speaks in a way which is stereotyping or indicating gender, race, ethnic, religious or economic prejudices. Sometimes, such direct confrontation requires courage but it is surprisingly efficient, especially when we are on generally good terms with co-workers. As a result, we may anticipate losing sympathy of the environment; however, if we say this in a non-aggressive and calm manner, than it may swiftly turn out that some co-workers begin to implement the principle we proposed, for they have never thought about it before and it did not result from ill will. Thus, one may act and care about friendly atmosphere at every level.

If we have no possibility to introduce rules applicable to the co-workers, then we may provide role models ourselves, that is demonstrate principles that interest us in our behaviour or language, without instructing others. Then we may notice that some will begin to adapt our language or behaviour, but only under the condition that they generally like us.

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If we cannot achieve anything with co-workers, then we may introduce an atmosphere of kindness and acceptance only at work with the clients. Thus, one may act both formally and on a greater scale, and informally, individually, to a degree in which we feel safe. Every of these methods contributes to social change.

It is difficult to provide some general guidelines, for there are various conditions, persons, functions, institutions, and consequences of our actions. Therefore, we must consider realities in which we live, and limitations which bind us. There is no single way.

In my opinion, explicit confrontation with co-workers is not safe for everybody and in every institution, for it may result in loss of a job. And our loss of a job may, for example, mean that our clients lose the only friendly psychologist in their town – someone about whom they learned only by word-to-mouth, and until now recommended to others in this way. Therefore, a question about balance of profit and loss is important.

Perhaps, even if external limitations will not allow us to fully flourish, it does not mean that we cannot do anything. Even considering limitations, we still can do some really good job. I think that it does not have to be “all or nothing”. We do as much as we can in given circumstances, and every little step forwards in relation to which was before constitutes a social change for better.

And what about situations when persons providing psychological assistance to LGBTQ persons accidentally meet their clients in non-therapeutic circumstances – in informal situations, social or private?

It is the specificity of work. Population of LGBTQ persons is a minority and, therefore, if in our private life we mingle with local LGBTQ communities, then such encounters seem unavoidable. It is similar when we work with heterosexual persons. Then it also may happen that we meet the client in a private situation, for example in a shop or at a party with friends. However, if we work with LGBTQ persons and mingle with this community, then a probability of a chance encounter, as well as of revealing of some connections in the network of social contacts is much greater, for this world is far smaller. One must realize that this will occur. In my opinion, there is no need to give up one’s world or friends due to work.

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What we can do, and what is helpful, is setting up rules. For example, when a LGBTQ person comes to our office, then we can touch upon this topic during one of meetings. We can say that it may happen that somewhere we meet informally by accident, and establish rules what to do in such event. Sometimes, I tell clients that if we accidentally meet somewhere outside the office, then I will leave the decision whether to “acknowledge” and greet me, or not, to them.

I do not greet them first because I am aware that I do not know with whom they are at a walk. For fear of inconvenient questions from the company (e.g. parents), that person may choose to pretend that they do not know me. Due to my thoughtless greetings, that person could find themselves in a troublesome situation. It is one of good practices which, in my opinion, is worth implementing. Besides, not only at work with LGBTQ persons, but in this case, due to small environment, it is particularly worth to consider this.

And one more important principle – hold your tongue. If it turns out that we have common friends with our client who do not know about our acquaintance, you should avoid talking with friends about anything concerning that person. It is so because it is easy to confuse the source of some information – from themselves in the office, or rather from themselves at some common social meeting with friends, or maybe from reports of others. Then it is easy for potentially fateful situation where, by mistake, we could say too much about that person and, in this way, inadvertently break a professional secret. The fact of having common friends with the client is neither comfortable nor easy situation, especially that also that person may obtain some private information about us, generally not intended for persons with whom we are in formal relations but well – one has to cope somehow.

Do you have any more guidelines, recommendations for persons performing aid work for LGBTQ persons?

Read! As for publications in Polish language, the newer – the higher probability that they will not reproduce out-dated information. In the case of older publications in Polish, especially those which were translated from even older Western publications – the earlier the year of publication, the greater possibility that the given publication contained out-dated information already at the release.

The newer trends in the field of therapeutic science and trends, present in Western countries where emancipation of LGBTQ persons is more advanced, have begun to infiltrate literature in Polish language on a slightly broader scale only after 2005 or 2010. Of course, the fact that some book has been published after 2010 does not automatically mean that the book will be good (laughter), but there is a greater probability that it will consider the current state of academic reflection. For persons for whom reading in English is not an issue, I think that reading Western publications is valuable.

Besides: educate, train. It is worth to check qualifications of centres which organize courses. Does the given centre possess sufficient qualifications to educate in assistance work in affirmative trend? Is it surely that kind of a course in which we want to participate? What do we know about qualifications and experience of persons conducting the course?

Unfortunately, one must bear in mind that – for the time being – professional and comprehensive education in the scope of psychological aid for LGBTQ persons most often is not offered within the framework of regular psychological studies, therapeutic schools, or postgraduate sexology studies. There, we will gain neither knowledge nor competences sufficient for providing professional assistance. It is a specialist knowledge and requires specialist training, and from the therapist – intentional effort to acquire that knowledge. It is not a knowledge that will come to us by itself; it is us who must reach for it.

At the end, tell where does your involvement in this subject come from? How did it happen that you took an interest in it?

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I cannot explain it. For sure, it was not a single factor. Essentially, I have been interested in sexology since childhood. I was born at the end of 1970s and read all sexology books and articles that I could lay my hands on. Back then, until 1980s, relatively a lot of these publications were published, also educational ones for children and teenagers. Kozakiewicz, Jaczewski, Wisłocka, Sokoluk, Imieliński, Lew-Starowicz... After 1989 the social atmosphere changed, a strong aspiration of morality appeared in the media, and the issue of sexual education disappeared for at least a decade. At least that is how I perceive it. Anyway, when I was growing up, I had an abundance of literature.

My occupation with the issue of sexual and gender orientations or identities started probably when I read Boczkowski's "Homoseksualizm" from 1988 and Lew-Starowicz's "Homoseksualizm" from 1999, and experienced a huge discord between what I read there, and what so-called "common people" said about these subjects. Back then, to me, these books seemed massively progressive, even revolutionary. These were the times before the theme of LGBTQ came about on a large-scale in the Polish media. In the media, this subject was basically not addressed

at all. Only in the sphere of private, disdainful comments or rumours full of horror, mouth to mouth, by the way, incidentally. Before 2003, before the “Let Them See Us” started by the Campaign Against Homophobia, it was not a subject truly interesting for the heterosexual majority, and heterosexual persons repeated only second-hand, inconsiderate, incredible stories about LGBTQ persons (as they still do today).

This discord intrigued me and awakened my rebellion: why it is said that homosexuality is a disease since it has been long acknowledged that it is not? Then I started to seek information. I began from researching homophobia. I had known very little about it so I was a bit in the dark in my research. These were different times. One could say that I was partially reinventing the wheel. The Internet was only entering into common use. I had no access to Western literature, including electronic publications, so in the beginning I could only base on printed sexology literature in Polish language which, as I already mentioned, compared to social attitudes seemed very progressive to me.

Then I found webpages of the American Psychiatric and Psychological Associations, and learned their official statements. It was a great eye opener, and even greater surprise that these Polish “Homoseksualizm”¹⁴⁹ were so out-dated. And then I encountered the queer theory which, initially, I could not even fit into my tight mind drawers. And then I had to break these drawers, and I saw the world in a completely new way.

When I returned after a few years, after getting familiar with the Western thought, to these Polish books which initially I had valued so highly, then I realized that the message carried by these books had been very out-dated and full of stereotypes already at the moment of publication. They presented long disgraced “theories of reasons” as valid and “scientific”. In general, they were interested in “reasons” and employed this type of language. They were based mainly on publications from 1960s, 1970s, and even older ones – that is from the age of medical model of homosexuality. And, in general, they did not consider the latest academic thought – that one which had been available when they were created. Despite that the only literature initially available to me had been already out-dated, the discord between its contents and social attitudes was so dramatic, that it motivated me to get involved in this area.

UNLEASHING THE SENSE OF PRIDE AND INFLUENCE ON ONE'S OWN LIFE – A CONVERSATION WITH ALICJA DŁUGOŁĘCKA

Alicja Długołęcka – PhD in Humanities, graduate of the Faculty of Education at the University of Warsaw, pupil of Prof. Andrzej Jaczewski and Prof. Zbigniew Lew-Starowicz, lecturer at the Faculty of Rehabilitation in Warsaw, where she conducts classes on the basics of psychotherapy and sexual rehabilitation. For many years, she has been involved in psychosexual education and sexuality of women – she conducts trainings for specialists and teenagers, gives lectures at the Postgraduate Studies in Sexual Education at the University of Warsaw, and on Clinical Sexology at the University of Social Sciences and Humanities, at the Medical University of Warsaw, and at the Postgraduate Medical Education Center in Warsaw; she is an author of numerous books and articles on this subject, a textbook for middle school students on “family life education”, and monographs “Edukacja seksualna” [“Sexual Education”], “Jak się kochać” [“How to Love”] i “Seks na wysokich obcasach” [“Sex on High Heels”], among others.

She devotes her scientific and popularising work to prevention of sexual disorders, broadly understood sexual education, and promotion of “sexual health”. Themes connected with women sexuality are particularly close to her.

Jan Świerszcz: You have written the first Polish book about coming out, and you are involved in sexual education, including education about LGBT persons. Where did this involvement connected with this subject come from?

Alicja Długołęcka: I started with HIV/AIDS prevention in the early 1990s so, like it or not, at the very beginning of professional life I have encountered the LGBT environment, although it certainly was not called so. Currently, my activities are more educational and focused on working with young people. In turn, I have learned, scientifically and unscientifically, about the phenomenon of painful, long-term coming out from persons I have spoken with - it was a community of Warsaw-, Wrocław- and Poznań-based lesbians, completely closed. Now they are around forty so I

can, in some way, speak about this subject from a time perspective. Together with the Jagiellonian University, a year ago we released "Wprowadzenie do psychologii LGB" ["An Introduction to LGB Psychology"], and there I wrote a chapter about disappearance of the coming out phenomenon, at least in the West. I hope that it will be similar in Poland as well, not in 15 years but, suppose, maximum 5 years.

During your work, you have met many LGBT persons. In your opinion, should a professional working with non-heterosexual persons maintain some kind neutrality and impartiality?

Sexual orientation is never something impartial. It would be, for it is only a certain theoretical construct, if the society was not heteronormative. But as long as heteronormativity is present in our life, understanding of any minority and being impartial is impossible without learning about this minority. However, I do not think that some intimate personal experience is an absolute condition. So, one does not necessarily have to be in a homosexual relationship, or possess homosexual orientation, to understand and support lesbians and gays. Personally, I think, and want to emphasize that it is my personal opinion, that one cannot work in the subject of LGBT without having homosexually oriented persons at least in one's environment. For me, it seems impossible. I think that a person who wants to work pedagogically/psychologically with non-heteronormative persons, is heterosexual themselves, and lives in a heteronormative way, will find it difficult if they will not have gays and lesbians in their close environment. Considering the number of persons non-oriented heterosexually, the probability of meeting such persons is very high for every one of us. One has to be non-heteronormative to the marrow in order to understand and support this minority group; I think it is a basic conclusion I make after years.

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Did you happen to be just heteronormative to the marrow? Where did this present attitude to these issues come from?

Of course! When I was a student, I had a very close friend with whom I was making many projects of artistic nature, and whom I suspected of a love affair with an older woman. He turned out to be gay but it came to light in a very unfortunate manner. In the Saski Park, I was sitting with

my friend from studies on a bench, and a sentence was uttered: "look, some fag is coming". I looked and saw that it was he, and I instantly understood his secret. Because we had already known each other quite closely, it was not the fact that he was gay that was some shock for me, but the fact that he did not tell me and hid from theoretically so close person. On the one hand, it was inconceivable for me, I felt somehow insulted; on the other hand, I understood in what containment he had to live since he had been hiding from the whole our community which, I believe, would have completely accepted him. And so I took an interest in theory of this subject. In turn, when I began to explore woman community, at the first meeting in a secret club, a friend from a sailing camp threw her arms around my neck. I understood that such persons are among us and apparently, this is my way as a pedagogue. These were the years when this choice of the course of work was a complete abstraction. Now, since more or less five years, I have a feeling that the subject of homosexually oriented young persons enters into the pedagogy because, I think, it happens slower in psychology. It enters without some excessive emotions and with adequate focus on essential issues. We already stop to focus on "where does the homosexualism come from?", and do not presume that a gay/lesbian is unhappy and lost. A certain awareness of factors that may influence the situation of LGBT persons appears. My beginning of interest in this subject was personal and resulted from friendship. When I started to write the Master's thesis, precisely about coming out, I went abroad. At a university in the Netherlands, I have found a lot of literature on this subject and saw that there exist special departments concerned with LGBT persons. It has very much opened my eyes.

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In the meantime, what was happening in the Polish scientific discourse? Have not you found similar sources?

Not at all. The literature consisted mainly of Boczkowski, a is very medical and anachronistic approach. What was important was the fact that an immeasurable space of learning philosophical and social trends absent in Poland has opened for me. Finally, I have seen a constructivist way of thinking, and not essentialism. In Poland, we were continuously

delving, also not fully consciously, in the theme: is human born like this, and why? There was little other reflection.

You said that in order to efficiently work with LGBT or non-heteronormative persons, one has to “personally experience” something? What experience or reflections are the most valuable here?

It is about the client's sense of safety in the presence of an assisting person. Non-heteronormative persons often feel barriers which prevent them from speaking about certain things about which they would like to speak. From the side of an assisting person, it is even about usage of articles in seemingly neutral questions, such as the one about a person with whom they spent the weekend. Despite appearances, it may be quite difficult to establish such safe relation on the emotional level, and this is something that one has to work on by themselves.

What must happen so that this comfort could be felt in the assisting, supporting person, and around them?

I think it is an issue of working on oneself, and concerns not only views, but something deeper. We are going back to the constructivist trend. The fact that, e.g. I fulfil a role of a woman, heterosexual woman, mother of two children, single-time married woman, that is I situate myself in a certain model, should not be obvious. It is about understanding that it is a certain scenario which one consciously selects in life, for the world does not have to be heteronormative and these categories and roles are not as obvious, as the majority of people thinks. This understanding requires deeper reflection, deeper observation of the world, and investigation of various relations.

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When a person gains awareness of various socially constructed roles and relations, then they will also see that the world is built on standards which exclude some persons, and privilege others. Should it be noticed as well?

I try to look in a non-oppressive way. It is about a possibility to live in truth, however it sounds. A person may self-actualize in life if they feel free. If they encounter barriers, then it may make them very deeply miserable and, depending on certain personal traits, they will either assume a fighting attitude, or withdraw into themselves, self-humiliate,

and simply live in hiding. A therapist, that “helper”, must break various constructs in their own head, in order to understand how they can help a person to prepare to function in this system. It seems to me that, in its essence, it is absolutely no different from making a heterosexual person aware of their functioning in a role. Because, e.g. a woman who gave birth to two children with a man whom she does not love, that is she does not live in truth, likewise lives in a certain scheme that limits her. She may not understand why it happened herself, for it is a certain cultural role, ascribed to her by parents and the environment in which she grew up. A great number of factors will influence the fact that she did not make such decisions in her life that allowed her to “live in truth”. I was stuck in various pigeonholes as well. The turning point in my way of thinking was the recent encounter with transgender persons. Another important breakthrough happened after research on homosexual women; a great number of heterosexual women began to report to me, reflecting upon... let us enigmatically call it “homosexual element” discovered in themselves. In addition, they expressed much resentment connected not with “forcing themselves to heterosexualism”, but with heteronormative way of life. They felt limited and, among others, it produced homophobia in them. We may create oppression in our own head, and it may concern very different areas of life. It is often independent from sexual orientation, because cultural prescriptivism also constitutes certain oppression – the fact that every woman must be a mother, that a man who is not financially responsible for persons under his care is not completely real man.

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This oppression also imposes certain models in homosexual relationships, models which may be entirely unfitting for people.

A homosexual couple will never be a classic Polish family?

I think that the peculiarity of homosexual relationships does not refer exclusively to the matter of sexuality, but to the issue of relations, which break the classic concept of a family. I absolutely do not say this in a negative sense. I think that Polish families would function in a completely different way, including having children, the way of raising them and of treating each other, if it was a matter of conscious, free choice. Due to their condition, their sexuality, a gay/lesbian is liberated from all these

schemes which are generally imposed on all of us. A heterosexual person may consider conscious parenthood, a homosexual individual is forced to it.

I can make a mental shortcut that women who talked with me about homosexual element were, in a sense, jealous of lesbians' freedom in life, freedom of thought, because they felt oppressed in a traditional role of a woman themselves. Do you understand?

I wonder if it can be said that a non-heterosexual person is free and liberated by their own condition itself, or if they just have completely different barriers in front of themselves, and entirely different issues to cope with.

It all depends on the perspective. For me, the basic category is the category of self-controllability. By this, I mean that work with another person is about liberation of the sense of pride, and of conviction that one can affect their own life. Basically, it is the only chance, and one should find these areas which allow us to live a rational life. If I work with a 17 years old gay from a small town, I often repeat: "Tough luck, if you aren't talented, cram, study. It will allow you to get out of here. And if you are further from the environment which doesn't understand this, if you get into a university or get a job which will give you independence, you'll be able to live as you want". It is not a work on affirmation or changing the close environment, because he will probably change this environment only when he comes back: When he is 28, strong and shaped enough to come with his partner and visit friends. Some will turn away, others will not, and this chain of changes will take place.

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I noticed that earlier you provided many examples and analogies, talking about women and situation of women...

Yes, because it is another discriminated and oppressed minority group.

So this analogy to being fettered to the constraints of social constructs, positioned in some place, and expected to fulfil some role resulting from sex concerns also women providing psychological assistance who, in this profession, are overrepresented in comparison to men? You said that that their task would consist of building, or supporting clients in the sense of pride, in that internal controllability, control over one's life, and influence on one's life. It is probably a great challenge for persons who, as you have noticed, may not be aware of schemes, which limit their own freedom?

Yes, of course. Recently I have been training future sexologists in this subject, and I asked a question whether they are to tell the client what their sexual orientation is, or not. The group consisted mainly of women and they arrived at a conclusion that, after all, it is established that the psychologist should not tell but, on the other hand, why not, it may be important for the client.

And when I asked a question “and which of you is homosexual”, no one revealed themselves, or there was no such person. Instead, they said, “if I was homosexual, I would not admit it that easily”. I have a friend, psycho-therapist, whom I have been urging for years to out himself. However, it is not easy because the doctors’ community can be very conservative. And as I said, the LGBT community is a community, which liberates us from certain standards, allowing us to accept certain values in our life with greater consciousness. When we were specifying a list of anxieties during the course, the basic anxiety was seduction by a homosexual female client. Participants of this training were definitely more afraid of being seduced by a women during therapeutic work, than by a man. However, after all, seduction is very often one of the client’s tactics, broadly described in literature anyway, aimed at verifying the therapist’s credibility in relation to the client and therapeutic relation. So, we are returning to what I have been speaking about earlier: a client needs to know if they can feel emotionally safe. For this establishing of atmosphere of safety to be manageable at simultaneous placing borders in the therapeutic relation, the therapist must go through this homosexual element in themselves, fully accept it, get accustomed it, and even like it. It must not cause paralysing fear. As long as it is not the case in our country then, taking Western therapy as an example, I think that situations in which the therapist does not hide their sexuality are more beneficial.

And do not you think that a person who is just prejudiced cannot leave their prejudices outside of the room, office, and help?

No, I think that one cannot leave their prejudices in this way.

Would not professionalism and neutrality consist in it?

No. I think it is a confusion of concepts. One cannot leave prejudices just like that. If a good therapist has such prejudices or feels some anx-

iety, then it probably means that they may be not ready. On the other hand, they do not have to be ready, there is never such obligation, but then they should not work with homosexual clients. It is similar as is with a world-view. If I am aware that I have some world-view which may result in non-acceptance of my client's choices, then I cannot be completely neutral. In such situation I should be responsible and mature enough to accept that I am not able to understand my client's problems, get an insight into his world.

I am thinking about psychologists who decide, or realize, that they have precisely this world-view. Such views that handicap their work with homosexual or non-heteronormative persons. In effect, they decide not to undertake such work and refer them on. They do not establish contact or therapeutic relation, and there is not really anyone to refer such clients to.

I do not even think about proposing selection of clients at all. It is a about the sense of personal responsibility. It is also the issue of that "homosexual element" which should be reworked. It is discussed very little and it is not reworked, and it is certain challenge for every psychotherapist who wants to work with gays/lesbians, to meet their "homosexual element" or lack of it. One should approach the theme in a reflective way and reforge this into conscious attitude. At the same time, it cannot be superimposed. Standards are superimposed and say that the only disorder in which the issue of sexual orientation appears is the egodystonic disorder related to non-acceptance of one's sexual orientation. It is clear what classification there is, so every psychologist and psychiatrist is obliged to assume such attitude. And what happens? It is known what happens. We have so many miracle workers who cure homosexuality and employ these various techniques... well, I do not even know how to call them. You probably think about it in politically. Of course, I fully support the way of thinking that in every assistance centre that should indeed be a man able to provide assistance to a non-heteronormative person.

I will not avoid the word "politically", but in this case, it seems to me that there is a certain moral imperative as well. For if there exists an assistance system having an offer for persons precisely with difficult violence experiences, and that system is not able to provide support to a certain social group, then that system is sick.

In a normal situation, in a certain ideal reality, everyone would be equal and given equal access to psychological assistance. In crisis situations, every person, regardless of sexual orientation or their non-heteronormativity, should receive professional support of comparable quality. However, living in a sick reality, maybe it would make sense to employ such an idiotic solution as imposition and seeing to that in every centre there is a helping person substantively prepared and having gone through the themes of gender and sexuality with themselves. See how it is with women and quotas. In a certain context, as long as there is no equality between persons of different genders, quotas make sense but, of course, only temporarily. Similarly, in principle, the therapist should not talk about their own sexual orientation, but as long as this is an extremely important and dividing social issue, providing such information grants the therapist much credibility in the eyes of the client.

How can hetero therapist help the client by revealing their orientation at the meeting?

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I recall that when I was beginning to work with a group of women, they were telling me that my heterosexuality even facilitated it. I was a “heterosexual person representative”, who is a model in the environment and accepts it. And it is worth to build such a safe relation with a heterosexual person especially in persons who experienced violence due to their non-heterosexual orientation. At the same time, there is some truth in that it is difficult to be a heterosexual “helper” and not act in the environment at all. If a psychologist, or psychiatrist, is completely unfamiliar, then it may be suspected that they will think quite schematically and completely will not grasp matters important for gays/lesbians. In addition, these persons will immediately recognize it. It is the issue of using certain terms, knowledge of certain environmental behaviours, social actions, books. I cannot imagine any way other than direct contact and acting in the environment that leads to understanding the world of non-heteronormative clients. There is a great lack of such understanding therapists acting close to the environment. Although if the therapy was to concern relations with parents, communication in a relationship, or raising a child, then sexual orientation should not have any meaning

for a professional. Therefore, professionals should be taught how to keep distance and not focus on the orientation when it has little significance. Despite that issues are rarely tightly connected with homosexuality, it is worth to have a non-heteronormative mind. Be able to throw the category, which is not an essence of such meeting, out of the mind, and focus on what the coming person specifies as a problem. Also, there are situations in which a person who knows all these processes, and with whose experience one may identify, will provide better support. For example, work with teenagers is difficult due to the lack of positive models of adult, homosexually oriented persons. No matter how much I tried, I will never be such a model. Direct contact is the best, e.g. playing basketball, making film festivals, realizing social projects and such...

Should young gays or lesbians searching for themselves also meet other gays, lesbians, and play football with them?

Of course! And it would be best if they had adults around them who do are not hiding. It is about these models existing in reality and not being an abstraction. Then, such young person surely would not feel the only one and alone in the world, and that they would not cope. I am talking about presence of adults at whom such young man can look and see that they are not people with anxiety neurosis, some totally frustrated, or losing themselves in promiscuity.

I cannot free myself of your thought that there are such issues with which LGB persons can come to a psychotherapist, and which are not connected with their sexual orientation. I think that whatever it will be, personal relationships, addiction or something else, it may not be investigated in isolation from social heteronormative context. As long as we live in a heteronormative society, one may probably always discuss this relation of the "issue" to the context in which that person is immersed.

You see, there is a certain kind of contradiction between us, and I think that once I used to think like you. Now, I think that these standards are more universal than we think, and also concern many other areas and groups. This is why I was speaking about women; however, heterosexual men are bound too. Where does homophobia in men of the macho type come from? Because they are artificially and thoughtlessly associ-

ated with heterosexual standards of being a man. And everything that is homo causes them to panic.

In general, when working with people, one must be aware of the context.

Yes, especially that the sexual context is very important in our culture and very difficult, causing strong emotions, for we live in a very censored way and are extremely evaluated through this context. When I work with women then I see how many of them submit to standards and cultural demands concerning family life; also, they have that oppression regarding the role of a mother in their heads. In general, it is the issue of living in relation to specified cultural demands and social evaluations connected with this. Therefore, I would not distinguish the specificity of issues connected with homosexuality so much. They of course exist but, maybe because I am concerned with sexuality, I would focus more on the specificity of the sexuality and gender itself, for I think that it is exactly gender what diversifies us more than orientation. Generally, it is about such work that, let me return to this slogan again, supports a person in their development and living in truth, whatever it is.

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Is it a kind of personal, or rather social, emancipation? Is this “living in truth”?

Yes, you have identified it very well, for it seems to me that sexual orientation is such a beginning, it is, but it does not have to be.

THE BASIC THING IS AWARENESS – A CONVERSATION WITH GRZEGORZ INIEWICZ

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Katarzyna Dułak: What is the base of your work with LGB persons?

Grzegorz Iniewicz: I divide the issues of LGB persons into two areas. The first one, common to the majority of patients, refers to issues connected with current or past relations, with present emotional problems. The second area is embroiled in it, closer connected with the orientation itself, e.g. the issue of functioning in social context, disclosing one's orientation, or acceptance of non-heterosexual orientation. It seems to me that it is necessary to see the life of LGB persons in a bit different context, connected primarily with the issue of discrimination, rejection. As shown in, say, research done by Marta Abramowicz or professor Ireneusz Krzemiński – indicators of violence, both mental, and physical, are significantly higher in LGB persons than in heterosexual ones, and this has to be considered, for it will affect both individual functioning, and functioning of the whole group due to experiencing so-called minority stress, resulting in conse-

quences for health and affecting functioning in relationships. Rejection, violence, discrimination and, in consequence, anger and frustration – it all affects the relations of LGB persons. In therapeutic work, it is an absolutely basic thing for a therapist to be aware of his personal attitude towards non-heterosexual persons. One can have less knowledge about, e.g. their functioning, this can be learned from patients, can be read, but it seems that the absolutely basic thing is that what happens with me in such relation. During supervision with young therapists, when I ask about orientation of patients whom we discuss and therapists' attitude to it, then they respond that they absolutely accept it. However, when I ask what happens when they sit in an office with a LGB person, it turns out that they experience very varied emotions. It is some kind of otherness, and it is difficult to be astonished at that, because, living in such a society, we are permeated with heteronormativity or homophobia. On the one hand, I observe this in my supervision work, and on the other hand, I find its confirmation in researches as well.

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As you mentioned, you are a supervisor, which means that you have contact with many persons concerned with counselling and therapy. What difficulties or errors in practice appear most often?

It often happens that therapists as if do not notice a non-heterosexual orientation – “ok, somebody has a homosexual orientation and we keep working”, on the other hand there is a danger that the therapist, or an assisting person in general, may relate all issues, difficulties to the sexual orientation. Then, it is difficult for them to look at a patient, client in a way other than through their non-heterosexuality.

I think that I would have more examples of not recognizing the consequences of non-heterosexuality than of excessive focus on it. Recently, with Bartosz Grabski, PhD, we have conducted a research, which we are preparing for a publication, with participation of psychotherapists and LGB persons who are to come to a therapy. I remember very astonishing situations that happened when we were gathering data; also, I was very surprised when three familiar therapists, asked if they had already filled our survey, responded that they did not do that because they have not encountered LGB persons in their practice. I wonder if it is possible

for therapists with over 20 years of experience not to have a non-heterosexual person in their practice. It is impossible even statistically speaking, and, besides, I do not think that these persons are perceived as such homophobic to be avoided by LGB persons. It is a good example illustrating that the issue of orientation is not recognized in the area of therapy.

Therapists, especially younger ones, beginning their work, quite rarely think about the issue of sexual orientation. When, during supervision, I ask, e.g.: "And how about the sexual orientation of that person?", young therapists are often surprised by my question. They assume patient's heterosexuality so much that it is hard for them to notice that it may be otherwise. In turn, when there is a "suspicion", they often find it difficult to distance themselves and not to relate everything to issues of orientation.

You have mentioned conducted researches. Could you tell about them?

The researches yielded interesting results; namely, we asked what is the relationship between emotional difficulties and orientation – in general, there was no difference between the group of psychotherapists and the group of LGB persons; respondents from both groups stated that not all problems should be related to orientation. However, it is a theoretical assumption and declaration; the question is – what happens in practice? As I said earlier, my supervision experience shows that it is not always the case.

In the researches, we also asked psychotherapists what they would fear the most in work with LGB persons, and it turns out that, first and foremost, psychotherapists fear their own helplessness in connection with social situation of LGB persons. It can be said that it is a difficult situation for therapists, because when one works with some group exposed to greater risk of violence or rejection, a certain kind of helplessness appears. According to the concept of minority stress, experiences of persons belonging to minorities are inscribed in the social structure, result from functioning of institutions, or lack of legal regulations. Patient's move or cutting off from toxic relations will not change it; it requires time and change of the whole social structure.

In turn, the greatest fear of LGB persons was that the therapist will try to change their orientation. I think that it reflects the heterogeneity of conduct among professionals. We have researched almost 3000 LGB persons so it was not some small group fearing that a therapist could try to change their orientation. In the second place, there was an anxiety that a therapist will not understand their problems, and, in the third place, a fear of rejection and aggression on the part of the therapist. I think that these anxieties are quite surprising.

It may seem that all psychotherapists want to help, work according to the professional ethics; however, there are also those who not only consider the possibility of changing patient's sexual orientation, but are also ready to realize it.

And what do you think about so-called correction, or reparative, therapies, aimed at changing sexual orientation?

I will be brief, I believe that it is non-substantial and unethical. I do not know if it needs elaboration. The first thing – if a homosexual orientation is a variation of proper development, then what right do I have to treat it? Do we treat what is healthy? Getting deeper into the subject, another aspect of non-substance consists in lack of research that would provide a foundation to conduct them. Every psychotherapy, according to the statement of the American Psychological Association, must be based on accurate, verifiable research showing that it works and does not harm. Research of conversion therapy not only shows that it is very doubtful if it even works, but also, and maybe primarily, that there is a great risk of being harmful. Since in various codes it is emphasized that a psychologist, psychotherapist, doctor should act according to the latest knowledge, an ethical issue arises. Thus, by what right a therapy of doubtful efficiency is employed, which, in addition, carries a high probability to contribute to appearance or intensification of anxieties, angers, depressions, or suicide attempts?

I have read a lot of literature on this subject, and it turns out that there is no cohesive theory to which such therapy would refer. It is rather a compilation of quite randomly mixed elements of various theories. For example, in the case of gays, there are attempts to seek the reason of

homosexuality in disrupted relations with a father. It is not confirmed in any research. From the perspective of my office, I can say that both heterosexual and homosexual men have issues with fathers, so I do not think that there is something exceptional in it.

The question about reasons of homosexuality seems to be an expression of heterosexism in itself, one does not seek reasons of heterosexuality after all.

It seems to me that it is driven by fear connected with otherness. It is clearly visible in the social context – fear that non-heterosexual persons as a minority may be dangerous, that they will infect with homosexuality, seduce children and they will all be homosexual, etc. It is absurd but it could be understood referring to the concept of a scapegoat which says that, in a society, it is good to have a group which could be put to blame on bad things that happen. We, as the better ones, can perceive ourselves as these magnificent ones. After all, these are well-known threads from our history. Homosexuality may also constitute a red herring, even a political topic.

This desire to change the orientation also has its religious context. A very common motivation to change orientation is experiencing itself, or deeds that it may encourage, in a category of sin. Besides, I have a certain doubt whether, in the case of influences aimed at changing orientation, we can even talk about “therapies”. Since if we take a closer look at them, it turns out that most often these are religious groups, there is a lot of prayer there, spiritual guidance, commonly shared faith that the orientation can be changed. If the issue of faith is so important for someone, then I understand that they are able to deny important aspects of their functioning. Deny and recognize that this orientation is something bad, undesirable, etc. Such research that attempt to show the efficiency of these “therapies” are basically poorly designed, because it is as if one researched some persons highly motivated to change it in themselves, and later verified if they succeeded by asking them about it. It is highly probably that they will succeed and if one interviews them later, it is awkward, or improper, for them to say that they have failed. From the methodological point of view, all these research are easy to contest.

Here, it is worth to mention an American researcher – Robert L. Spitzer who, at first, was in the group of psychiatrists which removed homosexuality from psychiatric classification, then he conducted research in which he tried to prove the possibility to change orientation and the efficiency of reparative therapies, to finally, in 2012, apologize everyone, especially lesbians and gays, for earlier statements that changing sexual orientation is possible and, therefore, one may conduct conversion therapies, what he did on the basis of research that did not give rights to such statements.

LGB persons are more exposed to violence and discriminations in the society, experience the effects of minority stress, what translates into their functioning in various areas of life. What is the role of the psychologist and psychological support here?

To start with, aid for LGB persons in Poland is very poorly organized, not to say that it is practically non-existent. As far as I know, LGB persons on their own search for therapists, who will not want to change their orientation, ask, and seek for recommended persons. Although there are organizations that offer aid, it is not a common network. If an average gay or lesbian searches for assistance, then I think that they are in a great trouble as to whom they should go. Although they may choose a psychologist or psychotherapist recommended by KPH or Lambda, such therapist is not always available. Let us say that it is only in large cities. As far as smaller towns, or persons who have no idea where to search, are concerned, it is a great issue.

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What can be done to change the situation?

In my opinion, it should be started with education of teachers. As researches demonstrate, teachers are a group often called on by teenagers in various difficult experiences. Teachers may recognize if something disturbing happens.

When I have classes with these professional groups, I pay attention to, if we are dealing with a depressive teenager after a suicide attempt, how many persons ask themselves if it may be an issue connected with the sexual orientation of that person. Usually, as I say when I conduct classes, in that moment silence appears in the classroom. Sometimes in-

dividuals raise hands that they actually consider this. A vast majority does not realise it. When I had classes with Scandinavian medicine students at a medical school for foreigners, when we were discussing this subject, it turned out that it is a standard question in an interview. They were surprised how it is possible not to ask about patient's sexual orientation; for them it is absolutely one of questions asked to a patient during the interview. I think it is essential to address the issue of education of persons who are to be concerned with aid in this scope.

There is a need to establish a whole assistance system; it is not a matter of training a few people. First, I think that it must be a standard knowledge, provided to students of medicine, psychology, sociology, pedagogy – that would have to be a start for this issue to be even considered.

I think that all campaigns and social actions are extremely important, for they attract attention that something like that even exists and, thanks to it, more and more people will start to pay attention.

The issue of homosexual teenagers is a very neglected area. They discover their non-heterosexual orientation, what is usually a difficult experience, in the period when otherness is rarely tolerated. Therefore, they are more exposed to violence or rejection by peers, even more than only some can count on support of family and friends. These difficulties are not only our suspicions – as research shows: 63% of homosexual teenagers considered the matter of suicide, compared to 12% among heterosexual teenagers. Is not this data frightening?

Another thing is the professionals themselves. I have the fortune that at two psychotherapeutic courses where I have lectures in Kraków, we have a whole block of classes devoted to this subject. But this is interesting too, despite that there are persons who study how to be psychotherapists, there is a selected group where there still is the issue of proper attitude of how to work, a lot of own fears, anxieties. Interestingly, when speaking on the forum, there is a general acceptance, but, for example, something else happens during specific classes. I remember a situation with a group where everybody said: “yes, we completely accept” and when we prepared a scene where they were supposed to talk with a gay couple, the first question was „what do you come with [Mr and Mgrs.]?”. I think that it shows well how much, even linguistically, we are

accustomed to heterostandards, heteronormativity. I also think that it is extremely important for that knowledge to appear during courses. For psychotherapists simply to recognize it.

I also think that it is necessary to establish specialist centres, for although adult persons may find something for themselves, the issue of work with families is absolutely neglected. When parents discover homosexuality of their child, the typical path is to go to a psychiatrist or sexologist.

This path is immediately a pathologization and medicalization of orientation. It goes straight to looking for pathology; it is the first reaction which we may understand anyway. Such desire to change, astonishment, shock phase, it is acceptable, parents have to go through this, but if there were such centres, then it would be possible for parents to calmly talk about it, not immediately embrace the path of pathologization.

Another essential issue is working with couples. It also requires therapists' awareness of their own beliefs and, on the other hand, one has to know about the specificity of functioning – e.g. how important is the issue of coming out. One of the more frequent problems concerning couples which come to me, is that partners are on different stages of revealing themselves. One person is revealed and openly functions in their environment, and the second is not and nearly nobody knows about their orientation. I feel that this is one of the most frequent issues, resulting in arguments regarding where they can go together, where separately, should they visit their families alone or together, etc.

Another important issue refers to raising children by single-sex couples, due to a large number of social prejudices connected with this subject, despite the fact that researches show that it has no effect on cognitive, social or emotional functioning of children. If psychotherapists themselves can have such prejudices, they will function in the society all the more.

The subject of raising children is one of the more controversial ones, it causes protests and even aggression from its opponents. Despite that, you boldly and openly speak about it in public, like in e.g. June issue of “Znak” [“The Sign”].

When dealing with this subject, I try to refer to researches, not even individual ones, but to meta-analyses in which the given issue is as if watched from different perspectives, using different tools. However, I realize that it is one of possible discourses on this subject. There are also others, based on world-views of the discussing persons, on their morality, ethics to which they refer. However, I think that while a discussion based on research may help us in finding adequate solutions, introducing world-view issues generally allows only to exchanging views. Because, how to discuss about them? They are either accepted or not. Because of that, probably most of discussions about homosexuality become a bit meaningless at some point – when knowledge from research starts to mix with world-view issues.

Is the attitude of persons providing support to LGB persons significant in relation to how they work?

I think it is. It seems to me that this cannot be separated. If, privately, I do not like, do not accept some group, e.g. Roma, black people, Jews, then it seems unlikely that, entering my office, I can suspend it. I am convinced that absolutely not. Besides, the code of psychologist, psychotherapist, although not formally existing but commonly adapted, clearly states that the psychologist must be fully capable of performing actions. When a person comes, and I cannot approve, emotionally accept them, or, as I have once heard, they are disgusted by talking about sex with gays/lesbians then, in such situations, it is impossible to provide professional assistance. Anyway, it is confirmed by research. Recently, I have been to the 1st International Conference on LGBT Psychology in Lisbon¹⁰², and there had been a very interesting presentation, during which the author presented researches showing clear connection between the attitude to non-heterosexual persons, and involvement in work with them.

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What should be done then?

The client or patient should be referred to another person. It is the issue of basic responsibility for how much I can cooperate with such persons.

¹⁰² The conference in Lisbon which took place on 20-22.06 2013.

Here, one should also pay attention to an important matter that, when working with LGB persons, not only context is essential, but also considering a certain specificity of development of one's homosexual identity. For example, I pay much attention to the age group of a person coming to me. It is one thing when this discovery of orientation developed in the period when homosexuality had been included in the DSM, and now it is another thing, despite the polarization of standpoints, there already is a clear standpoint that it is an absolutely normal development and one can identify with it. A lot depends on the environment. The issue of one's attitude regarding one's identity is extremely important.

Is there anything else to consider by persons providing psychological support to LGB persons?

The issue often raised in American textbooks, especially when a therapist is homosexual themselves, is that it is possible for the therapist to have relations with the patient on various levels. It may be a therapeutic relation but they also may belong to a single group, e.g. when they participate in manifestations, etc. When a LGB patient sees their therapist as an activist, then may gain trust for them but, on the other hand, it may make therapeutic relation more difficult. For the therapist, it may be not easy to maintain distance from the patient when they are connected by realization of some common idea. In turn, heterosexual therapist may not inspire trust, the patient may fear if they will be understood; on the other hand, it is easier for such therapist to maintain distance to issues reported by patients. Therefore, these issues, without clear solutions, require great mindfulness from the therapist. And it is good if they are discussed in the therapy.

You are working at the Institute of Psychology at the Jagiellonian University, and at the Clinical Department of the Child, Adolescent, and Adult Psychiatry at the University Hospital in Kraków – these are public institutions. Does the subject of homosexuality occur there, do you raise it?

I raise it while working at the University, in the form of scientific research; currently, with a group of students, we perform a research programme regarding minority stress, there are also classes connected with psychological aspects of functioning of LGB persons.

At the Department of Psychiatry, with the already mentioned Bartosz Grabski, we have been involved in therapeutic work with non-heterosexual persons for over a year. It is not a separate unit in the clinic but, one day, maybe something like this will be established. Anyway, our colleagues know that we are concerned with this subject and often refer their patients, in whom they recognize problems connected with the issue of sexual orientation as crucial for their functioning, to us. However, I have noticed that the majority of LGB persons prefers to come to a private office rather than to go through the machine of a state institution, what is connected with disclosing their orientation, sometimes to many persons. Private office provides greater sense of comfort, safety. The majority of persons who came to me had been directed by psychologists or doctors who know what subject I am involved in, or found me on their own because, e.g. they read my articles and know what my attitude to homosexuality is. It happens that I hear: "I have read your articles, so I come". This also shows how vital is the matter of clear recognition of the therapist's attitude to homosexuality.

When you were opening this office, did you encounter any difficulties from the institution or co-workers?

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If there were some difficulties, then they were not connected with the specificity of this group of patients. They resulted more from generalized organizational difficulties of an institution such as a hospital. On the other hand, I was surprised by attitude of two peers, psychiatrists, who once asked me, treating this question as obvious one, if we are involved in changing the orientation. I was shocked that such a question was even asked, and I thought how much such thinking is still present. I also think that a certain political correctness of our statements is imposed on this issue. In numerous discussions, many professional do not touch upon these subject; however, I think that it is somewhere in them. It is appropriate to say certain things. I think that it results in that during conferences, meetings we have a clear standpoint, that officially we help, do not change orientation, but I wonder what really happens in these offices, especially that patients coming to me tell me very different things. One of them said that when he was directed to the psychiatric ward with

symptoms of depression, the first thing he was told was that he had to cure his homosexuality, and only then they will start to treat his depression. I know that it is not the only such situation, I know from other persons working with LGB persons that it happens that psychologists, psychotherapists, psychiatrists want to treat. They do not always call it a treatment, but they undertake actions aimed at changing patient's sexual orientation into the "better" and „healthier" one.

What do you do in such situations?

Fortunately, my patients had a distance to such attitudes of doctors. However, a certain specificity of therapeutic work with non-heterosexual persons shows here; namely, the psychotherapist sometimes has to be an educator explaining certain issues. It happens more rarely with adult patients, and more often if one works with teenagers or families where there is a homosexual teenager. Work with their parents is basically often a kind of counselling, psychoeducation, explanation – what the son's or daughter's homosexuality is, that it is neither a mental disorder nor deviation, that it is not their fault that the child is gay or lesbian. It is also a beginning of the process, I emphasize – process, of coming to terms with homosexuality of the child. I stress this because one cannot expect parents to immediately accept and approve it. Of course, some of them have such emotional possibility, however many need support, talks, coping with their own anxieties or prejudices. Here, self-aid groups led by parents themselves would be extremely helpful, there is a great shortage of them. They should be supported so that they would be able to support their children in entering life in which they may experience many difficulties. And it is not about pretending that it is not the case, but about openly discussing it and finding solutions together. The worst that may happen is to be left alone with the problem. Situation of such parents can be understood a bit by analogy to emigrant families which find themselves in a country not necessarily favourable to them. One can escape, withdraw, or think how to adapt to this situation, how to cope.

You conduct research and publish, you are recognisable, and your standpoint is clear – you present an antihomophobic attitude, based on research. You openly speak that homophobia is not good. Do you encounter difficulties due to this?

I have not encountered difficulties so far. Sometimes there are persons who think differently but nothing happened to me in connection with my views. On the other hand, when I do this, I try to base on something very specific, e.g. on research. In discussions, I try to avoid ideologization of this issue; instead, I point to research. It seems to me that where we begin to introduce certain ideologization, discussions start because everyone has their world-view. I do not argue with this, I leave this. For me, the important matter is what scientific researchers say, and how much they agree with my professional practice.

An important issue worth emphasizing appears here – I, as a therapist, am not allowed to drive the patient towards any direction. It is very noticeable in teenagers. Working with them is very difficult, I believe that it is the most difficult group of patients. It is particularly difficult to talk in such a way as not to push a teenager towards any direction – neither homosexuality, nor heterosexuality, but to accompany them, aid in discovering what lies in them. I realize that when I start to push him, then I may become a reason of some emotional issues. Here, my favourite example of how easy it is to fall into a trap, what I always tell students during lectures, is the situation when we have a teenage boy in therapy. I remember, from lectures on developmental psychology, one of standard questions is, e.g. “Do you have a girlfriend?”. If we ask a teenager who is just discovering their homosexuality if he has a girlfriend, then we seem to be so heteronormative that there is very little possibility for him to say that it is otherwise, for he would not only have to reveal that he is fascinated in his peers or men, but also he would have to answer my question negatively in a, seems to me, delicate sphere. Additionally, a terrible heteronormativity of a therapist comes to light. I think that it is a very easy way to close the subject. Besides, when I work with adult patients, then I also ask a question about sexual behaviours and fantasies of, e.g. an adult man in a heterosexual relationship. I ask if he has fantasies with women, and add a question if he also has them with men. Patients are of-

ten surprised but continue and add that yes, it happened. In general, posing this question itself allows for options at work, shows that we can talk about this as well.

How did it happen that you became involved in this subject?

It was a very interesting story. My interest began several years ago, when I was at the conference in Rome. It was a conference on therapy of families and couples. As part of the conference there had been a presentation by an American therapist, unfortunately I do not remember her last name, which was to speak about the specificity of therapy of single-sex couples. Back then, I was very interested in this subject, I was working with heterosexual couples and I thought – what new could be here? I had a reaction – well, probably it will be similar and, out of interest, because there had been nothing more interesting to listen to, I went there, assuming that I will just listen, but thinking that probably nothing will surprise me. And I could not have been more mistaken. For me, this whole lecture was surprising. Then, I started to discover how many stereotypes I had, completely inadequate ones, totally unfitting to that thinking about single-sex couples. And then I became interested in it. Many people began to notice that I am interested in it, and patients started to come to me as well. It began when I talked with one, two, three persons about their experiences, because I knew that they had experiences in working with LGB persons, so they slowly, slowly began to recognize me, associate me with it. I also began to touch upon these subjects during conferences. In Kraków, few years ago, there was an interesting conference about therapy of couples, which I have been a co-organizer of, and it was interesting for me, that precisely there I have had a whole lecture about functioning of gays/lesbians. After the presentation, there have not been a single question from the audience. However, when the lecture ended and I went outside, to the corridor, suddenly many questions began. It was interesting for me, I was thinking what is it in this subject that, although I had a feeling that I am listened to very carefully, there had been no public questions, and suddenly, when I left, a whole lot of questions appeared in the corridor, in the back room.

It could be said that this issue appeared in my life due to some curiosity of mine. And such recognition of something what seemed to be otherwise, and by undermining of my own obviousnesses which I realized in Rome, good thing that not in Vatican.

And where did the idea for the book “*Wprowadzenie do psychologii LGB*” [“*An Introduction to LGB Psychology*”] come from?

From a certain helplessness. Together with Magda Mijas and Bartek Grabski, we felt that, when conducting classes with students, there was nothing to recommend for them to read. We could recommend English or Polish language texts but they were not always concerned with issues we wanted to introduce during classes with students. It turned out that there is a need for specific knowledge, e.g. a chapter about therapy, about history of the concept, about bisexual persons. It is an extremely important and underrepresented knowledge about regarding bisexual persons. After all, research shows that this is the group with the greatest difficulties. Since they can function both in heterosexual and homosexual relationships, bisexual persons have a lot of problems. It may seem that they have great large possibilities since they may enter into relationships with both persons of the same sex, and of opposite sex. Meanwhile, there is a lot of emotional tension in their life. They are rejected both in heterosexual communities, which do not trust them, and in homosexual ones, with accuse bisexual persons that in reality they are homosexual, but just do not disclose themselves. My peers, Magda Mijas, co-author of the textbook, and Marta Dora, PhD candidate at the Institute of Psychology of the Jagiellonian University, have recently conducted an interesting research consisting in analysis of advertisements appearing on portals where women search for women. It turned out that these advertisements often express unwillingness to establish relations with women who already are in relationships, or are bisexual. Therefore, they are, so to say, in a group of “rejected” by lesbians. Thus, psychological functioning of bisexual persons is an important and underestimated issue worth of exploration.

Splendid. Would you like to add anything else?

The most important thing that makes me happy is that, after all, this social awareness, also in specialists, grows. During classes with students and at therapeutic courses, I can see that these themes are sometimes accepted as certain obviousnesses – homophobic, heteronormative issues, heterosexism. I have an increasing feeling that I talk about subjects recognized by these groups. Maybe they do not completely know what to do with it, but it is not that we suddenly talk about aliens, we talk about real persons. During discussion, it suddenly turns out that most of us know such persons, and there is no special problem in relations with them. I think that it is also what researches show, that even those who have some prejudices towards homosexuality, when they know some gay or lesbian then they do not have issues in relations with them. And basically everybody knows someone.

Everybody knows someone but perhaps do not always know about it. Just like therapists you mentioned, who certainly met LGB persons in their longstanding practice, but these did not reveal their orientation to them

176 I think it is comforting that, when talking about LGB persons, we talk about something that is so surprising. What I observe is the lack of scientific discourse; on the other hand, the world-view, or ideological, one predominates, which seems ineffective to me because we may present our standpoints and it basically ends here. These are my views and it ends here. On the other hand, the issue of researches opens the room for reflection and change. It is a device that allows for the change of how counselling for LGB persons in Poland currently looks like.

RECOMMENDATIONS FOR POLISH SCIENTIFIC SOCIETIES REGARDING TREATMENT AND THERAPEUTIC ASSISTANCE FOR HOMO- AND BISEXUAL PERSONS

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Initiative group*

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The initiative group¹⁰³ and consultants representing scientific bodies agree with the statement of the World Health Organization (WHO)¹⁰⁴, according to which homosexuality, bisexuality and heterosexuality constitute equivalent and equal displays of human sexuality.

The existence of homosexuality, bisexuality and heterosexuality constitutes only few expressions of the broad range of interhuman diversity regarding all human features and properties. In the meantime, the view that as if homosexuality and bisexuality (in contrast to heterosexuality) constituted a physical illness, mental disorder, or health condition requiring therapeutic correction in itself, in the light of current scientific

¹⁰³ The initiative group consists of persons who began the process of gathering and formulating recommendations, and initiated the production of this document.

¹⁰⁴ See World Health Organization (1993).

knowledge based on research, turns out to be only a value judgement, and not scientific fact.

In compliance with the statement and recommendations of international scientific and therapeutic associations¹⁰⁵ concerning psychotherapeutic aid for LGB persons (lesbians, gays, bisexual persons), we state that, in the light on the current state of scientific knowledge, the proposal to correct the direction of psychosexual needs of homosexual and bisexual persons is as unfounded empirically and theoretically, as is the proposal to correct the direction of psychosexual needs of heterosexual persons. We recognize following the assumption typical for so-called “repair therapies” (also called “reparative” or “conversion”) in assistance work¹⁰⁶, according to which homosexual or bisexual needs of clients or patients in themselves would be an abnormality and require elimination as a requirement of achieving mental and physical health, as based on unfavourable moral judgements and inconsistent with professional ethics of professionals involved in aid for homosexual and bisexual persons¹⁰⁷. For it constitutes – in the light of research results until now, as well as reports of organizations which, until recently, conducted

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105 See American Psychiatric Association (2000): The American Psychiatric Association is opposed to any kind of treatment such as reparative or conversion therapy, which is based on an assumption that homosexuality in itself constitutes a mental disorder; or on an assumption that the patient should change their homosexual sexual orientation; American Psychoanalytic Association (2012): The psychoanalytic technique does not include intended efforts to “convert”, “repair”, change or shift somebody’s sexual orientation, gender identity, or gender expression. Directed efforts of this type are contrary to the fundamental principle of psychoanalytic treatment, and often result in significant psychological suffering due to their strengthening of internalized attitudes of destructive nature; cf. American Psychological Association (2008): All larger organizations focusing their activities around mental health have officially expressed concern about therapies calling for modification of sexual orientation. So far, no research fulfilling scientific standards and proving efficiency or safety of therapy aimed at changing sexual orientation (sometimes called “reparative” or “conversion” therapy) has been published. What is more – it seems that promoting a therapy aimed at [such] change reinforces stereotypes and contributes to maintaining of negative atmosphere around homosexual and bisexual women and men.

106 Using the term “therapy” to denote influences aimed at changing homo-/bisexual orientation to heterosexual (“conversion”) is not substantively justified. Therapy means “treatment”, and this should have its object. Persons undertaking to change somebody’s sexual orientation make both homo and bisexual orientation into objects of their influences, treating them as disorders. In the meantime, no sexual orientation constitutes a disorder, mental illness, or symptoms of these conditions – therefore, it may not be an object of treatment. In connection with this, influences directed at changing sexual orientation do not fulfill criteria which justify calling them a “therapy”.

107 Cf. Code of Professional Ethics for the Psychologist (2005).

“reparative” influences themselves – an action to the detriment of clients or patients¹⁰⁸.

Therapists, psychologists, physicians, and other specialists working or wanting to competently work at providing aid to LGB persons should acquire specialist knowledge and skills through constant involvement in the process of (self)education in the subject of LGB. So far, programmes of higher medical and psychological studies, as well as of the majority of therapeutic schools, do not sufficiently consider current knowledge specifically devoted to the subject of LGB. Learning this substantive knowledge is the condition necessary to provide professional assistance for this part of the population.

This document should be treated as a starting point for further recommendations regarding aid work for homosexual and bisexual persons.

We – the undersigned – appeal to persons concerned with psychological and medical aid, and to other specialists in mental health, for active opposition against stigmatisation of LGB persons persisting in the society – as based on unreliable knowledge and prejudices¹⁰⁹.

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¹⁰⁸ See American Psychiatric Association (2000), Bogle, Bussee and Marks (2007), Bogle (2007), Bussee (2007), Chambers (2013), Exodus International (2013), and Marks (2007)

¹⁰⁹ Since 1975, the American Psychological Association has been appealing to all specialists in mental health for active actions for removal of mental illness stigma associated with homosexuality (see Conger, 1975): Homosexuality in itself does not weaken the ability to make judgements, balance, conscientiousness, or general social skills and professional possibilities. Moreover, the American Psychological Association calls upon all specialists in mental health to provide example with their own actions for elimination of mental illness stigma long associated with homosexual orientations.

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DICTIONARY

Biphobia denotes prejudices towards bisexual persons. Biphobia may be found inside the LGBTQ community (e.g. “I would never date a bisexual girl because she would leave me for a man if only she had a chance”), and also in heterosexual environments (e.g.: “Eventually, he will settle down and get married”). Biphobia may also be internalised, what can be noticed when bisexual persons believe that they actually deserve bad treatment due to their identity (e.g. a feeling that they do not belong to the LGBTQ community if they date persons of “different sex”).

Cisgender is a category introduced by persons acting for transgender persons in order to name compatibility between possessed sex, felt gender (gender identity), gender, and other dimensions of sex. Such compatibility is evaluated as „normal” in the culture that assumes dichotomy and internal coherence of all dimensions of sex. A cisgender person, e.g. a ciswoman, fulfils social expectations connected with coherence between her sex registered at birth (she is specified to be a biological woman), gender identity (she feels like a woman), and gender expression (behaves and dresses in a way recognized by the society as feminine).

Coming-out („coming out of the closet”) is a personal (i.e. done to oneself) process of understanding, accepting, and acknowledging one’s own minority sexual orientation or gender identity and, at the same time, interpersonal (coming-out to other people) process of sharing this information with others. It is a continuous process that repeatedly occurs in lives of persons from the LGBTQ community. And although many persons believe that a person may be “inside” or “outside” of the so-called closet (“being in a closet” denotes non-disclosure of one’s sexual or gender identity), coming-out is usually connected with general openness towards others in regard to who one is. However, whenever a person faces a new situation, with new people involved, they must evaluate if sharing this information is safe and/or comfortable for them. Coming-out denotes examination of one’s affectional orientation and/or gender iden-

tity, as well as sharing it with others, including family, friends, people at the workplace, etc. Many times, this process may be arduous and difficult due to heterosexism, homo-, bi-, and transphobia, and similar phenomena. There are many different models which describe this process as a lifelong one for many LGBTQ persons.

Discrimination is an unequal, unjust treatment of a person due to their possessed trait. Reasons for discrimination may include, e.g. skin colour, age, religion, economic status, gender identity, sexual orientation. Discrimination may be direct (a situation in which a person is treated worse than others due to their membership to some group), or „indirect” (when apparently neutral and indiscriminate practice causes persons belonging to some group to find themselves in a less privileged position). Both forms of discrimination may lead to victimisation and persecution.

Discrimination is prohibited in Polish and European law, and there are certain detailed provisions regarding certain aspects of discrimination and types of situations which legislative authorities recognized as especially important (e.g. discrimination on the labour market). Discrimination is a form of oppression and may be connected with various kinds of violence.

Gender expression – an external manifestation of the individual’s gender identity, displayed by clothing, haircut, gestures and similar characteristics.

Gay – a man who is emotionally, sexually, mentally, and/or spiritually attracted to forming a relationship and sharing feelings with other men. In the English language, term gay is sometimes used to denote the whole LGBTQ community (e.g. gay pride, gay rights); however, in Polish it has no such application and most often it is used in regard to homosexual men.

Gender, or cultural sex, or socio-cultural sex identity. It is different from biological sex. Gender is a way of understanding, perceiving and attributing certain traits and behaviours to woman and man by the society and culture (*Gender – kulturowa tożsamość płci. Podręcznik dla trenerów. [Gender – Cultural Identity of Sex. Trainer Handbook]* (2005). Warsaw: Amnesty International, p. 21.) These constructs are established in re-

spective cultures and denote what is commonly recognized as proper for gender identity and gender expression (e.g. the division of types of clothing and colours into “masculine” and “feminine”).

Heteronormativity – a cultural assumption stating that everyone follows, or should follow, traditional standards of heterosexuality (e.g. man and woman meet, fall in love, get married, usually have children and remain together until the end of their lives). The foundation of heteronormativity is formed by an assumption about existence of two genders. Therefore, except of heterosexuality, heteronormativity reinforces the cultural assumption of gender binary.

Heterosexism refers to the assumption, or conviction, that all people are heterosexual, or should be. Heterosexism represents a system of ideology which denies the existence of rights, denigrates, ignores, marginalises, or stigmatizes anyone who belongs to the LGBTQ community by aiming to hush them up, or to make their existence in the society invisible. It is pervasive within the framework of social customs and institutions, and, in itself, similarly to other kinds of privileges, is not openly undermined in the dominant discourse, allowing for transfer of its idea from generation to generation in the process of socialization. The following statement is an example of heterosexism: “It is a pity for such a nice boy to be gay, to waste so much. He could have loads of girls!” - this sentence includes a hidden assumption that being heterosexual is in some way better, more valuable than being homosexual.

Homophobia is a prejudice towards lesbians, gays, bisexual persons, queers, persons questioning their sexuality, as well as phenomena connected with their culture or way of being. Homophobia also denotes behaviour motivated by prejudice, expressed in antipathy, aversion, irrational fear, distance, hatred, or violence towards persons perceived as gay, lesbian, bisexual, or transgender. Homophobia may also be internalised, what is visible when LGBQ persons believe that they actually deserve bad treatment due to their identity.

Homosexual – a term used in the past to describe a person who is emotionally, sexually, mentally, and/or spiritually attracted to form-

ing a relationship and sharing feelings with persons of “the same” sex. It should be remembered that many members of the LGBTQ community do not use this term to refer to themselves in connection with pejorative historical connotations related to it (e.g. usage of the term homosexuality in DSM and other clinical researches which classified it as a mental disorder). Therefore, we do not use that term in this publication. Instead of terms homosexual person or homosexual, we propose a term gay/lesbian. Sometimes we use a phrase “non-heterosexual persons” to denote all LGBTQ persons.

Intersexuality is defined as a state when one person possesses such physical traits (genetic, biological, anatomical, or physiological) that do not allow identifying their biological sex as unambiguously male or female.

Lesbian – a woman who is emotionally, sexually, mentally, and/or spiritually attracted to forming a relationship and sharing feelings with other women.

LGBTQ (acronym for lesbian, gay, bisexual, transgender, queer) may appear in an extended version, e.g. **LGBTQIQAF** (where I – intersexual, Q – questioning, A – ally, F – families and friends) – an abbreviation encompassing various kinds of non-heteronormative sexual and gender identities (lesbians, gays, bisexual, transgender, queer, intersexual, questioning persons), as well as their allies (A) and families and friends (F). In this publication, we employ the LGBTQ abbreviation, treating Q as an umbrella term denoting all non-normative gender and sexual identities.

Hate speech denotes various kinds of emotionally negative statements aimed against groups described as “worse”¹¹⁰. Hate speech includes statements (oral and written) and iconographic representations lying against, accusing, deriding, and humiliating groups and individu-

110 Lipowska-Teutsch, Anna, Ryłko, Ewa (eds.) (2010). *Przemoc motywowana uprzedzeniami. Przestępstwa nienawiści [Violence Motivated by Prejudice. Hate Crimes]*. Kraków: Towarzystwo Interwencji Kryzysowej, p. 11

als for reasons at least partially independent from them – such as race, ethnicity and religion, as well as sex¹¹¹, and others.

Oppression is a term used in this publication to denote the entirety of experiences of minority and disfavoured groups, connected with discrimination, violence motivated by prejudices, microinequalities, symbolic violence, and experiencing minority stress.

Affectional orientation – in some texts¹¹², authors employ the term affectional orientation instead of sexual orientation. Affectional orientation refers to the direction of needs (regarding sex, gender identity or gender expression) in emotional, physical, spiritual, and/or mental spheres. Using the term affectional orientation instead of sexual orientation is aimed at emphasis of multiple layers of relationships (emotional, sexual, spiritual, and mental), as well as reduction of emphasis placed on sexual behaviours as the only way of understanding one's identity. Due to the fact that identity of many persons is not exactly coherent with their sexual behaviours and desires (as exemplified in Kinsey's famous research which focused on sexual behaviours; as a result, it turned out that the occurrence of homo- and bisexual behaviours is significantly more frequent than it usually results from the majority of researches aimed at specifying the methods of self-identification with one's identity), using the term affectional orientation better reflects the multi-layered nature of identity. In this publication we employ the phrase sexual orientation as a synonym for affectional orientation.

Sexual orientation – denotes the emotional and physical attraction to persons of a specific sex, the direction of affectional, sexual, mental, and/or spiritual needs. It is a way in which a given person defines their

111 Kowalski, Sergiusz, Tulli, Magdalena. (2001) Mowa nienawiści. Raport 2001 [Hate Speech. 2001 Report]. Otwarta Rzeczpospolita, Warsaw: Stowarzyszenie Przeciwko Antysemityzmowi i Ksenofobii.

112 See ALGBTIC LGBQQIA Competencies Taskforce, Amney Harper, Pete Finnerty, Margarita Martinez, Amanda Brace, Hugh C. Crethar, Bob Loos, Brandon Harper, Stephanie Graham, Anneliese Singh, Michael Kocet, Linda Travis, Serena Lambert, Theodore Burnes, Lore M. Dickey & Tonya R. Hammer (2013): Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals, *Journal of LGBT Issues in Counseling*, 7:1, pp. 2-43. Available on 14.07.2013 from: <http://dx.doi.org/10.1080/15538605.2013.755444>.

sexuality from the point of view of persons in which they fall in love, or with whom they form intimate relations. It refers to emotions and general concept of oneself. These mentioned most often include heterosexual (attraction to persons of the opposite sex), homosexual (attraction to persons of “the same” sex), and bisexual (towards persons of different sexes) orientations. There are also other forms of expressing human sexuality, both named, e.g. asexuality (lack of need to maintain any sexual relations towards other persons), and unnamed. Provided categories are arbitrary, every person may specify their sexual orientation in a completely unique way, with a fully unique term. See gender identity.

Bisexual person– a woman or a man emotionally, sexually, mentally, and/or spiritually attracted to both women and men.

Cisgender person – a person who is normative in terms of gender. See cisgender.

Heterosexual person– a term used to denote a person emotionally, sexually, mentally, and/or spiritually attracted to forming a relationship and sharing feelings with persons of the opposite sex.

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Gay/lesbian – one of definitions of minority sexual identities – a person feeling affectional, sexual, mental, and/or spiritual attraction to persons of “the same” sex. See gay, lesbian.

Intersex person – a person whose biological sex cannot be unambiguously classified as “male” or “female”. The body may possess both female, and male traits, or it is difficult to unambiguously classify them as female or male. Formerly called hermaphrodite, although this term is still used by some members of intersexual persons’ community, it has lost many enthusiasts due to its negative characteristics. See intersexuality.

Transgender person– a person who is non-normative in terms of gender. See transgender.

Questioning persons – the term refers to persons who are not emotionally, sexually, mentally, and/or spiritually certain if they are attracted to women, men, both, or to people in general regardless of their sex.

Sex refers to corporeality. It is a set of diverse physical/anatomical traits which make people different.

Hate crime denotes any crime of criminal nature, aimed at people or their property, which includes choosing the victim or other targets because of their actual or alleged affiliation with or support of a group distinguished by characteristics common to its members, such as actual or assumed race, nationality or ethnic origin, language, skin colour, religion, sex, age, physical or mental disability, sexual orientation or other similar characteristics¹¹³.

Queer generally refers to persons self-identifying as non-heteronormative and/or outside of the dichotomic division of genders (e.g. persons from the LGBTQ community, persons who are against the institution of marriage, or those who practice polyamory). Queer may also have connotations with political identity, when a given person is also concerned with activism for rights of LGBTQ persons. Queer is also an umbrella term referring to the LGBTQ(IQA) community. In the past, in the Anglo-Saxon countries, it was, and still can be, used in a negative sense (weirdo, misfit) as an insult towards LGBTQ persons. However, in this publication, the word queer is used in connection with the transformation and recovery of this word's positive connotation by LGBTQ persons.

Sexism refers to oppression, persecution, discrimination, prejudices, displays of microaggression, etc., aimed at people in connection with their sex. Sexism is inseparably connected with heterosexism, for it is based on sets of behaviours which are deemed proper for women or men, including the expectation of entering into heterosexual relationships.

Ally – in this publication, this term refers to persons who provide – respectively – therapeutic or personal support to a person or persons who specify their identity as LGBTQ by themselves. Allies may be the loved ones, therapists, work colleagues, persons providing support, antidiscrimination and human rights activists, or any other persons supporting

¹¹³ Definition by the Office of Democratic Institutions and Human Rights (ODIHR) of the Organization for Security and Co-operation in Europe (OSCE). qtd. in: Lipowska-Teutsch, Anna, Ryłko, Ewa (eds.) (2010). *Przemoc motywowana uprzedzeniami. Przestępstwa nienawiści [Violence Motivated by Prejudice. Hate Crimes]*. Kraków: Towarzystwo Interwencji Kryzysowej, p. 11.

LGBTQ persons. They may be heterosexual persons, cisgender, or members of the LGBTQ community.

Stereotype is a widespread opinion or belief about certain social group and attributes of its members. Stereotypes replace knowledge, simply reality. They are acquired and perpetuated in the process of socialization. Stereotypes are characterized by persistence, resistance to attempts to change, and their evaluative nature.

Examples of stereotypes include a belief that gays possess traits culturally attributed to women (gentleness, caring about looks), and lesbians are more “masculine”.

Gender identity refers to the internal sense of being a man, a woman, both man and woman at the same time, or none of the above (describing one’s gender outside of the binary gender system). Gender identity usually complies with biological sex (registered at birth) of a given person (cisgender persons), but it also happens otherwise (transgender persons). Gender identity of a person may be specified only by a given person and nobody else.

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Sexual identity refers to how a person describes and names (or does not name) their gender and/or sexuality. Presently, within the queer theory, the term sexual orientation is being replaced by sexual identity, aimed at emphasizing self-description and subjectivity in defining one’s sex and sexuality. Sexual identity is different from sexual behaviour because it may, but does not have to, express itself in sexual behaviours.

Transphobia is a prejudice towards transgender, queer persons, or these whose behaviour effaces dominant gender standards. Transphobia may be found in the LGBTQ community (e.g. “I would never date a trans”), and in the heterosexual persons community (a phrase “Behave like a woman/man”). Transphobia may be internalised, what is visible when a transgender person believes that they actually deserved bad treatment due to their identity (e.g. exclusion from both the LGB community, and the heterosexual majority).

Transgender is an umbrella term used to describe identities of persons who doubt social standards of gender, including: queer persons, persons of non-conformist gender, transsexual persons, cross-dressers (transvestites, drag kings and drag queens), etc. Transgender includes all named and unnamed identities in which there is no socially expected compatibility between sex and its ascribed biological sex registered at birth, gender identity, and sex role fulfilled in the society, gender. Transgender is an umbrella term, including the whole human gender variety incompatible with cultural assumptions about gender. The opposite of transgender is cisgender.

Prejudice is a negative attitude towards certain social group and every person who belongs to it, or is associated with it. Prejudice may be manifested in antipathy, e.g. towards persons of different nationality, age, religion, or sexual orientation. In contrary to stereotype which consists mainly of cognitive component, prejudice is connected with experiencing negative emotions.

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Internalised homophobia– concerns non-heterosexual persons who assume that only heterosexuality is the correct form of a romantic-sexual relation; it is connected with non-acceptance of oneself as a gay/lesbian/bisexual person or non-heterosexual in another way (e.g. being in a relationship with a transgender person who does not specify their gender in an unambiguous way). Often coexists with prejudices and discrimination towards other LGBTQ persons.

Internalised transphobia– analogically to the internalised homophobia. It is a kind of internalised oppression, that is adoption of social stereotypes and prejudices about transgender persons. A form of internalised transphobia may consist in conditional acceptance of some transgender persons, e.g. those who adopt a label of disease and undergo the complete body modification operation towards woman or man, and lack of acceptance of those who undermine the gender binary system (e.g. define themselves as a “third gender”).

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DO YOU LIKE THIS PUBLICATION?

Campaign Against Homophobia (KPH) is a Poland-wide non-profit organization working for homo- and bisexual, as well as transgender persons (LGBT), and their families and friends, through advocacy, education and support. We provide legal and psychological aid, co-operate with governing bodies and media, train various professional and social groups, monitor Polish law for compliance with international standards of human rights, research the situation of LGBT persons, publish educational and informational materials, conduct social campaigns.

Our objective is full equality of LGBT persons. Our vision is a world in which human rights are respected, and everyone is treated equally and fairly, with respect to sexual orientation and gender identity.

Campaign Against Homophobia could do much more if it had greater amount of funds. We are a non-profit organization, i.e. we do not earn from our activities, and we aim for all our services and publications to be free of charge. However, we need financial resources in order to operate.

By supporting KPH, you may actively contribute to creating a society more friendly and safe for LGBT persons!

BECOME A SUPPORTING MEMBER!

Persons regularly supporting KPH may become supporting members. Regular support denotes aiding our actions through monthly payment of a specified amount (minimum PLN 10) for KPH, using the direct debit form.

HOW DOES IT WORK?

Fill 2 copies of the direct debit form, for the bank and for the association (included on the following pages), sign, and return by post free of charge to our address indicated on the envelope.

NOTE: LEAVE THE "PAYMENT IDENTIFIER" FIELD EMPTY.

- Once we receive filled forms, we shall submit one copy of the direct debit to the bank, which will verify the data and send us information about starting the direct debit.

- After correct verification, the bank transfers the amount you declared to the account of the Association on a monthly basis.
- In the case where there are no funds on your bank account in a given month, donations DO NOT accumulate in the next month.
- In order to cancel the direct debit, just send an e-mail with information about resignation from the direct debit to info@kph.org.pl, or resign at your bank.
- Direct debit is a safe form of support, and correct functioning is guaranteed by legal regulations, i.e. The Banking Law Act.

YOU CAN MAKE A ONE-TIME DONATION!

YOU CAN DONATE TO ONE OF OUR ACCOUNTS

in Euro (EUR):

BRE Bank SA

PL 17 1140 1010 0000 5270 5400 1002

SWIFT/BIC Code: BREX PL PW

in US Dollars (USD):

BRE Bank SA

PL 87 1140 1010 0000 5270 5400 1003

SWIFT/BIC Code: BREX PL PW

in Polish Zloty (PLN) and any other currencies:

Volkswagen Bank SA

PL 35 2130 0004 2001 0344 2274 0001

SWIFT/BIC Code: VOWAPLPI

Donations (support membership fees are donations too!) may be also deducted from income tax.

DONATE YOUR 1%

You can support us financially without contributing your money! It is enough to donate 1% of your tax to KPH – you will pay it to the State anyway. Just fill a proper blank in your annual tax return (PIT-36, PIT-37 or PIT-28). After calculating how much tax you have to pay, fill the last blanks of the tax return with a number **KRS 0000 111 209**.

You can also fill the tax return on-line, using a FREE SOFTWARE available at www.lprocent.kph.org.pl

CONSENT FOR DEBIT ENTRY

I HEREBY AUTHORIZE

STOWARZYSZENIE KAMPANIA PRZECIWI HOMOFOBII

UL. SOLEC 30A

00-403 WARSZAWA

ORIGINATOR'S IDENTIFICATION NUMBER (NIP) 521-32-04-077

To debit the bank account indicated below via direct debit, with amounts resulting from my obligation, within 10th day of each month.

I want to support the Campaign Against Homophobia with the following amount:

PLN 10; PLN 20; PLN 30; PLN ...

- I want to become a supporting member of KPH
- I do not wish to receive materials by post
- Name and full address of the Payer/Donor
- Telephone number and e-mail
- Date of birth (dd,mm,rr)
- Bank account number of the Payer/Donor in the NRB format
- Name of the bank running the bank account of the Payer/Donor
- Payment identifier
- Place and date
- Signature of the Payer/Donor – account owner, consistent with the signatures card in the bank

Simultaneously, this document consists a consent for the bank indicated above to debit my bank account via direct debit under my obligation to the aforementioned payee. The withdrawal of consent is required to be made in writing, under pain of invalidity.

I agree for my personal details to be used by the Kampania Przeciw Homofobii Association based in Warsaw at ul. Solec 30A, for the purpose of sending me information materials about activities of the Association, by post and electronic means of communication. I have been informed that I give my personal data voluntarily, and that I am entitled to access and amend it.

CONSENT FOR DEBIT ENTRY

I HEREBY AUTHORIZE

STOWARZYSZENIE KAMPANIA PRZECIW HOMOFOBII

UL. SOLEC 30A

00-403 WARSZAWA

ORIGINATOR'S IDENTIFICATION NUMBER (NIP) 521-32-04-077

To debit the bank account indicated below via direct debit, with amounts resulting from my obligation, within 10th day of each month.

- Name and full address of the Payer/Donor
- Address
- Date of birth (dd,mm,rr)
- Bank account number of the Payer/Donor in the NRB format
- Name of the bank running the bank account of the Payer/Donor
- Place and date
- Signature of the Payer/Donor – account owner, consistent with the signatures card in the bank

Simultaneously, this document consists a consent for the bank indicated above to debit my bank account via direct debit under my obligation to the aforementioned payee. The withdrawal of consent is required to be made in writing, under pain of invalidity.

The book you have in front of you is much needed, as well as interesting and accurate. Authors present the specificity of social context of functioning of non-heterosexual persons, discuss the subject of emotional difficulties resulting from this context, present the principles of providing support and psychological assistance to this group of clients. Interviews with four distinguished experts professionally involved in psychotherapeutic aid for non-heterosexual persons, as well as expert recommendations for Polish scientific associations, are extremely interesting additions to the main text. The publication should constitute an important reading for a broad circle of receivers professionally engaged in upbringing, assistance, and treatment.

Bartosz Grabski, MD, PhD

UJ CM Department of Psychiatry

The book is addressed to persons supporting individuals experiencing oppression motivated by homophobia. It presents issues connected with providing ethical and responsible psychological support to individuals exposed to violence motivated by prejudices and living in a society which shares these prejudices in a worrying degree. It points at the trap of perceiving the oppressed persons through their intrapsychical processes, disregarding the permanent threat for minority groups (minority stress). It opens the possibility of building the space of liberation in therapeutic relation – a space of understanding personal experience in the socio-political, cultural, and historical contexts, recovery of agency and control, essential for the sense of pride and empowerment.

Anna Lipowska-Teutsch

Crisis Intervention Society