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Internalized homophobia: A spiritually integrated psychotherapeutic approach using the principles of complex thinking

Daniel Rzondzinski[1]

1. Introduction

The goal of this article is to explain how a complex spiritually integrated psychotherapeutic model for assessment and treatment of internalized homophobia—rejection of sexual or gender identity because of negative psycho-social conditions—was developed. This work states that internalized homophobia is a product of the internalization of compulsory heteronormativity (based on homophobic principles coming from some Judeo-Christian perspectives) in the minds of 2SLGBTQ+ people, which leads to their rejection of their own true genders and sexual orientation identities.

The French philosopher and sociologist Edgar Morin (1999) suggests in his book *Introduction to Complex Thinking* that the main goal of complex thinking is to explain how disciplinary domains separated by the principle of simplification[2] can be integrated. Consequently, complex thinking attempts to integrate these disciplinary domains to achieve a multidimensional and holistic knowledge of reality. By definition, complex thinking is in direct opposition to the principle of simplification. However, complex thinking acknowledges the impossibility of omniscience. There is in complex thinking an internal tension, an ambivalence, between its goal of achieving this integration and the impossibility of achieving this goal. Morin says:

> The ambition of complex thinking emphasizes the articulations among disciplinary landscapes broken by the paradigm of simplification (one of the most important aspects of the paradigm of simplification); it isolates what it divides and it hides what it leaves out, it interferes. Complex thinking attempts to achieve multidimensional knowledge. However, complex thinking recognizes that complete knowledge is impossible to reach. One axiom of complex thinking is to state the theoretical or pragmatic impossibility of any kind of omniscience. Complex thinking is affected by an internal tension between its desire to achieve non-fragmented knowledge, not divided, not reduced; and the recognition that every knowledge is incomplete. [3] (p. 22)

The psychotherapeutic model presented in this article attempts to correct reductionism produced by the application of the principle of simplification. In order to do that, the model presented in this article integrates the conscious and unconscious levels of reality and includes the psychoanalytic concepts of unconscious desire and mandate. From

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[2] From Edgar Morin's point of view, the principle of simplification reduces or separates what has to be integrated, modifying the true nature of the object of study.

[3] Translation by the author.

the narrative perspective, the model includes the concept of externalizing conversations. Some principles of *2SLGBTQ+ affirmative psychotherapy* are also included. Finally, the model includes the concepts of spirituality and religion. In relation to these concepts, Nelson (2004) differentiates them in the following way:

> Our spirituality is our response to our human sense of incompleteness—whatever form that response might take … Religion, on the other hand, is the communal expression of that response—when persons bound together by similar spirituality develop group patterns of nurturing, expressing, extending, and preserving those experiences. (Nelson, 2004, p. 22)

The model presented in this article also emphasizes the concept of *spiritually integrated psychotherapy.* Pargament (2011) says:

> In this sense, spiritually integrated psychotherapy is neither a self-contained form of therapy nor a competitor to other types of treatment. Rather, it is a therapeutic approach that extends and enriches many forms of therapy by focusing more explicit attention on the spiritual dimension of people, their problems, their resources, and the process of change. One way spiritually integrated psychotherapy can enhance others modes of treatment is by providing another perspective on psychological problems. (p. 195)

The integration of these various psychotherapeutic models, approaches, and new technical concepts is facilitated by principles of complex thinking such as the dialogical principle, the recursive principle, the hologrammatic principle, the emergent principle, the eco-self-organization principle, and the fuzziness principle. These principles are explained below.

As stated above, the goal of complex thinking is in opposition to the use of the principle of simplification. Applying the principle of simplification is a type of reductionism. Reductionism has been used in the field of mental health for centuries.

> At the end of the nineteenth century and the beginning of the twentieth century, social sciences adopted scientific methods from physics, biology, and chemistry in order to be considered true scientific disciplines. Classical science uses two principles: disjunction and reduction. Disjunction means disconnection, separation, the parts from the whole or the whole from its context. Reduction means simplification, making simple something complex in nature and consequently changing the nature of the object. These strategies represent the two principles of the paradigm of simplification. (Rzondzinski, 2018, p. 1)

First, reductionism was used by classical psychiatry from the 16th to the 18th century. Next, reductionism was used by positivist (anatomical-physiological) psychiatry in the 19th century. Then reductionism was used by the (bio-chemical and genetic) medical psychiatry of the 20th century. Finally, the same kind of reductionism is used by neurosciences and psychiatry in our present century.

In the mental health field, reductionism is based on the idea that human subjectivity can be reduced to biological explanations such as genetics. From this point of view, biology,

biochemistry, and genetics can potentially explain the origin of any mental illness or mental health disorder. Following this position, these sciences can potentially completely explain the nature of human subjectivity.

Similar reductionist and homophobic ideology has been expressed by the Catholic Church and some Protestant and Jewish groups based on principles of "natural law." The Catechism of the Catholic Church (1993) says this about homosexuality: "homosexual acts are intrinsically disordered. They are contrary to natural law" (p. 128). In addition, there are the well-known references in the Bible. Among the most famous: "You shall not lie with a male as with a woman; it is an abomination" (NRSVUE, 2022, Leviticus 22:18) and "Males committed shameless acts with males and received in their own persons the due penalty for their error" (NRSVUE, 2022, Romans 1:27).

Natural law sustains heteronormativity and heterosexism. This means it sustains a traditional binary perspective of gender roles and rejection of any alternatives for gender, sexual orientations and/or sexual expressions.

The model presented in this article rejects this type of reductionism. Human nature cannot ultimately be explained only by biology, biochemistry, genetics, or natural law. From the perspective of complex thinking, human subjectivity might be explained much better by art, literature, philosophy, mythology, etc.

2. Morin's Principles of Complex Thinking

Edgar Morin (1999) developed the principle of simplification explained above. He also described six principles of complex thinking:

The Dialogical Principle.

This principle unifies two ideas that are necessary to explain a particular phenomenon, but which are mutually exclusive.

The Recursive Principle.

This principle, which is connected with the ideas of self-production and self-organization, states that the producer is modified by the product and the product is modified by the producer. These ideas are important for explaining complex systems such as the nature of life, the solar system, the universe, industrial society and the unconscious.

The Hologrammatic Principle.

This principle explains an important aspect of complex systems. In every complex system, the wholeness of the system is present in each part of the system. At the same time, each part of the system is present in the wholeness of the system.

The Emergent Principle. This principle recognizes how complex systems produce new attributes or properties.

The Eco-Self-Organization Principle.

This principle establishes the importance of considering the internal logic of a complex system, the system's external logic (environment), and the differences between the two. The producer needs to be understood in relation to the context. This principle encourages paying close attention to the ecological context of the complex system. For example, when a therapist is working with a 2SLGBTQ+ subject (complex system), the therapist needs to

understand how the homophobic social context (ecological context) of the client determined the internalized homophobia.

The Fuzziness Principle.

This principle establishes that it is impossible to predict with precision the behaviour of a complex system. A human being is a complex system. Due to that, it is impossible to predict with precision the outcome of any therapeutic process. If 2SLGBTQ+ people are dealing with internalized homophobia, the fuzziness principle suggests that the outcome of their treatment will be unpredictable because each person is a unique complex system.

3. 2SLGBTQ+ Affirmative Framework

In the 19th and 20th centuries, psychiatry and psychoanalysis considered transgender identities, like non-normative gender and sexual identities, to be expressions of mental health disorders. The 2SLGBTQ+ community has fought against this practice of pathologizing based on a heterosexist and heteronormative ideology and a lack of relevant scientific data. Because psychiatry and psychoanalysis have followed a biological reductionist perspective on sexuality, professionals in these fields have had great difficulty understanding sexuality as being socially and historically constructed, as Michel Foucault pointed out in 1976. Tamsin Spargo (1999) says the following:

> Has sexuality always been waiting for us to free it, and with it ourselves, from social constraints? Foucault rejected this "repressive hypothesis" and claimed that evidence from the 19th century pointed not to a prohibition on speaking about sexuality but to a remarkable proliferation of discourses about sexuality. So what was, is, sexuality? A vital feature of Foucault's argument is that sexuality is not a natural feature or fact of human life but a constructed category of experience which has historical, social and cultural, rather than biological, origins. (p. 12)

Traditional scientific views on 2SLGBTQ+ issues, for example, the Diagnostic and Statistical Manual of Mental Health Disorders first and second editions as outlined by Jack Drescher (2015), have been confronted by more recent political perspectives. This confrontation, along with new discoveries in the fields of gender and sexuality, has changed psychiatric and psychoanalytical approaches to working with 2SLGBTQ+ issues. Currently, many psychiatrists treat transgender subjects who suffer from gender dysphoria, and many psychoanalysts help transgender people follow their unconscious desires related to gender identification. Both groups of professionals avoid pathologizing transgender people or subjects with other gender and sexual identities.

From a historical perspective, it is possible to see that transgender identities were associated with homosexuality. It was a common belief that many homosexual subjects would become transgender people. Consequently, homosexuality was viewed as a transitional stage leading to a transgender identity. Another mistaken yet widely held view was that homosexual identity and transgender identity together represented a third sexuality outside heteronormativity.

An additional belief system, still considered valid by conservative Christians and other conservative religious groups, states that homosexuality and other sexual and gender identities are expressions of the Self which is damaged and needs to be repaired. Joe Kort (2018) describes "reparative therapy" in the following terms:

> Traditionally, psychology viewed homosexuality as a "stage" toward the natural eventual goal of heterosexuality. There still a belief among psychologists, social workers, and counsellors that homosexuality is just "straight gone bad," and that it is a behaviour rather than a true orientation. The belief is that 2SLGBTQ people are individuals who didn't make it out of childhood or adolescence successfully. They are developmentally stalled and somehow damaged, like a moth whose wings did not open fully when it emerged from its cocoon. This theory leads many psychotherapists to believe that in adolescence, young men and women get a second chance to "repair" their homosexuality. But trying to repair something that is not broken does an untold amount of damage to these young people's lives. (p. 3)

The therapeutic model presented in this article follows the framework of affirmative psychotherapy of 2SLGBTQ+ identities. Rather than pathologizing 2SLGBTQ+ identities, this model embraces these identities and sustains them against heterosexism and heteronormativity.

4. Freud, Foucault, and White: Towards a New Perspective

Sigmund Freud (1923), being a scientist and a neurologist, developed a new perspective on human subjectivity. He introduced the concept of the unconscious and developed psychoanalysis.

In psychoanalysis, Freud introduced such concepts as the ego, the superego, and the id, and described how the conscious, pre-conscious, and unconscious systems interact. His approach focused on how to make conscious what is unconscious so that the subject can become aware of unconscious desires. The psychotherapeutic model presented in this article supports Freud's approach.

Foucault (1976) allows us to understand the complex interaction among power, knowledge, and sexuality, as well as concepts such as panopticon, social orthopedic, and disciplinarian society. By reflecting on these ideas, White was able to develop "narrative therapy" and introduce the concept of "externalizing conversations."

Michael White (2007) indicates that many psychological problems are socially and historically constructed and are internalized in the mind of the subject. This article states that internalized homophobia is a socially constructed problem. This phenomenon can be explained because a negative dominant social narrative about the identity of 2SLGBTQ+ people named *social homophobia* was developed by the Christian church, and it was expanded in all Western societies. At the same time, social homophobia was supported by classical and positivist psychiatry from the 16th to 19th century. Consequently, the externalization of the problem (internalized homophobia) is the most important clinical strategy in the psychotherapeutic model presented below as well as in White's way of thinking.

White says that a person's identity is determined by the problem. A subject who is homosexual and lives in a homophobic society might have internalized a negative idea about being homosexual; consequently, being homosexual is seen as the problem. The subject may state that being homosexual is a deviation, a pathology, and an illness.

This point of view, in which the subject believes that being homosexual is the problem (so the subject is the problem), determines a negative perception of their own true subjectivity.

The subject might experience strong rejection of their true gender and/or sexual orientation, creating a difficult internal ambivalence conflict between the true gender/sexual identity and the internalized homophobia.

White states:

> Externalizing conversations can provide an antidote to these internal understandings by objectifying the problem. They employ practices of objectification of the problem against cultural practices of objectification of people. This makes it possible for people to experience an identity that is separate from the problem; the problem becomes the problem, not the person. In the context of externalizing conversations, the problem ceases to represent the "truth" about people's identities, and options for successful problem resolution suddenly become visible and accessible. (2007, p. 9)

5. Externalizing the Internalized Homophobia

The psychotherapeutic model described in this article also focuses on the separation of the subject's identity from the problem. By learning about the social and historical nature of homophobia, subjects can separate their internalized homophobia from their identity. They will be able to understand that the problem is not their own identity; the problem is the homophobia of their family, community, and social context. The therapist will emphasize that there is nothing wrong with the subject. The real psychopathology is not coming from within, it is coming from the homophobic society.

It is important to help clients understand that rejecting their true subjectivity to please the heteronormative social order will reinforce their internalized homophobia and any associated disorders such as depression, anxiety, and suicidal ideation. The only way for subjects to stop their illness is to accept their true identity and become the person they want to be.

6. Homophobia as a Socio-Sexual Discourse

From a historical approach, it is possible to affirm that homophobia is a result of a socio-sexual discourse that imposes compulsory heteronormativity. This discourse was imposed through the use of the technology of power described by Foucault in 1975. This technology has the ability to do the following:

- Accumulate power and knowledge
- Normalize and correct dysfunctional individual and collective behaviours using instruments such as the panopticon and social orthopedics
- Define how gender is socially constructed
- Allow the male gender to oppress the female gender
- Oppress other transgressor subjectivities assimilated to the female gender

Cruz Sierra (2011) says:

> If the power is a gigantic technology that is going through all social relationships, a machine which has the capacity to produce domination as its effects obtained through certain peculiar strategies and specific tasks, it is important to identify what

> mechanisms, instruments and strategies allow certain subjects to segregate and marginalize others who use their bodies to obtain pleasure differently from the heterosexual norm. The homosexual context that is associated is determined by several factors: the rejection of sexual diversity by religious discourse, the rejection of sexual diversity by social discourse (homosexuality is an immoral act), the rejection of sexual diversity by psychiatry and psychology (homosexuality is associated with sickness), the persecution of sexual diversity by the police and the repression of it by the legal system. The homosexual context can be diverse and it can impact differently among male and female populations.[4] (p. 41)

7. Homophobia as a Complex and Multidimensional Phenomenon

The model presented in this article is based on the idea that homophobia, lesbophobia, biphobia, and transphobia are complex and multidimensional phenomena, which involve the personal, interpersonal, cultural, social, historical, and political dimensions. Morin (1999) says about complexity:

> In fact there is complexity whenever the various elements (economic, political, sociological, psychological, emotional, mythological...) that compose a whole are inseparable, and there is inter-retroactive, interactive, interdependent tissue between the subject of knowledge and its context, the parts and the whole, the whole and the parts, the parts amongst themselves. Complexity is therefore the bond between unity and multiplicity. Developments proper to our planetary era confront us more frequently, ineluctably with the challenge of complexity. (p. 15)

Historically, the term *homophobia* was defined as social discrimination against and rejection of male homosexuals. This definition, which addresses only one gender and only the social dimension of homophobia, fails to recognize that homophobia is also a multidimensional phenomenon.

Later, the concept of internalized homophobia was developed to refer to the internalization of social homophobia in the mind of a male homosexual, causing the person to have a negative perception of his sexual identity. At present, the concept of internalized homophobia has been extended to include the entire 2SLGBTQ+ population.

In 1972, in his book *Society and the Healthy Homosexual*, the American psychologist George Weinberg provided a first definition and description of the nature of homophobia. Then, others developed the concepts of lesbophobia (discrimination against and rejection of homosexual women), biphobia (discrimination against and rejection of bisexual people), transphobia (discrimination against and rejection of transgender people), and queer-phobia (discrimination against and rejection of queer people). Hereafter, the term *homophobia* is used as an umbrella term that includes all these phobias. Note that the concept of homophobia referred to in this article is socio-anthropological in nature and does not meet the criteria for a phobia in psychoanalysis or in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5).

In the abbreviation 2SLGBTQ+, the number “2” and the letter “S” means *Two Spirited*, a concept developed by Indigenous people on the American continent. This person is a male-bodied person with a feminine essence or female-bodied person with a masculine essence.

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[4] Translated by the author.

The concept of "Two Spirits" can cross social gender roles, gender expression, and sexual orientation. The next three letters stand for *lesbian*, *gay*, and *bisexual*. The "T" is sometimes understood to stand for *transvestite* or *transsexual*, or for *transgender*, a category that includes transvestites and transsexuals. The "Q" stands for *queer* (rejects any possible binarism) and the plus sign for other sexualities and gender identities not included in the categories mentioned above. The most important commonality that defines the 2SLGBTQ+ community is its opposition to the concept of heteronormativity.

In this article, homophobia is described as a multidimensional phenomenon. Following ideas from Madragón (2009) and Morin (1999), homophobia can be described in relation to each of its contextual dimensions: personal, interpersonal, institutional, cultural, social, political, and historical.

- *Personal* homophobia happens when a subject believes that 2SLGBTQ+ people are suffering from a genetic or mental health disorder and are unable to control sexual desires that are considered deviant and immoral.
- *Interpersonal* homophobia affects the relationship between two people in an institutional context. This kind of homophobia happens when the homophobic subject rejects and discriminates against the 2SLGBTQ+ subject or subjects in an institutional context through the use of insults, social isolation (e.g., at workplace or school), and emotional or physical violence.
- *Institutional* homophobia is expressed through homophobic discourses and practices in various institutions, including political, governmental, educational, medical, and religious institutions, as well as companies. The most important homophobic institution in human history is the Catholic Church. The discourse of the Catholic Church attacks every sexual act without the aim of reproduction (e.g., masturbation). The homophobic discourse from the Catholic Church has contributed to a broader rejection of and discrimination against 2SLGBTQ+ people around the world and to supporting homophobia in the cultural dimension.
- *Cultural* homophobia is expressed through social norms, behavioural codes, and regulations. This type of homophobia can be unconscious or conscious, expressed implicitly or explicitly, and intentional or unintentional, in the laws formulated by the legal system. Cultural homophobia has always legitimated the social and sexual oppression of the 2SLGBTQ+ population. Many countries in the world do not grant any legal rights and protection to the 2SLGBTQ+ population. Several Islamic countries from Africa punish by death any homosexual activity. Same-sex marriages, adoption by 2SLGBTQ+ couples, and gender changes are permitted by only a few countries in Europe and the American continent.
- *Social* homophobia is expressed in a social system (society) through negative socio-sexual discourse related to 2SLGBTQ+ people. This discourse promotes heteronormativity and characterizes 2SLGBTQ+ sexual activity as abnormal. The level of social homophobia varies among societies: some are extremely homophobic while others are much more tolerant.
- *Political* homophobia refers to homophobia supported by the government of society. A dominant political party can establish what is and is not acceptable. In Nazi Germany, 2SLGBTQ+ people were murdered in concentration camps along with Jews

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and other ethnic minorities. The current Russian government supports discriminatory discourse against 2SLGBTQ+ people.

- *Historical* homophobia is homophobia based on developments in human history. Foucault (1976) argued that the concept of normality in relation to sexual practices is an artificial construct determined by historical developments. Levels of homophobia and homophobic behaviours have changed throughout history. Negative socio-sexual discourse based on heteronormative ideology produces internalized homophobia in the 2SLGBTQ+ population. Consequently, 2SLGBTQ+ people believe that their gender identity or sexual orientation is a deviation from normality. This situation negatively affects their psycho-sexual development.

8. From Heteronormativity to Internalized Homophobia

The term *heteronormativity*, introduced by Warner (1991), refers to the normalization of heterosexuality—the dominant sexual identity—and the pathologization of alternative sexualities as resulting from the existence of power relationships affecting human sexuality.

In order to develop a stable sexual identity and a healthy attitude toward it, which involves integrating this identity into the Self[5] and feeling comfortable expressing it to the world, the subject needs to live in a completely positive 2SLGBTQ+ environment. But this kind of environment does not exist on our planet, as every society has certain levels of social homophobia. Consequently, many 2SLGBTQ+ subjects are not able to develop a healthy and stable sexual identity as heterosexual people do. 2SLGBTQ+ subjects carry with them a certain level of internalized homophobia consistent with the level of social homophobia in their society. This internalized homophobia, which can take the form of rejection of gender identity, rejection of sexual orientation, or rejection of both, is associated with other mental health disorders, including anxiety, depression, addictions, and, in adolescent subjects, suicidal ideation.

Internalized homophobia emerges in the personal dimension of the subject. Many subjects consciously or unconsciously try to hide their sexual subjectivity from the people around them and try to make alliances with their oppressors in their social contexts (e.g., workplace, school, church). Kort (2018) says the following about internalized homophobia:

> Unconscious internalized homophobia manifests in negative imagery that becomes the lens through which gays and lesbians see each other and themselves. Learning to recognize subtle forms of unconscious internalized homophobia—even in gay and lesbian clients who are out and open—takes experience and skill. This is why it's vital to be aware of your covert homophobia, or you might collude with your client's internalized version, with your countertransference adding to their problems. (p. 34)

9. Assessment of Internalized Homophobia

Therapists should observe whether subjects exhibit the following symptoms associated with internalized homophobia:

[5] In psychology, the sense of self is defined as the way a person thinks about and views their traits, beliefs, and purpose within the world.

- Looking for friends and partners who are not effeminate, when the subject is a homosexual male who is not effeminate. This is an example of internalized homophobia when the goal is to hide the homosexual nature of a relationship within a homophobic context.
- Rejecting the need for the existence of 2SLGBTQ+ neighbourhoods. This rejection can indicate that the subject denies the existence of social homophobia, and also denies their own internalized homophobia.
- Resisting changing their name to one that reflects their true gender identity.
- Experiencing chronic anxiety resulting from the fear that the subject's true gender identity or sexual orientation could be discovered.
- In a bisexual subject, making public only relationships with partners of the opposite sex and hiding same-sex relationships.
- In a bisexual subject, making public their heterosexual side and hiding their homosexual side.
- In a male or female homosexual subject, trying to develop a relationship with a cisgender subject as a way of trying to hide their own true sexual orientation.
- In a male or female homosexual subject, trying to hide their sexual orientation in a non-homophobic social context.
- Conflict, conscious or unconscious, between spirituality/faith heritage and their true gender and sexual orientation.

10. Model Concepts and Treatment of Internalized Homophobia

The therapeutic model presented below integrates concepts from various theoretical approaches:

- Psychoanalytic theory (the concepts of therapeutic relationship, therapeutic alliance, transference, countertransference, and unconscious desire)
- 2SLGBTQ+ affirmative therapy
- Complex thinking
- Externalizing and re-authorizing conversations
- Spiritually integrated psychotherapy

The therapeutic concepts into action:

Therapeutic alliance, transference, countertransference, and two principles of complex thinking (the dialogical principle and the principle of eco-self-organization):

The therapeutic relationship is supported by a therapeutic alliance[6] and the unconscious processes of transference and countertransference. From the complex thinking perspective, the therapeutic relationship illustrates the dialogical principle because this relationship facilitates the communication and integration of conscious and unconscious realms.

There is a conscious logic and an unconscious logic. They are opposite and antagonistic. Through the dialogical principle it is possible to integrate opposite and

[6] Therapeutic alliance: the therapeutic alliance is a conscious agreement between the client and the therapist. The therapist agrees to support the client during the therapeutic process to achieve the client's therapeutic goals.

antagonistic entities in the same level of reality, which would be the “mind” or “psyche” of the subject.

The therapeutic relationship is also a complex adaptive system that allows the coevolution of the therapist and the client in relation to their internal and external worlds during the therapeutic process, which has the purpose of reducing the client’s internalized homophobia. In other words, the therapeutic relationship is focused on the interaction between and coevolution of the client and the therapist during the healing process. At the same time, the therapeutic relationship is supported by the complex thinking principle of eco-self-organization because the human mind is not only a product of the internal world (a view shared by traditional psychoanalysis, which supports psychological reductionism, and the neurosciences, which support bio-genetic reductionism), it is also a product of the external world, which is the ecosystem. Consequently, the therapeutic relationship is shaped by the internal conscious and unconscious logics as well as the external logic of the ecosystem.

Conflict between id and superego:

The therapeutic model presented here emphasizes the unconscious desire of the client. The therapist helps the client to make conscious the unconscious desire. It is possible to say that the client is facing an internal battle in psyche. On one side, there is the unconscious desire to live as a 2SLGBTQ+ person (this desire is from the id), and on the other side, there is the mandate that forces the client to be heterosexual (this mandate is from the superego, which is a representation of the family and social order, in which heteronormativity is mandated). The ego is exposed to this internal battle and needs to mediate between these forces from the id and the superego. To do that, the ego uses its defense mechanisms, since avoiding the internal battle is not an option. The ego needs to defend itself from the forces of the id and the superego at the level of the internal world. Secondarily, the ego needs to defend itself against homophobic attacks from the external world. At the same time, the ego also defends itself from the therapy implemented by the therapist. This action is called “resistance.” From a complex thinking perspective, the therapeutic relationship facilitates for the client the process of making conscious the unconscious desire (the emergent principle explains the production of new properties by a complex system). Consequently, the client is modified by the unconscious desire. This process is explained by complex thinking through the principle of recursion, in which the producer is modified by the product (the unconscious desire).

Unconscious desire and the principle of recursion:

When the unconscious desire is made conscious, it is assimilated into the ego. If the unconscious desire is not made conscious, the heteronormative mandate from internalized homophobia remains in place and any associated disorders continue. The subject, as producer, can produce health or pathology. Following the principle of recursion from complex thinking, subjects are determined by their own products.

True subjectivity and the heteronormative mandate:

The therapeutic model presented here emphasizes the subject’s unconscious desire and true subjectivity—the true gender identity and sexual orientation—which goes against the heteronormative mandate (narrative produced by the Catholic Church, other conservative Christian churches, and Jewish groups).

Relationship between individuals and the social context:

The hologrammatic principle from complex thinking affirms that every system is a whole, and the whole is present in each part of the system (individuals). Consequently, each individual expresses a level of social homophobia that is determined by the level of homophobia present in the heteronormative system as a whole.

Implementing externalizing and authorizing conversations:

The therapist begins implementing the externalizing conversation strategy when the unconscious desire of the client becomes conscious. The goal is to externalize the client's internalized homophobia. It is important to remember that the internalized homophobia of the client is a product of the homophobic heteronormative social system in which the client is living. At the same time that the therapist implements the externalizing strategy, the therapist also implements the re-authorizing conversation strategy. The goals of the latter are to help the client express their true sexual desire (rather than follow the heteronormative mandate supported by the internalized homophobia) and to allow the client to rewrite their own true subjectivity. From the complex thinking perspective, the process just described can be explained through the emergent principle. As this principle explains, new qualities emerge from the subjectivity of the client. These new qualities determine the therapeutic relationship and make possible the coevolution of the client and therapist, as explained by the principle of recursion. Due to the fuzziness principle, it is impossible to describe with absolute clarity the prognosis and outcome of the therapeutic process. Though humans are rational entities, their emotions and their unconscious make them unpredictable.

Spiritually Integrated Psychotherapy:

The therapist helps the client to explore the ambivalence conflict between their belief system, based on a religious, homophobic, heteronormative, heterosexist narrative represented by the mandate, and the client's true desire as a positive counter-narrative. The therapist will help the client to rebuild the belief system (religion/spirituality) in a way that the new belief system will not negatively affect the achievement of the true desire of the client. An example in which this writer was involved was the running of a psychotherapy group with ex-priests and ex-nuns expelled from the Catholic Church because of their non-heteronormative gender and sexual orientation. They faced a conflict between the homophobic narrative of the Catholic Church that shaped their faith and their true gender and sexual orientation. At the end of the group treatment, they achieved their true identity and at the same time were able to keep and develop their Christian faith.

Pargament (2011) says:

> Spiritually integrated psychotherapy is an approach to treatment that acknowledges and addresses the spirituality of the client, the spirituality of the therapist, and the process of change … Spiritually integrated psychotherapy rests on the assumption that spirituality is a vital dimension in the lives of many clients. It is not to be dismissed as a static or compartmentalized set of beliefs, practices, or emotions used occasionally to improve mood or health. It is, instead, a set of pathways that people follow in search of the sacred. (p. 176)

11. Internalized Homophobia and the Stages of Coming Out

How do subjects, with the support of therapists using the therapeutic model presented in this article, go through the stages of coming out by challenging and defeating their internalized homophobia?

The following analysis considers the six stages of the coming out process described by Joe Kort (2018). This analysis also emphasizes the unconscious coevolution of the therapeutic relationship between the therapist and the client as a complex system, and describes how the problem of internalized homophobia can be addressed by the therapeutic relationship.

- *Stage 1: Identity confusion.* In this stage, subjects do not consciously have any recognition of suffering from a deviation in relation to the heteronormative system. If the subject follows a homophobic faith tradition, the subject will not question the homophobic narrative; the subject will believe in it. In some cases, subjects feel they are different from their peers, but they are unable to identify the nature of these differences.
- *Stage 2: Identity comparison.* In this stage, clients start considering the possibility that their gender identity and/or sexual orientation is not consistent with the heteronormative system. Subjects that follow a homophobic faith tradition can experience an initial conflict between their gender/sexual identity and their faith. In Stage 2, subjects tend to use scientific terminology such as "being homosexual" rather than terms such as gay, lesbian, or trans.
- *Stage 3: Identity tolerance.* At this stage, subjects begin accepting that their true gender identity and/or sexual orientation does not follow the heteronormative system. At the same time, they begin to perceive their new subjectivity in a positive way. Many subjects experience a true existential crisis between their new identity and their faith heritage. They tend to hide this inner conflict from their families, from other churchgoers, and from their own church.
- *Stage 4: Identity acceptance.* Kort (2018) called this stage "the beginning of a gay adolescence" (p. 139) and noted important similarities between the behaviour of 2SLGBTQ+ people in this stage (no matter their biological age) and adolescent behaviour. In Stage 4, 2SLGBTQ+ people develop a new level of identification with the 2SLGBTQ+ community, which they perceive as a safe place and in which they can experience a sense of belonging. At the same time, they generally experience increased anger toward the homophobic segments of the society in which they live. Some subjects perceive their old churches, which support homophobic narratives, as unsafe places to belong. They start thinking and feeling that they need to leave their own churches but they don't know where to go.
- *Stage 5: Identity pride.* In Stage 5, 2SLGBTQ+ people display a clear preference for interacting with other 2SLGBTQ+ people and develop a confrontational attitude toward the heteronormative world. Some subjects develop an antagonistic and aggressive attitude toward their faith heritage and others definitively decide to leave their faith tradition. By not distinguishing between straight people who are heterosexist or homophobic and those who are not, 2SLGBTQ+ people are engaging in a cognitive distortion called generalization, which leads them to

assume that all heterosexuals, all Christians, all Jewish people are heterosexist and homophobic. In this way, 2SLGBTQ+ people project their suffering outward, challenging the heteronormative world through their coming out process.

- *Stage 6: Identity synthesis.* 2SLGBTQ+ people now understand that the concept of "them and us" is based on generalization and polarizing thinking, which are described in cognitive behaviour therapy as cognitive distortions. There is an awareness that the "them and us" concept is not consistent with their present reality. Subjects are able to develop balanced thinking, which is less ideological and less confrontational toward the heterosexual world. They discover that not all cisgender people, and not all Christians or Jewish people, support homophobic narratives. At this stage, some subjects start shopping and find new non-homophobic churches or spiritual practices. Many of them join the Metropolitan Community Church (an international 2SLGBTQ+ Christian church); others find their place in the United Church of Canada (an openly friendly church to 2SLGBTQ+ persons).

Progression through these six stages is not necessarily linear because they depend on the intensity of the subject's internalized homophobia, the intensity of the subject's desire to challenge the illness, the subject's level of consciousness of the desire, and the strength of the homophobic mandate from the heteronormative and heterosexist religious and social context in which the subject lives. It is important to note that, before treating any psychological issue, the therapist needs to assess the client's readiness to do so. Thus, the therapist of a client with internalized homophobia must first ascertain that the client is ready to deal with the issue. Regression to an earlier stage is a frequent occurrence in the coming out process (fixation at a particular stage is also common, but does not necessarily affect the order of progression through the stages).

In the initial stages, the therapist needs to work with the client to develop a strong therapeutic alliance and a positive transference and countertransference. The coming-out process is a psycho-social and spiritual process: healing (achieving the inner unconscious desire and spiritual wholeness) happens in the context of the therapeutic relationship. The client needs to feel safe working with the therapist. The coming-out process is, for the client, a process of individuation and differentiation. A strong therapeutic relationship, one in which the therapeutic relationship evolves as the therapist and the client coevolve, can help clients manage their anxieties. To develop a strong therapeutic alliance, the spiritually integrated therapist needs to pay close attention to their own degree of spiritual integration.

> The spiritually dis-integrated therapist may overlook valuable opportunities for change or unwittingly exacerbate the client's problems. In contrast, the spiritually-integrated therapist can draw on his or her understanding of and approach to spirituality as a powerful resource for change. (Pargament, 2011, p. 187)

From the complex thinking perspective, the therapeutic relationship illustrates the dialogical principle because it facilitates communication and connection between the mind of the therapist and the mind of the client, fostering the development of a strong therapeutic alliance as well as positive transference and countertransference. The lack of a strong

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therapeutic alliance and the presence of negative transference or countertransference can halt the coming-out process and cause the client to regress back into the closet.

In his treatment model, Kort (2018) emphasizes the conscious process without including unconscious or spiritual factors. This is an example of the use of the principle of simplification. However, it appears that this process is more complex because it includes the unconscious desire of the client and the internal battle in the client's psyche between the unconscious desire to live as an 2SLGBTQ+ person (this desire is from the id) and the mandate that forces the client to be heterosexual (this mandate is from the superego, which is a representation of the family and the social order including the homophobic narrative of many Christian churches, in which heteronormativity is mandated). At the same time, Kort does not consider that the coming out process is a spiritual journey. If one follows Kort's position, it is impossible to address the controversy between exclusivism and rejectionism.

Pargament (2011) says:

> Yet both exclusivism and rejectionism can prompt expressions of spiritual intolerance. While rejectionism reflects an intolerance toward any kind of spiritual belief or practice, unmitigated exclusivism represents an intolerance toward any spiritual expression other than that which the therapist holds to be true. Similarly, exclusivists reject solutions to problems other than those that grow out of their own particular spiritual orientation. (p. 189)

From a complex thinking perspective, the therapeutic relationship facilitates the client in making conscious the unconscious desire (the emergent principle: new properties) and, through the principle of recursion, the client as the producer is modified by the product (the unconscious desire).

During the last stages of the treatment, the therapist implements the externalizing strategy and also the re-authorizing conversation strategy. The first strategy will help the client to make conscious the unconscious desire. The second strategy will help the client to rewrite their previous identity to reflect their true identity as a 2SLGBTQ+ person.

Rewriting their previous identity to reflect their true identity as a 2SLGBTQ+ person implies challenging the heteronormative mandate supported by internalized homophobia and associated disorders such as anxiety and depression. From the complex thinking perspective, this process can be explained by the emergent principle, which states that new qualities (the true unconscious desire supporting the true 2SLGBTQ+ identity) emerge from the subjectivity of the client.

12. Conclusion

The purpose of this article is to explain the development of a complex spiritually psychotherapeutic model for assessment and treatment of internalized homophobia which is present in societies where heterosexism and heteronormativity are considered compulsory. Consequently, homophobia is described as a complex phenomenon because it includes multiple dimensions (personal, interpersonal, institutional, cultural, political, social, and historical) and because internal homophobia is considered an illness that affects the subjectivity of 2SLGBTQ+ people.

This psychotherapeutic model integrates elements of complex thinking, spiritually integrated psychotherapy, psychoanalytic theory, narrative therapy, and 2SLGBTQ+

affirmative psychotherapy, helping mental health professionals to recognize that internalized homophobia is a true psychopathology. At the same time, the model allows therapists and clients to explore the true nature of internalized homophobia as a multidimensional phenomenon which includes its comorbid disorders (e.g., anxiety, depression, low self-esteem, addictions, suicidal ideation) and which affects the personal dimension.

The model also has the following additional goals:

- To discourage psychotherapists from the pathologization of 2SLGBTQ+ people based on their gender identity and sexual orientation.
- To encourage application of this model so that people in the 2SLGBTQ+ community have access to more effective, non-pathological, affirmative psychotherapy.
- To support the 2SLGBTQ+ community in fighting against discrimination by making available to them the same level of access to effective mental health services that is available to the rest of the population.
- To emphasize that the coming out process is a psycho-social process but also a spiritual journey.

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