Queering the developmental model: *(De)*-constructing identities, experience, & building resilience in relational therapy

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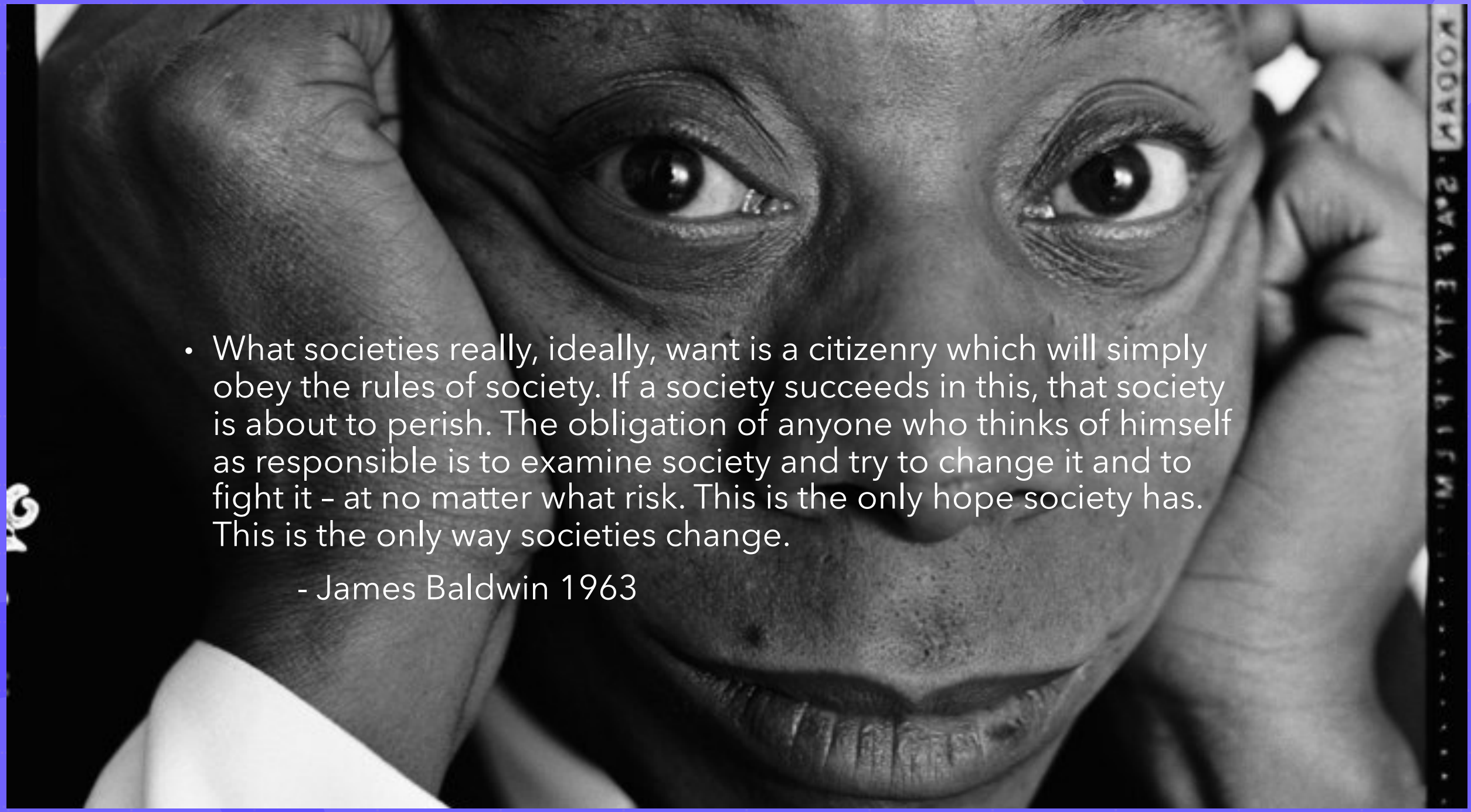
• What societies really, ideally, want is a citizenry which will simply obey the rules of society. If a society succeeds in this, that society is about to perish. The obligation of anyone who thinks of himself as responsible is to examine society and try to change it and to fight it – at no matter what risk. This is the only hope society has. This is the only way societies change.
- James Baldwin 1963

Objectives

At the completion of this presentation participants will be able to;

Frame how relational therapies inadvertently, reinforce and propagate systems of oppression that collude with racism, heteronormativity, misogyny, classism, ableism & ageism

Add a queer exploration to the self of the therapist in relationship to the systems that we interact with and expand the practice of couples and relational therapy.

Have a foundational understanding of queer theory and its application to relational psychotherapy via The Developmental Model.

An agreement

- Make space – Take space
- Safety vs. Comfort
- Notice your positionality & privileges
- Speak from your own truth
- Notice your body, feelings, & breathing
- Ask questions
- Take what works

Systems, Critical Theories, & White Supremacy

(Minuchin, 1974, Hall & Carlson 2016, Feola, 2021, Schouler-Ocak et al, 2021)

- *Systems have rules, roles, hierarchies, boundaries, structures & narratives to secure their boundaries*
- *When challenged to change or adapt to the needs of its members; systems either adapt or resist*
- *Racism, heteronormativity, classism, ageism & ableism are cultural narratives that secure homeostasis*
- *These 0 sum narratives are taught, womb to tomb, at intersecting levels of cultural experience;*

Micro: *FOO Identities, Region, neighborhood, resources & access, language, historical narratives, friends, neighbors, religion, SES, education, gender & sexuality, body integrity, biases, media, politics, absence of exposure*

Mezzo: *Region, community, state, historical narratives, resources & access, education, economic, gender & sexuality, local law, policies, media, policing, history & holidays, erasure of voice*

Macro: *National & international: resources & access, historical & national mythologies & narratives. patriotism, biases, gender & sexuality, in-groups & outgroups, laws, policies, agencies, history & holidays, economics, media, war, opposition to power sharing*

- *We can clinically & personally challenge these messages – or passively support them*

Orienting experience

- When did you **learn** you were *heterosexual, able-bodied, or cis-gender or white*?
- How have these ***intersecting identities*** formed how you ***see*** yourself, the world, & relationships?
- What ***narratives*** live in your whiteness, heterosexuality, able-bodied-ness or cisness?
- When did you ***come out to*** *others about being* white, or straight, or able-bodied or cis?
- What ***risks*** do you take ***to connect*** with white or straight or able-bodied or cis communities?
- What ***laws against*** *straight*, cis, able-bodied, or white people impact your **community**?
- What ***resistance to unjust policies*** do straight, cis, able-bodied, or white folks celebrate?
- What's the ***most important*** thing to know abut *straight or cis or able-bodied or white* experience?

What *is* 'Queer theory'

- Queer theory is a collection of postulates explored by QBIPOC & LGBTQIA+ researchers, social commentators, legal scholars, & clinicians exploring how privilege & power is maintained by dominant cultural groups (e.g., white, male, cis, Christian, heterosexual, class privileged & able-bodied), through institutions (e.g., education, economics, health care, laws, prisons, social, political & religious ideologies) that oppress the voices & knowledge of queer & marginalized people through structural, physical, & psychological violence centered in acts and narratives of racism, heteronormativity, misogyny, ableism, & ageism. (Butler, 1990, Sullivan, 1990, Rubin, 1992, Ferguson, 2004, Bernstein-Sycamore, 2008, Knauer, 2011, McRuer & Mollow, 2012, Logie & Jolie-Rwigema, 2014, van Anders, 2015, Argüllo, 2016, Barker & Scheel, 2016, Odets, 2019, Fleishman, 2020,Ward, 2020, Fielding, 2021).

- This process is seen in the absence of research about LGBTQIA +, & QIPOC family & relational dynamics in clinical literature & practice (Pepping et al, 2018, Spengler & DeVore, 2019, Spengler & Lee, 2020, Harvey et al, 2020).

- And is evidenced in the experiences of LGBTQIA +, & QIPOC reporting consistent micro-aggressions from cis & heteronormative clinicians (Sue et al, 2007, Shelton & Delgado-Romero, 2011, Spengler, Miller & Spengler 2016).

Weaving Queerness & CRT into therapy

Critical Race Theory explores how social, legal, & economic laws, biases, and practices maintain white supremacy at the expense of BIPOC & other marginalized communities (Matsuda, et al, 1993, Delgado & Stefanic, 2001).

Kimberly Crenshaw coined the term intersectionality in 1989 to describe how intersecting social identities create complex & unique systems of racial oppression among Black women, she later expanded the concept to describe the struggles of feminism in dealing with the sexual assault of Black women. (Crenshaw, 1989, 1992). Intersectionality & CRT also examine how marginalization communities are impacted by minority stress & injured at the physical & psychological level well being. (Geronimus, 1992, Carter, 2007, Wood-Griscombé, 2010, Smith et al., 2011, Franklin, 2014, DeGruy, 2017)

Understanding how systems of oppression interact to shape culture and our client's experiences, mental & physical health, as well as its impact on dominant cultural clinicians expands how we interrogate *our privileges & biases*, while exploring assessment & intervention options that embrace social justice in clinical practice (Motulsky et al, 2014).

Sexual & Relational Health

What is sexual health & relational health?

"…a state of physical, emotional, mental and *social well-being* in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

For sexual health to be attained & maintained, the sexual rights of all persons must be respected, protected and fulfilled." *(WHO, 2006a)*

The take away: To be an effective relational therapist means exploring the roles of coercion, discrimination & violence within the culture & the systems we work with/in. This requires a critical analysis of the ways in which we, as clinicians, have learned to construct what 'healthy' sex & sexuality is as well as how those beliefs impact our clinical practice.

Exploring The Self of The Therapist

Person of The Therapist

Maximizes the knowledge of self by identifying feelings, & biases that arise in therapy & the therapist while exploring how these experiences impact play our lives & practices.

Provides deeper mastery of self, our strengths & woundedness, by allowing for a more active, process driven & conscious use of self when assessing & intervening with clients.

Common Key Signature issues: fear of vulnerability, fear of rejection, fear of not being good enough, fear of not being in control, and fear of not being seen.

Source: Aponte, H., Kissel, K. (2016). The person of the therapist training model: Mastering the use of self. New York, NY: Routledge.

Sexological world view

The unexamined and changeable perspectives held by each of us concerning our values, beliefs, opinions and perspectives on relationships, sexual behavior, sexual orientation, gender roles and identity, etc. . .

The purpose of SWV is to examine our personal sense of sexual and erotic diversity and its impact on our work as professionals.

Source: Sitron, J. & Dyson, D. (2012). Validation of sexological worldview a construct for use in the training of sexologists in sexual diversity. *SAGE Open*, 2(1), 1-16, DOI: 10.1177/2158244012439072.

Bringing it all together

Developmental Model Assumptions

Relationships move through developmental stages e.g., bonding, practicing, rapprochement & synergy, akin to Mahler's attachment theory.

Struggles in relationship are related to attachment injuries hindering differentiation & conflict resolution.
Intervention is focused on developing a differentiated, inter-connected & less reactive sense of self.

The does not directly explore racism, heteronormativity, misogyny, classism, ableism & ageism as impacting development self & relational processes, or conflict management strategies.

Queering The Developmental Model

The developmental processes of BIPOC & LGBTQIA + people are complicated by racism, heteronormativity, misogyny, classism, ableism & ageism (Cross 1971, 1991, 2001, Poston, 1990, Ferdman & Gallegos, 2001, Kim, 2001, Horse, 2005, Balsem et al, 2011, Syed et al, 2018, Chisolm, 2020).

Well-meaning clinicians are often unaware of the complex developmental experiences of BIPOC & LGBTQIA + people.

The DM can be adapted to address these experiences & expand cultural 'differentiation' while expanding social justice as a tool of relational therapy.

Benefits of Critical & Clinical Integration

Technician = 'Knower'

- Model Compliance: Follow steps & protocol
- Clinician is expert, knower, and leader
- *May* recognize personal biases, privileges, power & identities
- Ahistorical, Non-intersectional & non-political
- Focused on micro-level experiences
- Fixed assessment process centered in pathology
- Attachment & differentiation
- Reinforces gender & sex performativity
- Erases erotological development
- Fixed goals and pathways (client goals secondary)
- Fixed interventions
- Process is model driven
- Centers homogeneity

Clinician = 'Potentiality'

- Model creation: Sits with uncertainty, & tailored intervention
- Clinician is co-learner, coach, therapist, educator
- Recognizes personal biases, privileges, power & identities
- Historical, intersectional, & politically attuned
- Focused on micro, mezzo, macro experiences
- Fluid assessment centered in adaptation
- Attachment & differentiation psyche, & system
- Challenges gender & sex performativity
- Embraces erotological development
- Goals are based on client desire and non-linear
- Interventions are adaptive to need
- Model is process driven
- Centers heterogeneity

"If you have come here to help me, you are wasting your time...

...But if you have come because your liberation is bound up with mine, then let us work together."

- Lilla Watson