Submitted in partial fulfilment of the Doctorate in Clinical Psychology

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**Doctoral Thesis**

# Experiences of therapy in a gender and sexually diverse world

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**Word Counts**

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# Thesis Abstract

We are living in an increasingly diverse world, as our collective understanding of gender, sexuality and identity continues to flourish. As we seek to understand ourselves and one another, many of us may turn to therapists and counsellors in order to make sense of our experiences. Yet, research suggests that a majority of mental health professionals are ill-equipped to work alongside gender and sexually diverse populations. The purpose of this thesis was therefore to shed light upon the experiences of therapists and clients as they navigate discussions of gender and sexual identity in the therapy room. This was achieved in three stages:

Section one presents a metasynthesis of qualitative research pertaining to the experiences of therapists and counsellors working with gender and sexually diverse clients. Six core concepts emerged from fourteen studies, identified through a systematic search. These core concepts were embedded within an overarching theme of 'the silencing and erasure of gender and sexual diversity' in therapy and counselling. Three of the concepts spoke to the perpetuation of this process and the remaining three highlighted preventative factors. The findings have implications for the training of therapists and counsellors.

Section two explores the 'coming out' experiences of eight sexually diverse young people, who disclosed their sexual orientation in therapy. Participants were interviewed and transcripts were analysed using interpretative phenomenological analysis (IPA). Their stories highlight the value of a therapeutic relationship in the disclosure of sexual orientation and emphasise themes of connection, acceptance and power within a wider social context.

Finally, section three offers a critical appraisal of the research journey. It contains reflections pertinent to the author's personal and professional development, as a trainee clinical psychologist and a fellow human being.

## Declaration

This thesis presents research submitted in November 2020 as partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology at Lancaster University. The work in this thesis is the author's own, except where due reference is made. This research has not been submitted for any other academic award.

Name: Chris Hunt

Signature:

Date: 23/11/2020

## Acknowledgements

Thank you to all of the people who participated in this research; for your honesty, enthusiasm and courage. I have learnt something valuable from each and every one of you and hope that I have done justice to your stories.

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Special thanks to Jack, for your unwavering support, kindness and patience. You always knew I would get there in the end – thank you so much for believing in me.

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**Section One: Literature Review**

# The attitudes and experiences of therapists working with gender and sexually diverse clients: A metasynthesis

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Abstract

This review is a metasynthesis of current qualitative literature exploring the experiences of therapists and counsellors working with gender and sexually diverse (GSD) clients. Fourteen studies were identified following a comprehensive systematic search of four electronic databases. Six core concepts were encapsulated within an overarching theme of 'the silencing and erasure of GSD identities' across counselling and therapy professions. Three of the core concepts regarded the perpetuation of this process: (1) Heterosexism and transphobia, (2) Lack of knowledge, skills and resources, (3) Fear and apprehension. A further three concepts regarded preventative factors: (4) GSD-affirmative practice, (5) Social advocacy, (6) Continuous growth and development. These concepts are discussed in regards to the cultural competence and training of therapy professionals.

*Keywords:* LGBTQ+; counsellor training; cultural competence; therapist attitudes; qualitative research

**The attitudes and experiences of therapists working with gender and sexually diverse clients: A metasynthesis**

Research suggests that people from gender and sexually diverse (GSD)[1] groups are more likely to experience mental health difficulties and are at greater risk of suicide than people who identify as cisgender or heterosexual (Haas et al., 2011; King et al., 2008; Reisner et al., 2016; Semlyen, 2016). These findings exist in a context of widespread homophobia, transphobia and mistreatment of individuals identifying as GSD (Norton, 1997; Smith, Bartlett & King, 2004). Yet there are several barriers that may prevent people who identify as GSD from accessing services in the first instance. These may include fear of discrimination from mental health professionals (Burgess et al., 2008) and/or traditional narratives of gender and sexual orientation, which portray GSD individuals as 'sexual deviants,' requiring 'treatments' for their pathologised behaviour (Drescher, 2015; Friedman & Downey, 1998). In order to better support people from GSD groups, clinicians require a wider understanding of the factors affecting their engagement with mental health services and the outcomes of counselling and psychotherapy, yet research is relatively scant (King et al., 2007).

Recently, there has been a growing body of literature in the area of 'cultural competence' within the mental health professions. Traditionally, this term has been applied to

[1] The terms 'gender and sexual diversity' and 'gender and sexually diverse' (GSD) are used here to refer to people from a broad spectrum of gender and sexual identities. This spectrum includes any individual who identifies themselves as possessing a gender that is not 'cisgender' (i.e. a gender which does not correspond with the 'sex' assigned to the person at birth), and any individual who considers their sexual orientation to be different from heterosexuality. Due to the overlapping nature of gender and sexual identity (van Anders, 2015), and the various ways in which these identities are expressed, it was considered important to conceptualise them within an inclusive framework. The use of 'GSD' is also supported by national U.K. counselling organisations such as Pink Therapy, who argue that the more commonly known 'LGBTQ+' umbrella has continued to exclude individuals despite its many revisions over the years (Sansalone, 2013).

clinicians working with racial and ethnic minorities (Sue, 1998; 1999), however it has since been adapted to include people from GSD backgrounds (Israel & Selvidge, 2003). Boroughs et al. (2015) define cultural competence in this context within three separate domains: (a) the clinician's *awareness* of their personal attitudes, beliefs and biases regarding gender and sexual diversity; (b) the clinician's *knowledge* of issues pertinent to GSD communities, including the potential impact of their own cultural background on the therapeutic relationship; and (c) the *skills* and tools required by clinicians to provide culturally sensitive assessments and interventions.

Various psychometric measures have been developed in order to assess therapist competence in the above domains and to reduce mental health disparities between GSD and cisgender, heterosexual populations (Bidell & Whitman, 2013). Examples include the Sexual Orientation Counselor Competency Scale (Bidell, 2005) and the LGB Working Alliance Self-Efficacy Scale (Burkard et al., 2009); both of which rely on self-report data in the form of Likert scales. Studies utilising these measures have typically found positive attitudes towards GSD clients and service users, with negative attitudes more common amongst male, white, heterosexual, religious and conservative mental health professionals (Brown, Kucharska & Marczak, 2017).

However, many GSD clients report experiences of openly heterosexist and, in some cases, homophobic reactions in the therapy room (King & McKeown, 2003; O'Neill, 2002). Transgender service users in particular have reported feeling stereotyped or misunderstood by their therapist(s), citing a lack of adequate therapist training as a significant contributing factor to problems arising in therapy (Benson, 2013). Such a disparity of findings may be partially due to the self-report nature of the psychometric tools used in competency-based research. Indeed, Brown, Kucharska an Marczak (2017) acknowledge in their review paper

the limitations of cross-sectional, quantitative data, which fails to differentiate between explicit and implicit attitudes.

Qualitative studies in particular may be well-placed to explore these issues through an alternative lens, due to an emphasis on implicit interpretations and a greater appreciation of the subjectivity inherent to client-therapist interactions (Nicolson, 1995). Dixon-Wood and Fitzpatrick (2001) make the case that qualitative research has much to contribute to systematic reviews; particularly in regards to investigating the nuances of individual experience and drawing upon the emerging understandings to develop theory. Such research also has the potential to uncover rich examples of harmful or exemplary practice, which might be drawn upon to enhance the practice of others. Yet there are currently no papers which draw together the existing qualitative research in this area.

One such method of integrating qualitative literature is via a form of metasynthesis known as a meta-ethnography, which collates the findings of qualitative research in order to develop new insights and interpretations (Schreiber, Crooks & Stern, 1997). This occurs through a process of extracting key themes and ideas from several research papers and bringing these together to form a collective whole (Noblit & Hare, 1988). In utilising this approach, the current review aims to integrate existing qualitative literature regarding therapists' and counsellors' attitudes and experiences of working alongside GSD clients. It is hoped that this research will contribute to a growing understanding of the more implicit factors impacting on GSD clients in therapy, and to the development of recommendations for therapeutic practitioners working in increasingly diverse communities.

## Method

This metasynthesis was conducted in accordance with guidance from Noblit and Hare (1988), as adapted for qualitative health research by Britten et al. (2002). The purpose of this

approach was to produce a synthesis which was interpretative, rather than descriptive, and which aimed to elicit new understandings by drawing together interpretations gleaned from previous researchers. A published quality framework, The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2009 checklist, was used to inform the review structure and design (Moher et al., 2009).

**Search Strategy**

Prior to conducting a systematic search, the research aims were separated into four constituent domains. These were determined using an adaptation of the SPIDER tool (Cooke, Smith & Booth, 2012), which considered separately the target sample, phenomenon of interest and research design intended to be investigated. After an initial scoping search, free-text and database search terms were devised and corroborated with a university subject-specific librarian. The final search terms agreed upon are presented in Tables 1 and 2.

[Tables 1 & 2 near here]

The following five inclusion criteria were devised to determine the eligibility of uncovered papers: (1) investigated a sample of therapists and/or counsellors (either qualified or in training); (2) included coverage of therapist/counsellor competency in working with GSD clients, or experiences of working alongside people from this population; (3) employed a qualitative approach to data collection and inductive methods of analysis; (4) published in English language (due to a lack of translation resources); (5) published in a peer-reviewed journal (for an initial screening of quality assurance). In addition, it was decided that papers could be excluded for the following reasons: (1) where analyses were solely quantitative, or brief and descriptive – lacking an interpretative analytical approach; (2) where the sample were not practicing counsellors or therapists, but rather academics or educators of GSD-related issues; (3) where the context of the research was not directly related to a mental health

setting (e.g. school mentoring or medical professionals practicing surgical procedures); (4) investigations of non-affirmative practice (i.e. conversion therapy/attempts to modify a person's sexual orientation or change an individual's beliefs about their gender).

Using the search strategy outlined in Tables 1 and 2, the databases of MEDLINE, CINAHL, PsycINFO and Web of Science were searched on 21st September 2020, with no date limiters. These searches were combined (yielding a total of 1,288 papers) and transported to EndNote software, which was used to keep a live record of the studies as they were screened. After removing duplicates, titles and abstracts were screened to determine their relevance to the research question. A total of 29 papers remained, to be reviewed in their full-text. Of these 29 papers, 16 were rejected due to one of the following reasons: there was no evidence of an inductive analytical approach, or findings were descriptive rather than interpretative (n = 9); the sample did not appear to include therapists or counsellors, or were unrelated to a mental health setting (n = 4); there was no investigation of therapist/counsellor competency or experiences in working with GSD clients (n = 2); the investigation was specifically of non-affirmative conversion therapy (n = 1). Reference lists of the remaining 13 papers were then examined to capture any additional studies that were not uncovered by the database search. One further study was revealed, resulting in a final total of 14 papers to be included within this review. This process is depicted visually in Figure 1.

[Figure 1 near here]

**Study Characteristics**

A summary of methodology and participant characteristics for each of the included studies is presented in Table 3. The 14 papers were published between 1991 and 2019. Only one paper was published prior to the year 2000 (Garnets et al., 1991) and this paper included a dataset from 1986. Countries represented by the papers included the USA (n = 10), the UK

(n = 2), Canada (n = 1) and Brazil (n = 1). Sample sizes were typically between 7 – 70, except for two larger-scale postal surveys (Eliason, 2000 & Garnets et al., 1991) which included samples of 242 and 1,481 participants, respectively. Half of all studies utilised one-to-one interviews as the method of data collection and the remaining 7 collected data via focus groups (n = 3), postal survey (n = 3) and written self-reflective narratives (n = 1). All studies employed a form of thematic analysis to analyse their qualitative data. Four studies applied variations of phenomenological approaches, 3 used grounded theory, 1 used consensual qualitative analysis, 1 used discourse analysis and the remaining 5 specified only a generic thematic approach.

The participants themselves represented a range of mental health professionals – the most common of which were counsellors (n = 10). Of those studies investigating a counsellor sample, 6 targeted qualified counsellors, 3 targeted counsellors-in-training and 1 included a mixed sample of qualified counsellors and trainees. Three studies investigated the experiences of practitioner psychologists, including representation from counselling and clinical psychologists. Additional professions represented included family therapists, art therapists and clinical social workers. The age range of participants was between 19 and 70 years and the majority identified as female, reflecting the gender divide typically observed in counsellor and therapist populations (BACP, 2014). Finally, there was variation with regards to the investigation of gender and sexual diversity. Four papers specified that they were investigating therapist/counsellor experiences in working with lesbian, gay and bisexual clients (LGB). Three papers pertained specifically to transgender or trans* clients. The remaining 8 papers did not specify a distinction between gender and sexuality, referring instead to the "LGBT" umbrella, or issues of gender and sexual diversity more broadly.

[Table 3 near here]

**Quality Appraisal**

The final papers were examined for quality using the Critical Appraisal Skills Programme (CASP, 2018), which outlines ten criteria important to qualitative research. Rather than excluding papers on the basis of their determined quality, this process was used to draw attention to methodological strengths and limitations which might contextualise the findings. This approach is in keeping with the recommendations of Sandelowski et al. (1997), who highlight the subjectivity of quality appraisal and suggest that to exclude findings on the basis of reported quality criteria would be detrimental to the comprehensiveness of a metasynthesis.

For purposes of comparison, a rating system was applied to each individual paper. The first two questions of the CASP were utilised as a screening aid to determine whether the researchers provided a clear statement of aims/objectives and the relevance of a qualitive approach. The remaining eight questions were then considered using a 3-point rating scale, depending on whether the researchers provided weak (1), moderate (2) or strong (3) considerations of the relevant domain (for a maximum possible total of 24). Three papers were randomly selected for cross-examination by an independent researcher, who was a trainee clinical psychologist on the same doctorate training programme as the first author. A comparison of scores revealed agreement across ratings of all three papers. These scores are presented in table 4.

[Table 4 near here]

**Analysis and Synthesis**

The seven-stage approach to meta-ethnography proposed by Noblit and Hare (1988) was used to inform the analysis, as adapted by Britten et al. (2002) and with additional consideration of the recommendations provided by Atkins et al. (2008). Practically, this was

an iterative process that involved the gradual development of several higher order interpretations of the combined study findings.

Firstly, each of the 14 papers were read several times and key themes and concepts were separately recorded. Interpretations contained in each theme were then compared to determine the relationships between them. Similar ideas were gradually combined and expressed as statements which encapsulated the key themes and ideas within them (at times, these statements reflected the language used by the researchers themselves). The findings of each paper were re-examined throughout this process to ensure that the analysis was sufficiently comprehensive and inclusive of the various themes contained within each paper.

The emerging key themes were then integrated further into 'core concepts,' through an additional process of comparison. These core concepts represented broader interpretations which synthesised those contained within the papers. Finally, the core concepts were examined to determine the relationships between them and to consider the collective narrative portrayed across each of the papers. Appendix 1-A depicts this process of gradual comparison, whilst appendix 1-B provides definitions of each key theme as they developed.

## Findings

[Figure 2 near here]

Six core concepts were discovered, which appeared to be encapsulated within an overarching theme of 'the silencing and erasure of GSD identities' across counselling and therapy professions (Figure 2). Three core concepts regarded the perpetuation of this process: (1) Heterosexism and transphobia, (2) Lack of knowledge, skills and resources, (3) Fear and apprehension. A further three concepts regarded preventative factors: (4) GSD-affirmative practice, (5) Social advocacy, (6) Continuous growth and development. Here, these core concepts will be discussed with supporting excerpts from the fourteen reviewed papers.

## The Silencing and Erasure of GSD Identities: Perpetuating Factors

### Core concept 1: Heterosexism and transphobia.

Evidence of prejudice and discrimination towards GSD-clients was found in the majority of papers (Asta & Vacha-Haase, 2013; Dillon et al., 2004; Eliason, 2000; Garnets et al., 1991; Gaspodini & Falcke, 2018; Grove, 2009; Harris et al., 2017; Owen-Pugh & Baines, 2014;  Ristock, 2001; Salpitero, Ausloos & Clark, 2019; Whitehead et al., 2012). In some cases, derogatory beliefs were shared openly by therapists and their colleagues: "if you have a uterus, don't you think you should use it?" (Garnets et al., 1991, p.967); "why would you want to study fags?" (Dillon et al., 2004, p.173). In other cases, these beliefs appeared to be more implicit: "transmitted through jokes, ironic comments and stereotyped examples of human behaviour or any attitude that promotes pathologisation" (Gaspodini & Falcke, 2018, p.5).

Some therapists and counsellors framed their beliefs and assumptions as a product of the time at which they completed their training: "It was what we learned at that time, that being homosexual was a perversion" (Gaspodini & Falcke, 2018 - p.5), however the findings largely pointed towards ongoing misconceptions regarding gender and sexual diversity. For example, there was a tendency towards assumptions that GSD identities are always encompassed by suffering: "nobody ever phones up [a therapist] and says 'you've got to see this kid, he is heterosexual'…it's just one of those things" (Owen-Pugh & Baines, 2014, p.23), or assumptions which minimised potential difficulties: "I guess I don't understand why they need to tell. Heterosexual people don't" (Eliason, 2000, p.321).

Additionally, themes of heterosexism and transphobia were identified in the theoretical conceptualisations used by some therapists to describe the development of gender and sexuality. A striking example of this is as follows: "I'm convinced that homosexuality is

a genuine personality disorder and not merely a different way of life. Everyone that I have known socially or as a client has been a complete mess psychologically" (Garnets et al., 1991, p.966). Other papers noted an emphasis on the biological determinants of gender at the expense of alternative explanations and the lived realities of clients: "Well that's total hogwash; it's total baloney; it's been proven wrong, and but anyway I was schooled in that time, so I came a long ways" (Whitehead et al., 2012, p.392; in response to feminist socialisation models of gender development).

These personal and theoretical assumptions appeared to translate directly into therapists' practice. A significant recurring theme throughout the papers was the use of power by therapists, such as to withhold treatment from GSD-clients (Garnets et al., 1991; Whitehead et al., 2012), or to impose personal and/or religious beliefs: "until we change our approach to embrace a biblical sin based treatment regime, we never truly change people's lifestyles" (Eliason, 2000, p.322).

A related pattern was the suppression of conversations in therapy and training, which connects with the overarching theme and might be considered a function of the therapist's use of power. For example, Owen-Pugh & Baines (2014) point towards an "ambivalence over whether or not to discuss clients' sexuality" (p.24), whilst Ristock (2001) suggests an overall investment in maintaining heteronormative discourse at the cost of GSD-erasure. Given these findings, it is perhaps unsurprising that some therapists reported having difficulty in accessing the "client's world," and developing a deeper understanding of their experiences (Owen-Pugh & Baines, 2014, p.23). Indeed, in some circumstances it appeared that repeated exposure to difficult therapeutic encounters culminated in a lack of trust on the part of the client and, subsequently, discomfort in the therapeutic relationship:

*I hear the stories every day from my trans friends, and my trans clients that come in telling me about how horrible their previous therapist has been -and then it takes a really long time to build that trust or, sometimes I can't even engage them at all.*

*(Salpietro, Ausloos & Clark, 2019, p.204)*

**Core concept 2: Lack of knowledge, skills and resources.**

Many of the papers highlighted a lack of adequate training regarding GSD-related issues across a variety of therapist and counsellor training programmes (Asta & Vacha-Haase, 2013; Garnets et al., 1991; Hancock, McAuliffe & Levingston, 2014; Harris et al., 2017; O'Hara et al., 2013; Owen-Pugh & Baines, 2014; Rivers & Swank, 2017; Salpitero, Ausloos & Clark, 2019). A specific case was made regarding a need for training on issues of gender, as few therapists expressed confidence in their knowledge: "it's such untrodden territory… transgender is something that is kind of out there, is a big question mark… lack of education is still out there and how to integrate that or apply that to therapy" (Rivers & Swank, 2017, p.28).

There appeared to be a sense that GSD-specific training (particularly that which is experiential in nature) was held by trainers and courses in less esteem than theoretical content and research methods: "I think counselling psychologists, unfortunately, talk the talk but don't always walk the walk. At least in the program I was in, that was not a priority, teaching people to be advocates…" (Asta & Vacha-Haase, 2013, p.515). Furthermore, therapists and counsellors who did have GSD-specific content made available as part of their core training tended to describe this content as "superficial" (Salpietro, Ausloos & Clark, 2019, p.204), or pointed towards an unmet need for self-reflection and ongoing discussion: "To have open discussions about those experiences and prejudices…none were covered in a way that

allowed people to thrash these things out and expose themselves and their prejudices…it's in exposing them that you get the chance to change" (Owen-Pugh & Baines, 2014, p.22).

A consequence of this lack of knowledge and discussion seemed to be that students, therapists and counsellors who personally identified as GSD felt a weight of responsibility in raising awareness of their identities and/or challenging the assumptions of their colleagues (O'Hara et al., 2013; Owen-Pugh & Baines, 2014; Rivers & Swank, 2017; Salpitero, Ausloos & Clark, 2019). Additionally, these individuals expressed difficulty in navigating complex issues such as self-disclosure in the absence of sufficient guidance from their supervisors and mentors: "Am I disclosing or being unnecessarily disclosing? …A level of personal information which it might be inappropriate to reveal…a dilemma that I didn't expect my heterosexual colleagues would be having to face" (Owen-Pugh & Baines, 2014, p.24).

**Core concept 3: Fear and apprehension.**

A recurring theme amongst therapist's experiences was of underlying fears and anxieties which inhibited communication and self-reflection, or negatively impacted upon clinical work with clients (Asta & Vacha-Haase, 2013; Dillon et al., 2004; Gaspodini & Falcke, 2018; Harris et al., 2017; O'Hara et al., 2013; Owen-Pugh & Baines, 2014; Ristock, 2001; Rivers & Swank, 2017). In several cases, these fears were related to offending GSD individuals through the use of incorrect or pejorative terminology: "I have a friend who dresses up as a woman. I'm like, well, he hasn't had surgery, so is he transgender or is he not transgender?" (O'Hara et al., 2013, p.245). In part, these fears may be related to a lack of cultural knowledge, however therapists also recognised a tendency to focus excessively on their commitment to inclusive language at the cost of being present with their clients in therapy:

*We might get too caught up in trying to get all the right terms and we forget that this is just a normal person…[there is a] balance between making sure you get everything right and treating them like you would any client.*

*(Rivers & Swank, 2017, p.27)*

Additional fears pertained to judgements from other people, such as a fear of being perceived as “complacent” by members of the GSD-community or imposing an unwelcome presence: “I was introducing myself as an ally…it was a member of the community who said, no, you are an advocate, because this is what you are doing, and educated me about it” (Asta & Vacha-Haase, 2013, p.507). Some therapists feared being mistaken as GSD themselves, in a manner which Dillon et al. (2004) describe as ‘homophobic self-consciousness:’

*Strangers who overheard me talking about it in public shot strange looks in my direction- I've no doubt that many concluded that I'm gay. In other cases, I remember censoring what I would say simply because I knew it would spark reactions that I didn't have the time or energy to contend with.*

*(Dillon et al., 2004, p.168)*

Developing a self-awareness of personal belief systems also seemed to elicit fear in many therapists, particularly when confronted with their own prejudices or lack of knowledge:

*It feels like a rude awakening and a bit of a jolt…like being thrown in the canal and then learning to swim…there is a sense of it being the wrong way round and I don't feel like I was well-enough equipped.*

*(Owen-Pugh & Baines, 2014, p.23)*

Those who discovered conflicting beliefs and values typically found these difficult to reconcile or experienced a sense of distance from their communities: “I was sitting in an African American church and at that moment I felt really distant from my community. I don't want to be somewhere that doesn't support the people I support” (Harris et al., 2017, p.150). Taken together, these fears appear to contribute towards a reluctance to acknowledge bias within therapy/counselling professions or an avoidance of the issues entirely:

> *Like most things, we avoid pain, and the stuff we are talking about here is painful. It is you peeling back what I need to see and telling me, you’re still not seeing it…We think that we have gotten somewhere that we haven’t gotten. I think we fool ourselves into thinking that we are further down the road.*
>
> *(Asta & Vacha-Haase, 2013, p.508)*

## The Silencing and Erasure of GSD Identities: Preventative Factors

### Core concept 4: GSD-affirmative practice.

In this context, GSD-affirmative practice refers to therapeutic work with GSD-clients which seeks to validate the client’s experiences and authenticity. Davies and Neal (2000) suggest that a GSD-affirmative approach requires therapists to possess a degree of comfort and self-awareness regarding issues of gender and sexuality. Several examples of GSD-affirmative practice were found in the reviewed studies (Dillon et al., 2004; Garnets et al., 1991; Gaspodini & Falcke, 2018; Grove, 2009; O'Hara et al., 2013; Owen-Pugh & Baines, 2014; Rivers & Swank, 2017; Salpitero, Ausloos & Clark, 2019; Whitehead et al., 2012).

Contrary to the prejudicial beliefs described previously, some therapists rejected the notion of pathology underlying gender and sexual diversity and instead worked with clients to address social and contextual factors:

*Cure! ...Not today, when the person comes for treatment, this is not on the agenda, except for some things of family acceptance, but this relates to the relationships of how they deal, but not in that sense as if it were a disease.*

(Gaspodini & Falcke, 2018, p.6)

Practically, this approach tended to involve affirmation through the use of general person-centred principles: “I just try to promote her loving and accepting herself and thinking positively” (Salpietro, Ausloos & Clark, 2019, p.209), or specific efforts to model the acceptance of difference and promote visibility:

*I also put on my email list what my personal pronouns are for me. So they know who they're dealing with too, and I also think that helps recognise that I'm willing to work with them on their pronouns and have a better understanding of what they deem relevant as pronouns.*

(Salpietro, Ausloos & Clark, 2019, p.209)

However, therapists also recognised that truly affirmative practice must involve their own self-reflective process. For example, therapists spoke of taking steps to recognise prejudicial assumptions in order to prevent their enactment on clients: “Today I try to police myself, because it is prejudice. Why does a man come and you ask 'do you have a wife?' You may not have a wife, you can have a husband” (Gaspodini & Falcke, 2018. p.7).

In becoming aware of their own beliefs and challenging societal norms, some therapists were able to conceptualise gender and sexuality in ways that fostered new understandings within themselves. For example, a heterosexual therapist attending an affirmative training programme described their experiences as follows:

> *What I actually learned by the second and third meetings was that everyone had their own ideas about sexuality, how it is developed, where it originates and who determines it for the individual. What I began to understand was that the development of heterosexuality had everything to do with homosexuality and bisexuality and vice versa.*
>
> *(Dillon et al., 2004, p.169)*

At times, these new understandings gave rise to affirmative frameworks in which therapists portrayed GSD-clients not as 'victims,' but as individuals who have elected to free themselves from societal constraints:

> *You have the possibility of transcending the traps and the unconscious structures that we have for being these commonly prescribed genders…You have the chance to be really free and see through the traps of society. That's the nobility of it [gender variation].*
>
> *(Whitehead et al., 2012, p.397)*

**Core concept 5: Social advocacy.**

Many papers described themes pertaining to the role of the therapist in social advocacy for GSD people (Asta & Vacha-Haase, 2013; Dillon et al., 2004; Garnets et al., 1991; Grove, 2009; Ristock, 2001; Rivers & Swank, 2017; Salpietro, Ausloos & Clark, 2019; Whitehead et al., 2012). There appeared to be a wide perception that social justice is central to therapy and counselling professions, both within and beyond the therapy room: "Counselling is really a path for greater social justice. I think marginalized people have all stripes of that and we need to advocate for them and teach them to advocate for themselves" (Rivers & Swank, 2017, p.27). This concept is therefore concerned with the application of social justice through therapist advocacy of GSD groups and identities.

Broadly, therapists described a general understanding of the social context surrounding GSD-clients and recognised the impact of prejudice on identity formation and self-esteem: “He comes in and talks about his job a lot or his relationships…and frustrations with family. And yeah, identity is always present and certainly has made his life more challenging as he has navigated prejudice” (Salpietro, Ausloos & Clark, 2019, p.204). Interestingly, a number of therapists commented on the intersectionality of identities – including the challenges that possessing multiple minority characteristics can bring and the presence of ‘hidden’ minorities within the GSD community: “From social media, I gained the assumption or impression that yes, lots of LGBTQ people are white; [however,] there is diversity in this group” (Rivers & Swank, 2017, p.28). Some therapists also described how their own (ethnic) minority characteristics helped them to appreciate the struggles faced by their GSD clients and peers, spurring them to advocate more strongly:

> *I felt like that was the one community that took me in and didn't really question whether I belonged or didn't. I knew that was a community I had felt very much a part of, in an adopted sort of way, and that I could relate all of my experiences, even though I fully understood that they were very different.*
>
> *(Asta & Vacha-Haase, 2013, p.511)*

Yet despite these understandings, there was also recognition that some clients, particularly those with multiple minority characteristics, are not receiving adequate support from services: “It’s a struggle and something that needs to be addressed that the women who come forward for services are not usually women of colour and it’s happening for particular reasons” (Ristock, 2001, p.67). Poor training and a lack of confidence in matters surrounding diversity were typically cited by therapists as factors underlying these issues:

> *[Trans-advocacy] is an emerging area for practice and research and supervision particularly, and unless we have more people doing this kind of research…we're not going to have many more that are educated, that feel confident enough, and competent enough to provide this kind of practice.*
>
> *(Salpietro, Ausloos & Clark, 2019, p.210)*

Nevertheless, promising developments were noted by those therapists who received specific training post-qualification, highlighting the value of such programmes moving forward:

> *Finally, I started to ask myself…'am I as sexually affirmative as I claim to be? Am I ready to stick up for an LGB individual if someone is attacking them?...' I decided that I may not be as far…as I would like to be, but being a part of this research team helped me to understand what I wanted to work towards.*
>
> *(Dillon et al., 2004, p.172)*

**Core concept 6: Continuous growth and development.**

In considering their own developmental journeys, therapists described various approaches to learning but were generally in agreement that these processes were ongoing (Asta & Vacha-Haase, 2013; Dillon et al., 2004; Grove, 2009; Hancock, McAuliffe & Levingston, 2014; Harris et al., 2017; O'Hara et al., 2013; Owen-Pugh & Baines, 2014; Rivers & Swank, 2017; Salpietro, Ausloos & Clark, 2019; Whitehead et al., 2012). Broadly, these developmental experiences included learning from interpersonal relationships (such as friendships, colleagues, mentors and clients) and intrapersonal learning in the form of self-reflection and experiential training.

As alluded to in previous core concepts, therapists generally considered relationships with others, both within GSD and cisgender, heterosexual communities, to be fundamental in their own personal and professional development. For example, many therapists described drawing on experiences with friends or acquaintances within GSD-communities to inform

their beliefs: “I feel these friendships…gave me a lot of insights into the experiences and issues of gay men living in a predominately heterosexual society and the sense of oppression and pressure to conform to the norm” (Dillon et al., 2004, p.83). Others described value in communicating their ideas with colleagues to enhance their practice: “[consultation] is actually as important, if not more important, than education. You can do the continuing ed-and that's great-but [if you are] not consulting with colleagues also doing the work, [it is] not as functional” (Salpietro, Ausloos & Clark, 2019, p.206). In most cases, therapists also framed the therapeutic encounter itself as a mutually beneficial process, in which therapists could learn from and with their clients: “I'd like to learn more about what the struggles are but it feels like the client teaches me that without having to go off and train” (Owen-Pugh & Baines, 2014, p.23).

In addition to learning from others, therapists who reflected on their own personal experiences found meanings which could be applied to their practice. In several papers, experiential activities were cited as particularly effective methods of training – for example: “[issues] come out through the experiential activities and we all kinda process as colleagues” (Hancock, McAuliffe & Levingston, 2014, p.86). Generally, these self-reflective and experiential methods elicited new insights which moved therapists towards deeper understandings of gender and sexual identity: “I have male characteristics, female characteristics, and maybe some other characteristics which I don't know about…it's incredible. I think about this deeper because I also see myself in it” (O'Hara et al., 2013, p. 247).

Regardless of the individual route taken, these developmental experiences were typically defined as fluid and in the context of an evolving society: “I am on a journey to better understanding and greater affirmation of LGB issues and individuals-through reading, watching films and attending events…and/or getting to know many more individuals on a

personal, genuine level" (Dillon et al., 2004, p.174). Crucially, some therapists reflected that their developmental journeys might always remain incomplete, and that to believe otherwise would be to reduce the unique complexities of each individual client:

> *We want to master populations and say I'm good, I get them…but you can't fit people into these little compartments…there's continual learning, especially from your client, but also outside work and research…I'm never going to be done learning about populations.*
>
> *(Rivers & Swank, 2017, p.27)*

## Discussion

The purpose of this review was to synthesise research pertaining to the attitudes and experiences of therapists and counsellors working clinically with GSD clients. In doing so, it was hoped that new insights would be developed regarding some of the more implicit factors affecting therapeutic practise within these populations. The findings highlighted a process of silencing and erasure of GSD identities within therapy and counselling professions, despite recent efforts to promote GSD-affirmative and culturally sensitive interventions. Many therapists reported feeling anxious or unsure about how to tackle issues of gender and sexual diversity in the therapy room, with the majority referring to inadequate training and personal fears about discussing these issues more openly. Professionals self-identifying as GSD described a burden of responsibility to educate their peers, else risking the avoidance of these issues entirely. Nevertheless, examples of inclusive practice were also noted and therapists generally expressed an interest in furthering their development whilst acknowledging the importance of ongoing self-reflection.

One of the main contributing factors to the anxiety expressed was a lack of preparation in core trainings, particularly regarding gender diversity. Many therapists

described lacking sufficient cultural knowledge and feeling out of their depth when clients brought issues that they were not personally familiar with. In some cases, this lack of awareness and discomfort gave rise to prejudiced assumptions, which might prove harmful if enacted in therapy. A more subtle effect was the avoidance of conversations related to gender and sexuality (unintentionally or otherwise), which in itself can feel stigmatising and shameful for some GSD clients (Hoff & Sprott, 2009).

Given this lack of preparedness, there was a resounding call for more tailored GSD content to be introduced into therapy training programmes, which echoes the recommendations of previous research (Boroughs et al., 2015; King et al., 2007). On one hand, it could be argued that an appreciation of diversity should be embedded within the general ethos of therapist/counsellor training, such that tailored GSD content is not strictly necessary as the same underpinning values can be woven naturally into the training process (Roysircar, Dobbins & Malloy, 2010). However, the historic context regarding the treatment and pathologisation of gender and sexual diversity within mental health professions warrants specific attention – particularly as this history has contributed to the continued mistrust of mental health professionals by some GSD clients (Benson, 2013; King & McKeown, 2003). In light of this contextual backdrop, researchers have suggested that a more focused training approach is necessary if we are to advocate successfully for GSD-affirmative practice (Godfrey et al., 2006).

The lack of adequate GSD training within therapy and counselling programmes is not a recent discovery (Croteau et al., 1998), but an issue which has faced considerable resistance over the years (Sue et al., 2019). The findings of this review suggest that fear is a significant factor underlying such resistance and one which contributes to the silencing and/or avoidance of GSD narratives in therapy training and practice. In part, this fear was related to the prospect of 'outing oneself' as possessing prejudices which are perhaps not conducive to the

idyllic notion of an unconditionally accepting therapist (see Asta & Vacha-Haase, 2013). Yet there also appeared to be deeply-rooted fears of change expressed by some individuals, who felt conflicted when presented with narratives of gender and sexuality which did not reflect their own personal experiences. These findings are consistent with the barriers described by Sue et al. (2019), who suggest that resistance to diversity manifests itself emotionally in the form of guilt, anger, and fear – thereby evoking further defensiveness and avoidance. It is therefore especially important that therapists and counsellors are supported to give voice to their own internal struggles so that they, in turn, may support their clients to speak more openly about the issues affecting them.

Indeed, self-awareness was often depicted by therapists in the reviewed papers as a vehicle for greater social justice. Other researchers have commented on the significance of social advocacy in counselling and therapy professions (Ali et al., 2008), arguing that training should extend beyond the therapy room to supporting wider communities, promoting inclusion and systemic change. In the case of this review, some therapists reported difficulties in knowing how to engage with GSD communities or lacked awareness of local resources which could be utilised as part of their practice. Others did possess confidence in this area – typically those therapists who had pre-existing relationships within the GSD community, or who had sought further training independently. These findings offer further support for integrating GSD content more explicitly within training programmes, so that therapists may feel more adequately equipped to work within diverse social groups.

Importantly, therapists understood their growth and development in terms of a continuous undertaking which they recognised could not be wholly encapsulated within their core training. Rivers and Swank (2017) spoke to this in their paper, in which the participants described an ever-changing societal context which they felt required a commitment to ongoing learning and reflection. Various methods were described by therapists to support in

this task, including learning from the experiences of others (GSD friends, colleagues, mentors and clients) and educating themselves about GSD issues via wider reading and study. To this end, the 'cultural competency' of the therapist might be conceptualised as an iterative endeavour, in which the purpose of core training is to enkindle a more independent and dynamic learning process.

**Clinical Implications**

The findings of this metasynthesis provide further support for the recommendations of Boroughs et al. (2015), who suggest that counselling and psychotherapy training courses should provide GSD-related content as part of their core curriculum. In particular, the findings highlighted a need for reflective spaces and experiential group discussions, in which trainees could be encouraged to share, understand and re-evaluate personal beliefs and prejudices. Examples of post-qualification training experiences demonstrate the value of such groups and are a testament to the importance of self-awareness in Boroughs et al.'s (2015) definition of 'cultural competence' when working within GSD populations.

Facilitating self-reflection amongst trainees inextricably requires a level of competency and trust in course tutors and trainers, who must be equally as willing to reflect on their experiences. As highlighted by Davies and Barker (2015), the current situation is such that GSD students typically find themselves responsible for delivering brief workshops to educate their cisgender, heterosexual peers – a finding which resonates with the 'weight of responsibility' described in this metasynthesis. By recognising the significance of gender and sexuality to the majority, as well as minority groups, it may be possible to distribute this responsibility more evenly amongst trainees and trainers alike.

A related implication of the findings regards the translation of GSD-training into clinical practice. Therapists and their clients might benefit from more openly addressing

gender and sexuality within the therapy room, recognising that these topics may be avoided due to fear and/or stigma. Equally, therapists should be prepared to move away from the notion of gender and sexual diversity as pathological or inherently problematic. GSD-affirmative approaches offer a framework in which therapists and clients can discuss these topics in ways which invite acceptance and promote a positive therapeutic relationship (Davies & Neal, 2000). By continuing to engage in such discourse – in therapy, supervision and training – therapists are likely to feel more confident in attending to gender and sexuality within their routine practice.

**Limitations**

Firstly, it is important to acknowledge the use of the term 'GSD' that has been adopted throughout this research. As discussed previously, GSD was selected in a deliberate attempt to recognise and include the diverse range of gender and sexual identities that exist; particularly those which extend beyond a heteronormative or binary lens. Whilst the term 'LGBT' is more universally adopted to describe people within this population, this term is considered an issue of contention as it inevitably excludes individuals who do not fall within the 'lesbian, gay, bisexual, transgender' umbrella. Such identities might include men who have sex with men but choose not to define themselves as gay or bisexual; people born intersex; or people who consider themselves gender-fluid, non-binary or not traditionally 'trans.' Indeed, this also raises the issue of whether gender and sexuality should be included within a singular framework or investigated separately. The findings of this review highlight some important differences between therapist attitudes regarding sexuality and gender, suggesting that there is scope to tease these concepts apart. However, the quantity of literature in this area is particularly lacking and this appears to be representative of the scarcity of GSD health research more generally (Hughes, Damin & Heiden-Rootes, 2017;

Phillips et al., 2003). Therefore, until more research is conducted, it remains difficult to review attitudes regarding gender and sexuality separately in their own right.

An additional consequence of the limited research available was the variation of time periods in which the studies were conducted. Of the fourteen papers reviewed, datasets varied in age – from as early as 1986 to as recent as 2019. In some respects, this variation in time might be considered problematic due to the evolution of attitudes regarding gender and sexual identity over time. However, it is important to note that similar themes were encapsulated in studies of earlier and more recent time-points. For instance, evidence of heterosexism and transphobia was found in almost all papers reviewed (regardless of time period), indicating that attitudes may not have shifted as dramatically as public opinion may otherwise suggest.

Of course, such research is likely to be influenced by various social and political factors – many of which were beyond the scope of this review. Cross-cultural differences in religion, legal frameworks (including criminalisation), and societal acceptance or condemnation of diverse identities and sexual practices are all factors which significantly impact on the experiences of GSD populations and those around them (Kwok & Wu, 2015). For example, after generations of protesting for equal rights, the legal recognition of same-sex marriage in some cultures has perhaps unsurprisingly been found to improve GSD mental health and wellbeing (Wight, LeBlanc & Badgett, 2013). Therapists are not removed from these wider societal changes and their attitudes are also shaped by the cultural contexts that they are exposed to. Moreover, the training that therapists received will have been developed according to particular ideologies, and these will also vary depending on the surrounding culture and beliefs. The majority of papers discussed within this review originated from the US, where training courses may differ from other countries in terms of content and delivery. As such, this review presents a largely Westernised perspective of gender and sexual

orientation – though it is recognised that here, too, there is diversity in opinion and theoretical practice.

A final limitation regards the CASP ratings, which found the reviewed studies to be of mixed quality. Of note, reflexive accounts of the relationships between researchers and participants were rarely reported. Reflexivity is central to the process of qualitative research as there is a wide recognition of the researcher's influence on qualitative data collection and analysis (Mauthner & Doucet, 2003). In the reviewed studies, the subjective influence of researchers will undoubtedly have impacted upon their interpretations and, subsequently, the interpretations gleaned from this metasynthesis. Unfortunately, as these influences were rarely discussed it was not possible to wholly account for them within this review.

**Future Research**

In parallel with the findings of King et al. (2007), this metasynthesis has highlighted a paucity of research in regards to GSD mental health and psychotherapy – as evidenced by the relatively small number of studies discovered within a broad systematic search. In synthesising the findings of those studies relevant to this review, several avenues are suggested for future investigations.

Firstly, more research is needed to determine whether gender and sexual orientation should be considered as separate areas of cultural competency, or whether to conceptualise them within a single, inclusive framework as was deemed appropriate for this review. Given that gender diversity is a more recent area of mental health research relative to sexual orientation, additional studies are required before meaningful comparisons can be made. Salpietro, Ausloos and Clark (2019) suggest utilising grounded theory to begin establishing gender exploration as a unique therapist competency.

In addition, with regards to the intersectionality of identities there is a need for research that sheds light on the more nuanced issues faced by people possessing multiple minority characteristics. This might include developing a deeper understanding of the barriers preventing certain minority groups from accessing therapy (particularly ethnic minorities who also identify as GSD) and solutions that can be implemented by services. Of those factors identified from this review, the theme of fear and apprehension regarding therapists' open exploration of diversity warrants particular investigation.

**Conclusions**

This review offers a synthesis of qualitative research investigating the experiences of therapy professionals working with gender and sexual diversity. Emerging from the findings was an overarching theme regarding a process of silencing and erasure of GSD identities within counselling and psychotherapy. Factors contributing to this process included the presence of heterosexism and transphobia, a lack of knowledge, skills and resources due to inadequate training, and fear experienced by therapists at the prospect of facing their own unconscious biases and prejudices. Nevertheless, many therapists expressed a desire to confront these issues within their respective professions, alongside a commitment to GSD-affirmative practice and social advocacy. Therapists considered their development towards GSD cultural competence as an ongoing process, in which their initial training was typically framed as a missed opportunity for self-reflection regarding gender and sexual diversity. To this end, therapy training programmes may benefit from a greater inclusion of GSD-specific content as part of their core curricula.

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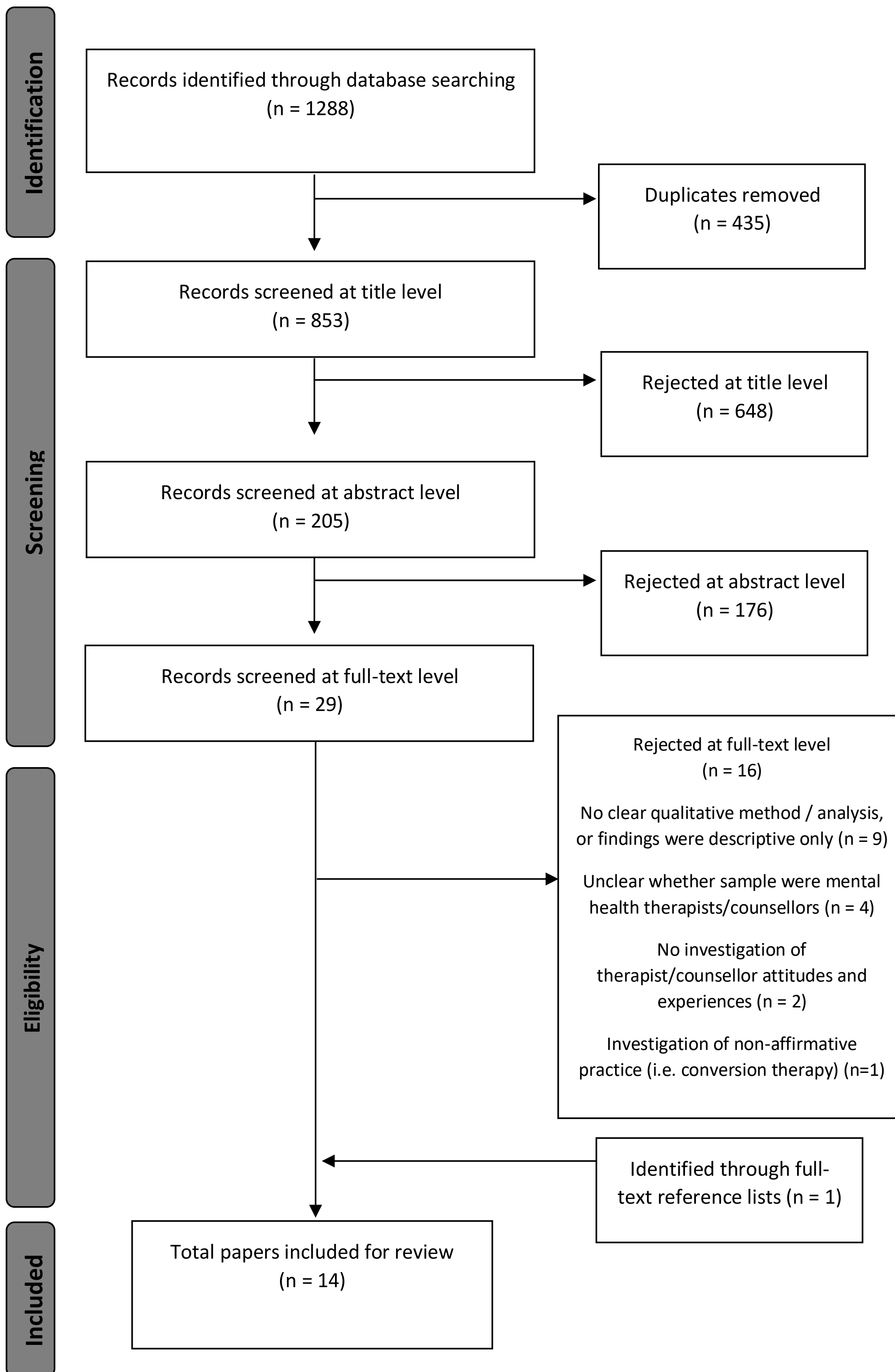


*Figure 1*. PRISMA flow-diagram depicting the process of literature searching and selection.

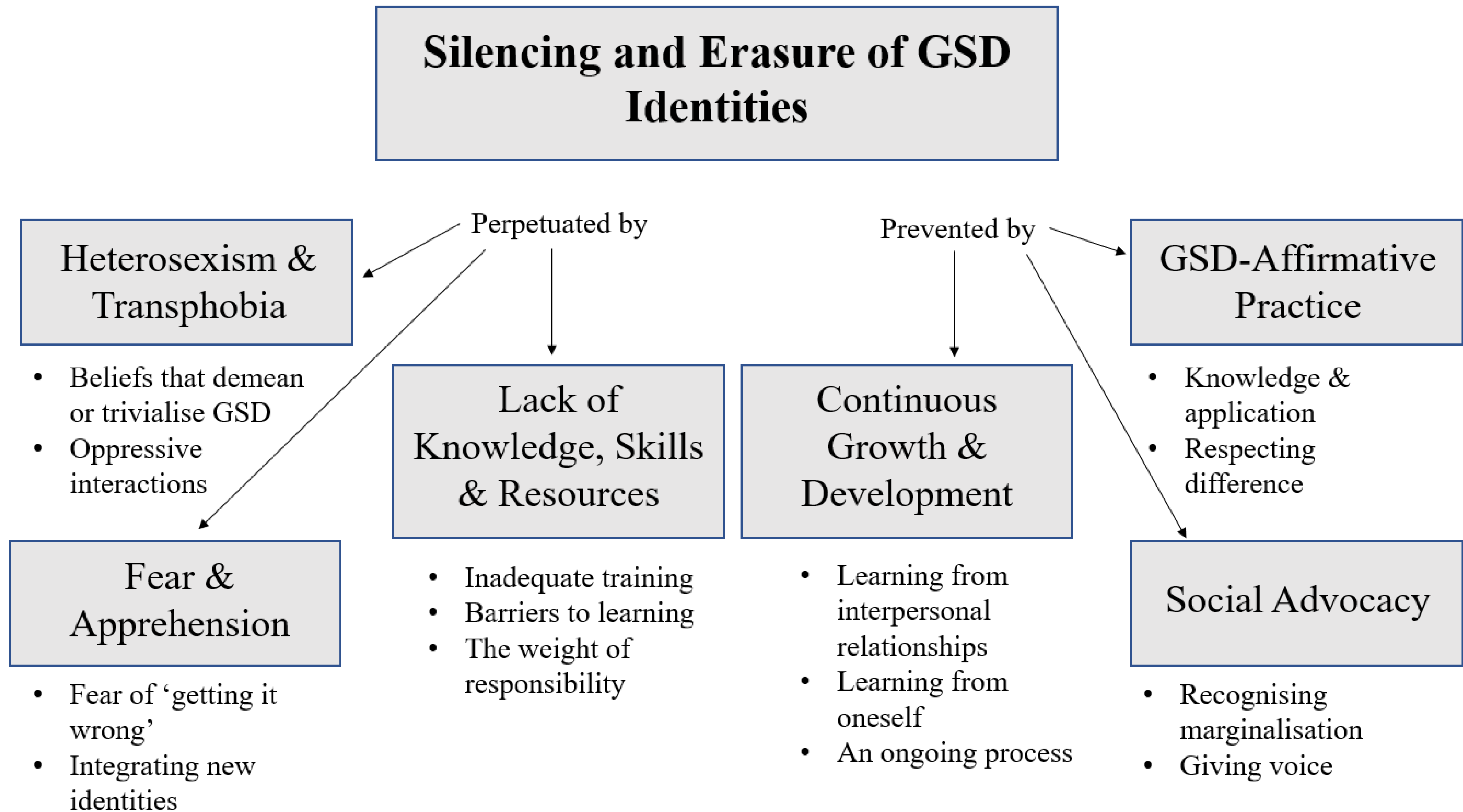


*Figure 2.* Flow diagram depicting each core concept in relation to the overarching theme

*Table 1.* Free-text search terms, informed by the SPIDER tool.

| | Domain | Search Terms |
|---|---|---|
| **Sample (1)** | Gender and sexual diversity | “LGBT*” OR “gay*” OR “lesbian*” OR “bisex*” OR “queer” OR “non-heterosexual” OR “homosexual” OR “sexual minorit*” OR “sexual divers*” OR “transgender” OR “transsex*” OR “gender divers*” |
| | | AND |
| **Sample (2)** | Therapists and/or counsellors | “therapist” OR “counsellor” OR “counselor” OR “psychotherapist” OR “psychologist” OR “counselling” OR “affirmative therapy” OR “affirmative counselling” |
| | | AND |
| **Phenomenon of interest** | Attitudes and experiences | “attitude*” OR “perception*” OR “experience*” OR “assumptions” OR “bias*” OR “preparedness” OR “competence” OR “competency” OR “training” OR “development” OR “awareness” |
| | | AND |
| **Design & Research type** | Qualitative research | “qualitative” OR “mixed method*” OR “interview” OR “focus group” OR “survey” OR “thematic analysis” OR “content analysis” OR “grounded theory” OR “narrative analysis” OR “interpretative phenomenological analysis” OR “phenomeno*” |

*Table 2.* Database subject headings and thesaurus terms.

| | Domain | Database* | Subject terms (+ indicates terms exploded) |
|---|---|---|---|
| **Sample (1)** | Gender and sexual diversity | MEDLINE MESH Headings | (MH “Sexual and Gender Minorities”) OR (MH “Homosexuality”) OR (MH “Gender Identity”) |
| | | PsycINFO Thesaurus Terms | DE “Sexual Minority Groups” OR DE “Homosexuality+” OR “Gender Identity+” |
| | | CINAHL | (MH “LGBTQ Persons+”) |
| **Sample (2)** | Therapists and/or counsellors | MEDLINE MESH Headings | (MH “Psychotherapy”) OR (MH “Counseling”) |
| | | PsycINFO Thesaurus Terms | DE “Psychotherapy” OR DE “Affirmative Therapy” OR DE “Counseling” |
| | | CINAHL | (MH "Counselors") OR (MH "Psychotherapy") OR (MH "Counseling") |
| **Phenomenon of interest** | Attitudes and experiences | MEDLINE MESH Headings | (MH "Attitude of Health Personnel") |
| | | PsycINFO Thesaurus Terms | DE “Therapist Attitudes” OR DE “Psychologist Attitudes” OR DE “Counselor Attitudes” OR DE “Counselor Education” OR DE “Counselor Trainees” |
| | | CINAHL | (MH "Attitude of Health Personnel") OR (MH "Cultural Competence") |
| **Design & research type** | Qualitative research | MEDLINE MESH Headings | (MH “Qualitative Research”) |
| | | PsycINFO Thesaurus Terms | DE “Qualitative Methods” OR DE “Interviews” OR DE “Grounded Theory” OR DE “Content Analysis” |
| | | CINAHL | (MH “Qualitative Studies +”) OR (MH “Interviews+”) OR (MH “Focus Groups”) OR (MH “Narratives”) |

**Note: Function not available on the Web of Science database*

*Table 3.* Study and participant characteristics

| Paper | Research Question | Methodology | Participants |
|---|---|---|---|
| 1. Asta & Vacha-Haase (2013) | To explore heterosexual psychologists' experiences and development, working as "allies" within the LGBT community. | *Data collection:* one-to-one interviews<br>*Qualitative Analysis:* interpretative phenomenological analysis | *Sample size:* 14<br>*Professional group:* Counselling psychologists & pre-doctoral interns<br>*Age:* 27-63 years<br>*Sex:* 12 females, 4 males<br>*Setting:* USA |
| 2. Dillon et al. (2004) | To investigate the process by which a group of counsellors-in-training confront their heterosexist biases, towards a position of LGB-affirmative practice. | *Data collection:* written self-reflective narratives following several group discussions and seminars<br>*Qualitative Analysis:* consensual qualitative analysis | *Sample size:* 10<br>*Professional group:* graduates in mental health counselling<br>*Age:* not stated<br>*Sex:* 2 females, 8 males<br>*Setting:* USA |
| 3. Eliason (2000) | To determine the knowledge and attitudes of substance abuse counsellors regarding LGBT clients. | *Data collection:* postal survey<br>*Qualitative Analysis:* thematic | *Sample size:* 242<br>*Professional group:* counsellors working within community- and hospital-based substance abuse treatment agencies<br>*Age:* 19 – 65 years<br>*Sex:*73% female, 27% male<br>*Setting:* USA |
| 4. Garnets et al. (1991) | Part of a larger scale investigation to provide an empirical basis for the development of guidelines for LGB practice, conducted in 1986. | *Data collection:* postal survey<br>*Qualitative Analysis:* thematic | *Sample size:* 1,481<br>*Professional group:* psychologists<br>*Age:* 26-86 years<br>*Sex:* 69% female, 31% male<br>*Setting:* USA |
| 5. Gaspodini & Falcke (2018) | To investigate how issues of sexual diversity and gender appear and are experienced by professionals of clinical practice in psychology. | *Data collection:* Focus groups<br>*Qualitative Analysis:* thematic | *Sample size:* 14<br>*Professional group:* clinical psychologists<br>*Age:* 24 – 60 years<br>*Sex:* 14 females<br>*Setting:* Brazil |

| | | | |
|---|---|---|---|
| 6. Grove (2009) | Two questions: 1) How competent are counselling students to counsel LGB clients; 2) What do trainees perceive as their most effective learning experiences? | *Data collection:* postal survey<br>*Qualitative Analysis:* grounded theory | *Sample size:* 58<br>*Professional group:* Counselling diploma students<br>*Age:* 21 – 70 years<br>*Sex:* 48 females, 10 males<br>*Setting:* UK |
| 7. Hancock, McAuliffe & Levingston (2014) | Exploration of factors associated with counsellor competency in working with sexual minority victims of intimate partner violence. | *Data collection:* one-to-one interviews<br>*Qualitative Analysis:* grounded theory | *Sample size:* 10<br>*Professional group:* counsellors and therapists working in the field of intimate partner violence<br>*Age:* 30 – 60 years<br>*Sex:* 8 females, 2 males<br>*Setting:* USA |
| 8. Harris et al. (2017) | What are the experiences of African American Christian counselling students in integrating their faith and ethical responsibilities in working with LGB individuals? | *Data collection:* one-to-one interviews<br>*Qualitative Analysis:* phenomenology | Sample size: 7<br>*Professional group:* counselling students & graduates<br>Age: 22-46 years<br>Sex: 7 females<br>Setting: USA |
| 9. O'Hara et al. (2013) | To uncover educative experiences contributing to counselling students' understanding of transgender persons. | *Data collection:* focus groups<br>*Qualitative Analysis:* thematic | *Sample size:* 7<br>*Professional group:* counsellors in training<br>*Age:* 25-34 years<br>*Sex:* 6 females, 1 male<br>*Setting:* USA |
| 10. Owen-Pugh & Baines (2014) | To explore the clinical experiences of novice counsellors working with LGBT clients; and to clarify the extent to which their training prepared them in working with this client group. | *Data collection:* one-to-one interviews<br>*Qualitative Analysis:* thematic | *Sample size:* 16<br>*Professional group:* “novice” counsellors<br>*Age:* 25-57 years<br>*Sex:* 11 females, 5 males<br>*Setting:* UK |

| | | | |
|---|---|---|---|
| 11. Ristock (2001) | To examine feminist counsellors in working with lesbian women who have been abused by their partners. | *Data collection*: focus groups<br>*Qualitative Analysis:* discourse analysis | *Sample size:* 70<br>*Professional group:* counsellors<br>*Age:* 20-63 years<br>*Sex:* 70 females<br>*Setting:* Canada |
| 12. Rivers & Swank (2017) | What are the lived experiences of counselling students engaging in LGBT ally training? | *Data collection:* one-to-one interviews<br>*Qualitative Analysis:* phenomenological | *Sample size:* 10<br>*Professional group:* counsellors in training<br>*Age:* 20-36 years<br>*Sex:* 10 females<br>*Setting:* USA |
| 13. Salpietro, Ausloos & Clark (2019) | To examine the experiences of cisgender counsellors working with gender diverse clients, and to highlight training experiences, strengths, challenges and values. | *Data collection:* one-to-one interviews<br>*Qualitative Analysis:* phenomenological | *Sample size*: 12<br>*Professional group*: licenced counsellors<br>*Age:* 26-65 years<br>*Sex:* 10 females, 2 males<br>*Setting:* USA |
| 14. Whitehead et al. (2012) | To understand how practitioners make diagnostic and treatment decisions when working with gender diverse clients. | *Data collection:* one-to-one interviews<br>*Qualitative Analysis:* grounded theory | *Sample size*: 35<br>*Professional group:* various (counsellors, family therapists, clinical social workers & psychologist advertising services as 'trans-supportive')<br>*Age:* "40's – 50's"<br>*Sex:* "majority female"<br>*Setting:* USA |

*Table 4.* Quality Appraisal Ratings

| | **Paper** | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CASP Question** | Asta & Vacha-Haase (2013) | Dillon et al. (2004) | Eliason (2000) | Garnets et al. (1991) | Gaspodini & Falcke (2018) | Grove (2009) | Hancock, McAuliffe & Levingston (2014) | Harris et al. (2017) | O'Hara et al. (2013) | Owen-Pugh & Baines (2014) | Ristock (2001) | Rivers & Swank (2017) | Salpietro, Ausloos & Clark (2019) | Whitehead et al. (2012) |
| Was there a clear statement of the aims of the research? | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Is a qualitative methodology appropriate? | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Was the research design appropriate to address the aims of the research? | 2 | 2 | 1 | 2 | 3 | 2 | 3 | 2 | 3 | 2 | 2 | 3 | 2 | 2 |
| Was the recruitment strategy appropriate to the aims of the research? | 2 | 2 | 2 | 2 | 3 | 2 | 1 | 2 | 2 | 3 | 2 | 3 | 2 | 2 |
| Was the data collected in a way that addressed the research issue? | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 2 | 2 | 3 | 2 | 2 | 2 |
| Has the relationship between researcher and participants been adequately considered? | 3 | 1 | 1 | 1 | 1 | 2 | 2 | 3 | 1 | 3 | 1 | 2 | 3 | 1 |
| Have ethical issues been taken into consideration? | 1 | 1 | 1 | 2 | 2 | 3 | 1 | 1 | 1 | 3 | 1 | 2 | 2 | 1 |
| Was the data analysis sufficiently rigorous? | 3 | 3 | 1 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 2 | 3 | 3 | 2 |
| Is there a clear statement of findings? | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 2 | 2 | 2 | 2 | 2 | 1 |
| How valuable is the research? | 2 | 2 | 2 | 2 | 2 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 1 |

| Total score (/24) | 18 | 15 | 12 | 15 | 17 | 19 | 17 | 19 | 16 | 20 | 15 | 19 | 18 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**Appendix 1-A**

**Development of themes and core concepts.**

| Key Themes, first iterations | Key themes, final iterations (2nd order constructs) | Core concept, first iterations | Core concept, final iteration (3rd order constructs) | Relevant papers |
|---|---|---|---|---|
| Perceiving GSD-identities as a non-issue; Underestimating impact of disclosure; Automatic attribution of problems to sexual orientation; Assuming an a priori suffering due to GSD identity; Misinformed beliefs about gender; Misinformed beliefs about bisexuality; Preconceptions regarding sexual development; Causal attributions; Construction of gender as a purely biological or spiritual phenomenon; conceptualisation of GSD clients as broken; Conceptualisation of psychopathology; Implications of religion; Fetishization of gender exploration; Othering of same-sex relationships; Negative assumptions about parenting capacity; Heteronormative assumptions; Implicit pathological knowledge; Discrepancy between professional values and expectations | Preconceptions & misinformed beliefs; Harmful conceptualisations of GSD; Prejudice & negative assumptions | Beliefs that demean or trivialise GSD | Heterosexism & Transphobia | Asta & Vacha-Haase (2013)<br>Dillon et al. (2004)<br>Eliason (2000)<br>Gaspodini & Falcke (2018)<br>Garnets et al. (1991)<br>Grove (2009)<br>Harris et al. (2017)<br>Owen-Pugh & Baines (2014)<br>Ristock (2001) |
| Therapist's capacity to withhold treatment; Pathologisation via diagnoses; Oppression in the therapy room; Decisions to terminate therapy; Unintentional application of dominant heteronormative discourse; Imposing personal or religious beliefs on clients; conflict between counsellor views & client recovery; investment in maintaining dominant narratives; differences acknowledged but unexplored; Avoidance of sexuality in clinical practice; Unable to voice concerns; Silencing of GSD issues; Shutting down conversation; Erasure of lesbian experience; Disregarding gender fluidity denies client choice; Actively discouraging same-sex relationships; Discrimination in treatment; Shame-based interventions; Explicit pathologising language; Negative experiences perpetuated by therapists; Pathological practice; Negative assumptions about internal experiences; Discomfort in | Exercising power; Silencing; Shame-based interventions; Interpersonal discomfort | Oppressive Interactions | | Salpietro, Ausloos & Clark (2019)<br>Whitehead et al. (2012) |

| | | | | |
|---|---|---|---|---|
| face of gender incongruity; Feeling challenged in practice; Difficulty entering client's world; Interpersonal difficulties; Distrust from clients | | | | |
| Call for increased training; Discussions rarely happen in training; A need for more reflective spaces; An unmet need for discussion; Avoidance in training; Disappointment with lack of discussion; Variation in academic content covered; Limited self-reflection; Superficial training; Breadth at the expense of depth; Academic programmes 'gloss over' GSD issues; Gender work as a specialty area; Gender as 'untrodden territory'; Specific training needed for trans* issues; The specific complexities of transitioning | Lack of GSD content; Superficial training; A need for gender-specific training | Inadequate training | Lack of Knowledge, Skills and Resources | Asta & Vacha-Haase (2013) Garnets et al. (1991) Hancock, McAuliffe & Levingston (2014) Harris et al. (2017) O'Hara et al. (2013) Owen-Pugh & Baines (2014) Rivers & Swank (2017) Salpietro, Ausloos & Clark (2019) |
| Guilt & Frustration (not doing enough / not knowing how); Limited time; Difficulty finding working strategies; Challenges from family systems; Challenges from society | Personal challenges; Societal challenges | Barriers to learning | | |
| Lack of GSD knowledge; Lacking awareness of how GSD fits with psychological theory; Poor knowledge negatively affects confidence, despite existing skills; Failure to recognise internalised homophobia in clients; Supervisors might not understand; GSD students feel pressured to raise awareness and challenge; GSD students feel a pressure to perform; Navigating self-disclosure without guidance | Lack of lay-person knowledge; Pressure on GSD communities | The weight of responsibility | | |
| Stereotypes & inadequate language; Confusion with terminology; Fear of saying the wrong thing; Cautious about language; Fear of offending with incorrect terms; It's not my place; 'Ally' complacency; Anxiety about being judged; Negative reactions from others; Necessity of trust & safety for self-reflection | Insufficient language; Fear of offending; Fear of complacency; Fear of being judged | Fear of 'getting it wrong' | Fear & Apprehension | Asta & Vacha-Haase (2013) Dillon et al. (2004) Gaspodini & Falcke (2018) Harris et al. (2017) O'Hara et al. (2013) Owen-Pugh & Baines (2014) |
| Past experiences conflict with new teachings; conflicting values; religious beliefs can be conflicting; contrasting values difficult to | Conflicting values; The struggle for | Integrating new identities | | |

| | | | | |
|---|---|---|---|---|
| reconcile; individual attitudes don't fit wider group; Awareness is a struggle; Homophobic self-consciousness; Struggle of working with internalised homophobia; Challenge of integrating new identities; Integration can be lonely and confusing; Generational differences & ingrained beliefs; | self-awareness;<br>A loss of self | | | Ristock (2001)<br>Rivers & Swank (2017) |
| Practices based on depathologisation; GSD-affirmative interventions; Affirmative therapy using person-centred techniques; Accessing community resources; Knowledge of community resources; Use of the public domain; Knowledge based on depathologisation; Awareness of non-binary gender identities; Understanding fosters empathy; Use of therapeutic alliance; Sexuality as important but not isolated; Balance between sexuality and other issues | GSD-affirmative interventions;<br>Knowledge and use of external resources;<br>Seeing beyond GSD | Knowledge & application | GSD-Affirmative Practice | Dillon et al. (2004)<br>Garnets et al. (1991)<br>Gaspodini & Falcke (2018)<br>Grove (2009)<br>O'Hara et al. (2013)<br>Owen-Pugh & Baines (2014) |
| Putting flawed assumptions aside; Recognition of heteronormative assumptions; Respecting difference; GSD individuals are not inherently victims; conceptualisation of GSD in a framework of power; Recognition of a fluid model of gender identity | Withholding personal prejudice;<br>Inclusive conceptualisations of GSD | Respecting difference | | Rivers & Swank (2017)<br>Salpietro, Ausloos & Clark (2019)<br>Whitehead et al. (2012) |
| Interplay between sexism, racism, violence & homophobia; Overlap with GSD and other minority groups; A hidden minority; Visible and invisible differences; Intersecting identities; Recognising impact of societal prejudice; Media propagates stereotypes; Attitudes stem from wider society; Awareness of social and political factors | Intersectionality of identities;<br>Understanding social context | Recognising marginalisation | Social Advocacy | Asta & Vacha-Haase (2013)<br>Dillon et al. (2004)<br>Garnets et al. (1991)<br>Grove (2009)<br>Ristock (2001) |
| Making a difference in social activism; Beyond therapy - advocacy; Engaging with advocacy post-training; Externalising problems to societal systems; knowledge and confidence promotes advocacy; Counselling as a vehicle for social justice; centrality of social justice; A duty to be 'allies' in sessions and in society | Engagement with social activism;<br>The centrality of social justice in counselling | Giving voice | | Rivers & Swank (2017)<br>Salpietro, Ausloos & Clark (2019) |

| | | | | |
|---|---|---|---|---|
| | | | | Whitehead et al. (2012) |
| A need for competent supervisors; Learning from supervisors; Reinforcement from others; Mentors act as role models; Perceptions of others are important; Learning from clients fosters growth; Unique aspects of GSD clients; Similarities with other clients; Understanding others; Understanding depends on agency culture; Life experiences challenge assumptions; Attitudes from family backgrounds; External contacts; Exposure adds a new perspective; Personal relationships | The importance of supervision; Mentorship and modelling; Learning from and with the client; Significance of personal relationships | Learning from interpersonal relationships | Continuous Growth & Development | Asta & Vacha-Haase (2013) Dillon et al. (2004) Grove (2009) Hancock, McAuliffe & Levingston (2014) Harris et al. (2017) O'Hara et al. (2013) |
| Value of experiential training; Group work - a way forward; Experiential training fosters understanding; Training supports capacity to challenge assumptions; Key 'turning points' facilitate change; Informed by personal experience; Drawing on lived experience; Personal life experiences; Experience of oppression; Self-education; A desire to increase awareness; Self-knowledge; Utilising personal faith; Self-reflection facilitates understanding | Experiential training; Lived experience; Self-reflection | Learning from oneself | | Owen-Pugh & Baines (2014) Rivers & Swank (2017) Salpietro, Ausloos & Clark (2019) Whitehead et al. (2012) |
| Society is constantly evolving; Ally development involves continuous growth; Fluid process; Continuous growth; Training needs to be dynamic; 'On the job' learning; Learning happens post-training too | Fluid process of development; Training is dynamic | An ongoing process | | |

## Appendix 1-B

**Definitions of 2nd order constructs.**

| Key Themes; First iterations | Key Themes; Final iterations (2nd order constructs) | Definition |
|---|---|---|
| Challenge of integrating new identities; Integration can be lonely and confusing; Generational differences & ingrained beliefs | A loss of self | An apprehension regarding the loss of some sense of self when attempting to integrate GSD values with personal beliefs and experiences |
| Gender work as a specialty area; Gender as 'untrodden territory'; Specific training needed for trans* issues; The specific complexities of transitioning | A need for gender-specific training | The need for specialty training pertaining to issues of gender, given the complexities and lack of consensus in this area |
| Past experiences conflict with new teachings; conflicting values; religious beliefs can be conflicting; contrasting values difficult to reconcile; individual attitudes don't fit wider group | Conflicting values | A discrepancy between the therapist's own personal values and the fluidity and inclusivity required by GSD communities |
| Making a difference in social activism; Beyond therapy - advocacy; Engaging with advocacy post-training; Externalising problems to societal systems; knowledge and confidence promotes advocacy | Engagement with social activism | Involvement with behaviours which seek to promote, impede, direct, or intervene in social, political, economic, or environmental reform with the desire to make changes in society for GSD groups |
| Therapist's capacity to withhold treatment; Pathologisation via diagnoses; Oppression in the therapy room; Decisions to terminate therapy; Unintentional application of dominant heteronormative discourse; Imposing personal or religious beliefs on clients; conflict between counsellor views & client recovery | Exercising Power | The operation of power within the therapeutic relationship in such a way that may be oppressive – such as withholding treatment |

| | | |
|---|---|---|
| Value of experiential training; Group work - a way forward; Experiential training fosters understanding; Training supports capacity to challenge assumptions; Key 'turning points' facilitate change | Experiential training | Experiential exercises that took place during training (albeit rarely) were considered amongst the most influential in helping therapists to consider their own biases and assumptions |
| Anxiety about being judged; Negative reactions from others; Necessity of trust & safety for self-reflection | Fear of being judged | Therapist concerns that they would be negatively perceived by others, either due to their biases or by being perceived as homosexual |
| Ally complacency | Fear of complacency | Therapist's concerns that identifying themselves as 'allies' within the GSD community may lead to complacency in their advocacy |
| Fear of saying the wrong thing; Cautious about language; Fear of offending with incorrect terms; It's not my place | Fear of offending | Cautiousness regarding the use of GSD-specific language due to a fear of offending clients |
| Society is constantly evolving; Ally development involves continuous growth; Fluid process; Continuous growth | Fluid process of development | The conceptualisation of personal development as a process that is never truly completed, but rather evolves over time |
| Practices based on depathologisation; GSD-affrimative interventions; Affirmative therapy using person-centred techniques | GSD-affirmative interventions | Interventions in clinical practice which seek to affirm a client's GSD identity and which respects the client's freedom to their personal beliefs and experiences |
| Causal attributions; Construction of gender as a purely biological or spiritual phenomenon; conceptualisation of GSD clients as broken; Conceptualisation of psychopathology; Implications of religion | Harmful conceptualisations of GSD | Notions of GSD development which might be considered harmful or offensive to people within the GSD community |
| GSD individuals are not inherently victims; conceptualisation of GSD in a framework of power; Recognition of a fluid model of gender identity | Inclusive conceptualisations of GSD | Conceptualisations of GSD within a non-pathologising framework, which does not blame them for their experiences and which respects the diversity of these populations |
| Stereotypes & inadequate language; Confusion with terminology | Insufficient language | A lack of clarity regarding the language used to describe the wealth of diversity in GSD populations |

| | | |
|---|---|---|
| Discomfort in face of gender incongruity; Feeling challenged in practice; Difficulty entering client's world; Interpersonal difficulties; Distrust from clients | Interpersonal discomfort | The discomfort experienced by some therapists in engaging with people from GSD populations or when faced with issues related to gender and/or sexual orientation |
| Interplay between sexism, racism, violence & homophobia; Overlap with GSD and other minority groups; A hidden minority; Visible and invisible differences; Intersecting identities | Intersectionality of identities | The interactions that occur between various aspects of social and political identity (e.g. gender/sexuality/race/age/social status), often combining in ways that perpetuate discrimination |
| Accessing community resources; Knowledge of community resources; Use of the public domain; Knowledge based on depathologisation; Awareness of non-binary gender identities; Understanding fosters empathy; Use of therapeutic alliance | Knowledge and use of external resources | The awareness of and utilisation of resources within the community to assist with interventions (advice/signposting etc.) and of psychological theories which may support in understanding GSD-related issues |
| Call for increased training; Discussions rarely happen in training; A need for more reflective spaces; An unmet need for discussion; Avoidance in training; Disappointment with lack of discussion; Variation in academic content covered; Limited self-reflection | Lack of GSD content | The lack of content regarding GSD issues highlighted by therapists on their training courses |
| Lack of GSD knowledge; Lacking awareness of how GSD fits with psychological theory; Poor knowledge negatively affects confidence, despite existing skills; Failure to recognise internalised homophobia in clients; Supervisors might not understand | Lack of lay-person knowledge | The lack of a solid knowledge base regarding GSD issues within the general population of therapists and counsellors |
| Learning from clients fosters growth; Unique aspects of GSD clients; Similarities with other clients; Understanding others | Learning from and with the client | Utilising therapeutic interactions not only as a means to support clients, but to learn from their shared experiences |
| Informed by personal experience; Drawing on lived experience; Personal life experiences; Experience of oppression | Lived experience | Therapists and counsellors reported that their own identification as GSD has contributed significantly to their practice and understanding of GSD-identifying clients |

| | | |
|---|---|---|
| Reinforcement from others; Mentors act as role models; Perceptions of others are important | Mentorship and modelling | The significance placed on role models (within the therapist's profession and/or within the GSD community) |
| Guilt & Frustration (not doing enough / not knowing how); Limited time; Difficulty finding working strategies | Personal challenges to learning | The internal and individual challenges faced by therapists in learning about GSD issues and advocating for the GSD community |
| Perceiving GSD-identities as a non-issue; Underestimating impact of disclosure; Automatic attribution of problems to sexual orientation; Assuming an a priori suffering due to GSD identity; Misinformed beliefs about gender; Misinformed beliefs about bisexuality; Preconceptions regarding sexual development; | Preconceptions & misinformed beliefs | The false ideas and information assumed by therapists and counsellors in working with GSD populations |
| Fetishisation of gender exploration; Othering of same-sex relationships; Negative assumptions about parenting capacity; Heteronormative assumptions; Implicit pathological knowledge; Discrepanct between professional values and expectations | Prejudice & negative assumptions | Beliefs and assumptions shared by some therapists which, if enacted upon or shared, might cause harm to people identifying as GSD |
| GSD students feel pressured to raise awareness and challenge; GSD students feel a pressure to perform; Navigating self-disclosure without guidance | Pressure on GSD communities | The pressures experienced by therapists who identify as GSD to bring awareness to GSD-related issues and advocate for GSD wellbeing |
| Sexuality as important but not isolated; Balance between sexuality and other issues | Seeing beyond GSD | The capacity to recognise that whilst gender and sexual orientation may be important to GSD clients, they do not occur in isolation and may not always be directly related to the client's reasons for attending therapy |
| Self-education; A desire to increase awareness; Self-knowledge; Utilising personal faith; Self-reflection facilitates understanding | Self-reflection | A process of introspection which therapists and counsellors considered a significant part of their development, involving the recognition of their own biases and beliefs |
| Actively discouraging same-sex relationships; Discrimination in treatment; Shame-based interventions; Explicit pathologising language; Negative experiences | Shame-based interventions | Treatments and actions by the therapist which might evoke feelings of shame within a GSD-client, or active discouragement of their experiences |

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| perpetuated by therapists; Pathological practice; Negative assumptions about internal experiences | | |
| Life experiences challenge assumptions; Attitudes from family backgrounds; External contacts; Exposure adds a new perspective; Personal relationships | Significance of personal relationships | Encounters with other people outside of professional circles as a means to develop understanding about GSD populations |
| Investment in maintaining dominant narratives; differences acknowledge but unexplored; Avoidance of sexuality in clinical practice; Unable to voice concerns; Silencing of GSD issues; Shutting down conversation; Erasure of lesbian experience; Disregarding gender fluidity denies client choice | Silencing | The prevention of discourse regarding GSD issues and the active erasure of GSD identities within therapy and counselling, intentional or otherwise |
| Challenges from family systems; Challenges from society | Societal challenges to learning | The external and societal challenges faced by therapists in learning about GSD issues and advocating for the GSD community |
| Superficial training; Breadth at the expense of depth; Academic programmes 'gloss over' GSD issues | Superficial training | Therapists described the content that is present on training courses as superficial and lacking in depth |
| Counselling as a vehicle for social justice; centrality of social justice; A duty to be 'allies' in sessions and in society | The centrality of social justice in counselling | Recognition of social justice as holding a key focus within mental health professions - both within the therapy room and beyond |
| A need for competent supervisors; Learning from supervisors | The importance of supervision | The utilisation of supervision as a space to learn from and with more experienced colleagues |
| Awareness is a struggle; Homophobic self-consciousness; Struggle of working with internalised homophobia | The struggle for self-awareness | The fear and apprehension experienced by therapists when faced with their own belief systems and prejudices |
| Training needs to be dynamic; 'On the job' learning; Learning happens post-training too | Training is dynamic | Similarly to personal development, training was conceptualised as an equally fluid and dynamic process - especially given the ever changing context of society |

| | | |
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| Recognising impact of societal prejudice; Media propogates stereotypes; Attitudes stem from wider society; Awareness of social and political factors | Understanding social context | The therapist's awareness of the context within which GSD individuals find themselves and how this context may perpetuate a person's difficulties |
| Putting flawed assumptions aside; Recognition of heteronormative assumptions; Respecting difference | Withholding personal prejudice | The capacity for the therapist to prevent their own personal biases and assumptions from negatively impacting on the therapeutic encounter |

**Appendix 1-C**

**Journal of Gay & Lesbian Mental Health: Instructions for Authors.**

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**Section Two: Research Paper**

# ‘Coming out’ in therapy: The experiences of young people disclosing their sexual orientation to mental health professionals

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Abstract

The disclosure of sexual orientation in therapy is a topic that has previously been investigated from the perspectives of sexually diverse therapists, but rarely from the position of sexually diverse clients. The present study addresses this gap in the literature by exploring the experiences of eight young people who disclosed their sexual orientation in a therapy setting. One-to-one interviews were transcribed and analysed using interpretative phenomenological analysis. Four themes were discovered, which provided a relational framework for understanding participant experiences of coming out to their therapists: (1) Questioning the self: Who am I?; (2) Questioning the therapist: Who are you?; (3) Questioning the relationship: Who are we? (Together, or apart?); (4) A flawed society. These themes are discussed with reference to operations of power and the therapeutic alliance. The findings may be of particular interest for sexual minority therapists and therapists working clinically with sexually diverse youth.

*Keywords:* LGBTQ+; sexuality; young people; coming out; therapy; qualitative research

‘Coming out’ in therapy: The experiences of young people disclosing their sexual orientation to mental health professionals

The disclosure of one’s sexual orientation, commonly referred to as ‘coming out,’ has been defined as a “critical life experience” for sexually diverse people (Plummer, 1995; p.57). Contemporary coming out narratives highlight the influence of such experiences on cognitive and emotional development, with profound implications for mental health and wellbeing (Dunlap, 2014). Yet, there is a growing body of literature which suggests that a majority of mental health professionals are ill-equipped to work alongside sexually diverse populations. Existing research has found evidence of prejudicial beliefs amongst therapists, counsellors and psychologists (Eliason, 2000; Garnets et al., 1991; Gaspodini & Falcke, 2018), which can feel exposing to address (Dillon et al., 2004). Newly qualified clinicians have pointed towards an absence of training regarding gender and sexual diversity (Grove, 2009; Owen-Pughes & Baines, 2014); particularly that which invites personal self-reflection and advocacy development (Asta & Vacha-Haase, 2013). These findings are especially concerning given the increased rates at which people from gender and sexually diverse groups access therapy and experience difficulties with their emotional and psychological wellbeing (Cochran, Sullivan & Mays, 2003; King et al., 2008).

Young people are perhaps a particularly important group in mental health research as the onset of various mental health difficulties typically occurs during adolescence. Indeed, Russel and Fish (2017) cite that suicide is the third leading cause of death for people between the ages of 10 and 14, and the second leading cause for those between 15 to 24. For sexually diverse youth (SDY), some studies report a threefold increase in the risk of suicidality when compared to their heterosexual peers (Marshal et al., 2011). There are a number of factors that are likely to contribute to the specific difficulties faced by SDY, including an increased prevalence of childhood trauma (McCormick, Scheyd & Terrazas, 2018) and experiences of

peer discrimination or hostility due to sexual preferences (Duarte et al., 2018; Price et al., 2019).

Adolescence and early-adulthood are also considered to be fundamental stages of identity formation (Kroger, 2007), which adds further complexity to the difficulties faced by SDY. According to Erikson's (1950; 1968) influential theory of psychosocial development, human beings are faced with a series of important psychological conflicts throughout life which must be overcome to sustain a coherent sense of self. These stages are not static, in that we may return to them at various time points, however there is a general consensus that certain developmental ages correspond with specific psychosocial goals.

In early adolescence, Erikson (1968) purported that the goal of the individual is to consider the depths of their identity by making comparisons with others and establishing unique attitudes, interests and behaviours. Through to early-adulthood, the individual then begins to consider their place within a wider society. For many people, this includes the formation of intimate relationships. Both of these stages are relevant to the development of sexual orientation and may pose additional challenges for people who recognise that their sexual attractions differ from their peers.

Similar staged models have been proposed to define processes of coming out. In reference to homosexuality, Cass (1979; 1996) suggested a progression through a series of developmental milestones, beginning with initial confusion regarding one's sexual orientation and moving through periods of peer comparison, tolerance, acceptance and, ideally, successful integration of the person's sexuality with their wider sense of self. Whilst this process is likely to be affected by a range of contextual factors, there is an assumption that the earlier stages tend to begin in adolescence.

Despite their popularity, stage approaches to sexual identity have received considerable criticism regarding their applications to modern society (Kenneady & Oswalt, 2014). These models were developed during a time of limited understanding regarding sexual diversity, using an exclusively dichotomous (heterosexual/homosexual) framework of sexuality (Eliason, 1996). The models therefore do not account for the wealth of diversity within these populations, nor do they consider the intersectionality with other social and cultural characteristics (Brauner, 2000). In addition, the assumption of a linear transition between stages contradicts recent evidence, which suggests that many SDY experience their sexualities as fluid and changeable (Katz-Wise, 2015).

Importantly, coming out is not typically an isolated experience but one that SDY continue to face as they interact with new people. Experiences will therefore vary significantly, depending on the individual's personal and social context. Current SDY research tends to focus on disclosures of sexual orientation in familial and social environments (Russel et al., 2014; Tanner & Lyness, 2004). However, many SDY may choose not to disclose their sexual orientation within a family setting for various reasons – such as intolerant attitudes towards sexual diversity, fear of abuse or being made an outcast from the family (Friedman et al., 2011). Therapy may present a space removed from these environments, in which identity can be openly discussed and explored. As such, it is important to understand how these conversations emerge and are shaped in therapy, so that mental health professionals are adequately equipped to support SDY without contributing to further distress.

The existing literature suggests that a large proportion of sexually diverse clients actively seek out sexually diverse therapists and, in some cases, achieve better outcomes than with therapists who identify as heterosexual or who choose not to disclose their sexual orientation (Brooks, 1981; Green, 2011; Jones, Botsko & Gorman, 2003; Liddle, 1996). One

potential explanation for these findings is the minority stress model (Meyer, 2003). This model states that people from sexually diverse groups may conceal their identities from others to protect them from stigma and discrimination. However, it is suggested that such concealment comes with a considerable cost to the person's wellbeing – perhaps due to the cognitive and psychological burden of suppressing such a significant aspect of one's identity (Smart & Wegner, 2000). A therapist who openly identifies as sexually diverse may be perceived as less threatening to the sexually diverse client, due to an assumption of some shared understanding or experience (Beutler et al., 1991). As such, the client may feel more able to talk openly with the therapist about their sexual identity, freeing them from the potential stress otherwise induced by concealing their sexual orientation or other related aspects of themselves.

Qualitative research has generally supported this notion. For example, interviews with sexually diverse therapists have indicated that self-disclosure of sexual orientation is often utilised as a therapeutic tool when working with sexually diverse clients (Lea, Jones & Huw, 2010; Porter, Hulbert-Williams & Chadwick, 2015). Such therapists refer to a heightened sense of rapport with their clients following the disclosure, which is thought to create a safe space from which to work through the client's distress. Yet few studies have investigated disclosure from the perspectives of the clients themselves.

One paper has explored the coming out experiences of lesbian, gay and bisexual clients in therapy by way of a postal survey (Evans & Barker, 2010). The findings highlighted a similar relationship between safety and disclosure, such that participants required a sense of trust in the therapist before disclosing their sexual orientation and that, in doing so, there was usually a feeling of relief. Interestingly, therapist self-disclosure was found to be of less importance to the participants in this study, who expected that therapists would be safe and empathic, regardless of their sexual identities. Nevertheless, the lack of

knowledge and heteronormative assumptions made by a minority of heterosexual therapists was experienced by participants as problematic and gave rise to feelings of distance and discomfort in the therapeutic alliance.

The present study contributes to the growing body of literature in this area. The purpose of this research is to investigate the experiences of SDY in disclosing their sexual orientation to therapists and/or counsellors. The aim is to achieve this through an in-depth, qualitative investigation, which seeks to understand how discussions of sexuality take place in therapy and to uncover some of the more subtle factors impacting on this process. It is hoped that by understanding the nuanced ways in which sexual identity is discussed within the therapy room, SDY, and their therapists, can be more adequately supported.

## Method

### Design

Interpretative Phenomenological Analysis (IPA) was selected as an appropriate qualitative method to address the research question as it is concerned with the examination of personal lived experience (Smith, Flowers & Larkin, 2009). As highlighted by Smith and Osborn (2015), IPA is especially useful in exploring topics which are psychological, complex and emotionally laden, which previous research highlights is reflective of many experiences of sex and sexuality (Coyle & Rafalin, 2000; Jarman, Walsh & De Lacey, 2005). Central to this process of exploration are the principles of phenomenology and hermeneutics (Smith et al., 2009). Practically, IPA seeks to explore the ways in which participants experience themselves and the world around them. This is achieved through active interpretation by the researcher and, therefore, is a multi-layered process of sense-making (Smith and Osborn, 2008).

IPA is also idiographic in its approach, such that it is designed to explore both the commonalities and divergences of a shared experience (Smith et al., 2009). This idiographic stance separates IPA from alternative qualitative methods, such as thematic analyses, which are more concerned with broader patterns of meaning across aggregated data (Braun & Clarke, 2006). To preserve the minutiae of a particular experience, IPA is typically conducted with small, homogenous samples which are purposefully selected. Importantly, Murray and Wilde (2020) emphasise that it is the essence of the experience in question that needs to be homogenous, as each participant is an individual in their own right. Therefore, it is possible to utilise IPA with participants who possess a variety of social and demographic characteristics, provided there is an assumption of some shared experience. For the purpose of this study, the experience in question was of disclosing a minority sexual orientation in a therapy context.

**Participants and Recruitment**

[Table 1 near here]

A staged approach to recruitment was taken due to pragmatic concerns regarding the recruitment of young people, especially given the sensitive topic of research (Powell & Smith, 2009; Turner & Almack, 2017). Initially, several regional and national youth groups and charities were identified and approached for advertisement of the study. These organisations catered for young gender and sexually diverse people between the ages of 13 – 18 years. The first author attended several group meetings to promote the study over a two-month period. A brief outline of the research background was presented, including information about participation. Inclusion criteria were as follows: (1) self-identification as having a sexual orientation which is not heterosexual; (2) experience of disclosing their sexual orientation to a therapist or counsellor; (3) between the ages of 13 – 18 years. It was

also emphasised that the participant's sexual orientation need not be the reason that they were seeking therapy, but that it was nevertheless disclosed at some point during the process. Information posters were also advertised online via social media.

After several months, only two participants had volunteered to take part and so a decision was made to extend the target age range up to 25 years. Amended posters were shared via social media and were displayed across a university campus in the north-west of England. Six more participants came forward, raising the total to eight participants overall. The characteristics of the participants are presented in Table 1.

Participants described various reasons for accessing therapy, including stress, anxiety, low mood and obsessive/compulsive thoughts and behaviours. In the majority of cases the therapy had taken place in the United Kingdom (UK), however some participants referred to experiences of therapy in the United States (Alex, Jerry), Germany (Jerry) and Hong Kong (Joe). When asked, most participants were unsure of the specific therapeutic modality or approach that they had received, however three participants recalled mention of cognitive behavioural therapy (Alex, Hamish, Lucy).

All but one participant had disclosed their sexual orientation to other people prior to beginning their therapy. Five participants had openly shared their sexual orientation with both friends and relatives (Carol, Jerry, Joe, Joshua, Lucy), two participants had openly shared this information with friends, but not relatives (Hamish, Jacob), and one participant discovered her sexual orientation whilst her therapy was taking place (Alex).

**Data Collection**

A semi-structured interview schedule was developed by the research team and reviewed by stakeholders, who were facilitators of one of the aforementioned youth groups (Appendix 2-A). The interview questions were designed to elicit discussion in various

domains of the participant's experience, such as their feelings about the disclosure, beliefs about the therapist's knowledge of gender and sexual diversity, and an impression of how the disclosure might have impacted on the overall experience of therapy. These questions were intended merely as a guide and not to be read verbatim, so as to allow the interview to dynamically unfold in a way that was grounded in the participant's unique experience. One interview was conducted face-to-face (Hamish), whilst the remaining seven occurred via Skype. The use of technology such as Skype is becoming increasingly popular in qualitative research, and has the advantage of overcoming constraints related to time, location and physical mobility (Janghorban, Roudsari & Raghipour, 2014). All interviews were recorded and transcribed by the first author. The mean length of interviews was 57 min.

**Analysis**

Interview transcripts were analysed by following the guidance of Smith et al. (2009). In keeping with the idiographic approach of IPA, each transcript was separately analysed before collating the findings into broader themes. Transcripts were initially read and re-read by the first author, who also listened back to the recording to retain a sense of the participant's voice. Initial thoughts and reflections were noted down on a separate column of the transcript during this process. These notes were then coded into key words or phrases that encapsulated descriptive, conceptual and linguistic interpretations of the participant's comments (Appendix 2-B). Thereafter, codes were physically sorted into more discrete themes via a process of comparison. At this point, the first author returned to the transcript to identify quotations which supported the theme in question and a written summary of the theme was produced (Appendix 2-C). This process was repeated for each transcript, producing between 4 – 5 separate, but related themes for each participant. A final stage of comparison was then conducted, whereby the themes themselves were sorted in a similar

fashion to the initial codes. This resulted in a final set of superordinate themes, which captured the combined stories of each individual participant (Appendix 2-D).

Importantly, the analysis evolved dynamically as discussions took place within the wider research team. An audit trail was kept to document the process and reflections were shared openly in regular supervision. This included sharing and discussing the first interview transcript as a quality check and to guide future interviews. The purpose of this was not to identify an objective *truth* per se, but rather to ensure that subjective influences had been considered and appropriately factored in to the analysis (Yardley, 2008). In addition, guidance was drawn from the quality criteria outlined by Smith (2011) to maintain credibility. For example, internal coherence was considered by ensuring that the final themes were supported by a sufficient density of evidence (in this case, extracts from at least 3 participants within the sample). Table 2 outlines the contributions made by each participant to the final set of themes.

[Table 2 near here]

**Reflexivity**

As the lead researcher and interviewer for this study, it is important that I acknowledge my own identity as a gay male. At the time of interviewing, I was also a trainee clinical psychologist, in the final year of my doctoral qualification. I had experienced therapy from the perspective of both therapist and client, meaning that I was in a unique position from which to be conducting the research. I would have met the criteria to participate in this research myself and this was important to hold in mind, so as to not confuse my own experiences with those of the participants.

I was attracted to IPA as a methodological approach due to its emphasis on individual differences, which provided a frame to assist me in this separation. As part of this process I

wrote a reflective diary, in which I captured my thoughts and feelings following each interview, and reflexively considered my own stance during the interviews themselves. By ensuring that my questions were open, and by drawing on each participant's language, I felt confident that the experiences elicited more closely resembled the participants' than my own. This was not an attempt to remove myself from the process entirely; indeed, Smith and Osborn (2008) suggest that it would be futile to do so. Rather, in being aware of my own interpretative stance I felt more able to adopt the role of a "researcher…trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2008, p.53).

### Ethics

The study received ethical approval from the Faculty of Health and Medicine Research Ethics Committee at Lancaster University – the details of which can be found in section 4 of this thesis. It is important to note that parental consent was not sought for those participants under the age of 18, given the sensitive nature of the topic and the risks involved for young people who may not have disclosed their sexual orientation to their families. Efforts were made to seek informed consent from the participants themselves, who were provided with a detailed information sheet prior to taking part. Stakeholders reviewed the language used in all relevant documentation to ensure that it was relevant to the target population. In addition, each participant provided a pseudonym to be attached to relevant data excerpts, in order to assure their anonymity.

## Findings

[Figure 1 near here]

Four interrelated superordinate themes were identified. These themes, including the relationships between them, are presented diagrammatically in Figure 1. The following is a presentation of each theme, supported by anonymised data excerpts.

**Questioning the Self: Who am I?**

> *Because that is the biggest thing about sexuality really, it's like figuring out who you are and then announcing it to the world, that's the terrifying thing about coming out (Jacob)*

All of the participants interviewed described an introspective process of sense-making regarding their sexual orientation and identity. Across participants, there was an experience of revealing previously unknown or unsaid feelings about sexuality through means of acknowledgement and disclosure to the therapist. Fundamentally, the experience of this introspective process depended on where participants placed themselves in their own individual journeys. For Hamish, sexuality was a *"minor part"* of her wider sense of self and one which she appeared distanced from. Upon realising her attraction to girls during adolescence, Hamish described a conscious process of *"compartmentalising"* – that is, separating this part of her until she felt ready to pay it more thought. In doing so, Hamish's sexuality appeared to become an unspoken aspect of her identity that she would internally move away from in order to maintain distance.

In contrast to Hamish, Alex developed an awareness of her sexuality later into early adulthood, during her course of therapy. This meant that Alex was faced with the difficult task of integrating newfound aspects of her identity and reconciling them with her past memories:

> *I think it just kind of hit me like-yeah, this is you- and looking back at things in the past it kind of makes more sense…but emotionally I'm still hearing those voices in my head from high school being like 'there's something wrong with you,' so it's hard when I know that I shouldn't necessarily be feeling that way but I am…it's hard to reconcile those two (Alex)*

As evident in the above excerpt, such introspective processes were not entirely removed from other people, but rather influenced by notions of power. Several participants described a lack of ownership regarding their identities; either because they deemed their sexuality *"abnormal"* and therefore initially rejected it, or because their feelings were doubted by others. In being denied the opportunity to make sense of their experiences, at their own time and pace, some participants felt that their difficulties had been exacerbated:

> *I was kind of new to all of this, I was just realising like- I wasn't exactly 'normal' as people say, and this kind of- I was trying to like figure out if I was gay, bi, pan, I don't know, at the same time everyone else was trying to figure out what I was…but I felt like if I had some time to kind of- think about it myself- I might have kinda' had an easier time with it… I've never really come out on my own terms either – not much about my gender and sexuality has been on my own terms (Joshua)*

Given that participants felt as if they lacked a sense of agency, there was often a guiding mechanism operating in the disclosure and exploration of their sexualities during therapy. In some cases, the therapist embodied this guiding role, whereas others described being driven by an unknown presence. Particularly in the latter cases, it was as if participants felt compelled by disallowed parts of themselves to be known, to be accepted and to be released from oppression. Those participants who came to articulate their experiences with their therapist usually discovered previously hidden aspects of themselves which gradually moved them to a position of self-acceptance:

> *I've had a really good experience with counselling…It's just easy to shrug off that isolation and that loneliness but I think it does kind of eat away at you for a very long time under the surface, and I think until you speak to somebody that's trained to talk*

*about these kinds of issues and help guide you through them, you're not really gonna know the damage that may have done (Carol)*

**Questioning the Therapist: Who are You?**

In addition to the internal, self-appraisals outlined in the first theme, participants also discussed their appraisals of the therapist – including the characteristics possessed by them and who they came to represent for participants. Interestingly, there appeared to be an element of duality to this appraisal process. Participants distinguished between the therapist as a trained and trusted *"professional,"* and as a *"person,"* possessing their own individual biases, prejudices and imperfections:

*If the general public assumes my sexuality to be heterosexual I wouldn't mind too much as with a therapist, but I have a high expectation for therapists to be more inclusive and sensitive when talking about relationships…so I felt that [my therapist] was really unprofessional saying those statements about 'oh I think there's something wrong with them because they're [into] BDSM'… I think she engaged a little bit into her own opinions and sharing her personal, not professional opinions with me- so I found that quite shocking (Joe)*

Overall, there was variation in the estimations that participants gave of their therapist's understanding of gender and sexual diversity. However, few participants felt that their therapist's knowledge of sexual diversity extended beyond a *"basic"* comprehension. For some participants, the perceived insecurities that the therapist held about their knowledge and skills hindered the relationship and surrounded the participant's disclosure of their sexuality with hostility.

*The LGBT ambassador [and counsellor] herself is a straight cis woman who isn't properly educated but I think the school just kind of threw her into the job without*

*kind of giving her any knowledge- she's told multiple of my friends that she's not good at her job... she would just ask questions that were outright kind of- very personal questions, just dive straight into it er- she- it was just really tense and kind of not nice (Joshua)*

These perceptions of insecurity or lack of knowledge were particularly apparent when the therapist was assumed to be heterosexual. For Jerry, there was an assumption that heterosexual therapists would not sufficiently understand his difficulties as a gay man, and so he actively sought out therapists who also openly identified as gay:

*I think it's really difficult to see someone's experience from the other side, so I think like [a straight therapist] might understand the concept of being gay but they can't fully understand what it's like to be gay- it doesn't mean they can't help me but I'm sure they have to make a lot of assumptions that are based off of what a straight person thinks a gay person deals with (Jerry)*

For others, the therapist's relative lack of knowledge presented an opportunity to re-balance the distribution of power within a therapeutic encounter. For example, Carol found herself in the role of an *"educator"* and took pride in being able to share her knowledge with an uninformed yet inquisitive therapist. Carol reasoned that she would feel more insecure in the presence of a sexual minority therapist due to a hypervigilance about her choice of language and use of *"correct"* terminology:

*I think in talking to somebody who's not in the community it's kind of less daunting because they're coming at it from like a blank slate I guess, and I think that one of the things that's constantly at the back of my mind is that if I'm embedded in the community like I have to say the right things and I have to, you know, there's- everything is kind of black and white and there's a right and wrong to a lot of these*

*kind of discussions, and if I say something wrong- you know I'll get- I'll get shunned for it, so it's kind of, there's less kind of pressure talking to someone who's new to these issues and the community (Carol)*

Taken together, the experiences described above highlight some of the complexities of the therapist's role in the discussion and exploration of sexuality. To some extent, the therapist's identity shaped the way in which these conversations took place – by opening or closing relevant discourse. However, the meaning of the therapist's identity was also shaped by each participant's own beliefs and experiences. Ultimately, it was the participants who questioned whether their therapist was someone to be trusted and, thereafter, the participants who decided what could and could not be shared.

**Questioning the Relationship: Who are We? (Together, or Apart?)**

Between each participant and their therapist existed a relational space which impacted on, and became impacted by, disclosures of sexual orientation. This space was a coming together of the participants with their therapists; each contributing their own separate identities in the formation of a mutual, therapeutic alliance. For those participants who initially struggled to disclose their sexuality, the relationship with their therapist was felt to be missing something fundamental. Jacob referred to this as a process of *"hiding:"*

*If you can develop a good relationship with your therapist then you're gonna be a lot more comfortable saying it, but also until you say it, it might be a bit harder to develop that relationship with them – because you're hiding it, and it's gonna feel like you're hiding it and you're not telling them everything, so therefore you feel like you can't open up properly (Jacob)*

For many participants, these relational processes echoed their earlier experiences of coming out. Whilst participants highlighted some significant differences in coming out to

therapists compared to coming out to friends and relatives, for example, there were also clear underlying patterns that seemed to be repeated in the therapeutic relationship. Participants usually articulated a sense of fear at the prospect of sharing their identities – many suggesting that these feelings contradicted their assumptions about the therapist's openness to diversity. These feelings were often salient in the descriptions that participants gave of their earlier experiences of coming out to their parents, implying the development of a relational blueprint which impacted on future disclosure:

> *I think gay people often have a very kind of complicated relationship with their parents- maybe not everybody but…I think in my mind how are you supposed to have a healthy relationship with your mother and father if you were a child and you were afraid of them finding out an extremely important part of you and, you know, so you build walls at the same time as loving them (Jerry)*

The existence of relational *"walls"* articulated by Jerry, above, was a profound feature of many participants' experiences. In starting therapy, participants often seemed to be searching for a connection in which they could gradually begin to deconstruct the walls that had been built throughout their childhood and adolescence. For many, the development of such a connection felt like taking a significant risk. Most salient was a risk of rejection and loss of community or sense of belonging, which Carol described as follows:

> *…so it's definitely something that I kind of have to weigh up in my head- whether it's worth it erm- whether it's worth risking that sense of community and whether I actually feel that sense of community or not, I'd rather just not- you know- go out and put myself in that situation just in case I really don't feel that sense of community (Carol)*

Importantly, the decision to take such a risk in therapy depended on the significance of the investment placed in the relationship. For some participants, this meant a greater intensity of fear if the therapist was held in high esteem. For others, there was a sense of indifference regarding the disclosure – particularly if the therapist was deemed insignificant:

> *The only difference was when I told my parents I felt relieved and when I told a therapist it didn't change me…because I don't care what [the therapist] thinks of me (laughs) and I do care what my parents think of me…I don't have a relationship with her- like honestly if she turned around to me and said 'I never want to see you again' I'd be like 'ok bye' whereas if my parents turned around and said 'I never want to see you again' that would be a little bit more traumatic (Hamish)*

**A Flawed Society: 'I can't fix the world'**

For participants, the therapy space did not exist in a vacuum but was instead influenced by a much wider social context. These influences were overwhelmingly negative and spoke to themes of power and oppression. Common amongst the majority of participants, and regardless of cultural background or ethnicity, was a general sense of *'taboo'* regarding sexual diversity in a predominately heteronormative world. Various examples of prejudice and homophobia arose in participants' accounts of their experiences – including overt and more subtle forms of discrimination. These experiences provided a filter through which participants learnt to understand their sexual identities and, subsequently, the ways in which they came to disclose this to others. For example, Lucy described how the weight and frequency of these negative influences were carried over to her therapy from school:

> *I think what made it harder [to disclose] was sometimes the people in school…they bullied me but it was quite harsh…it was constant and it was every day, and a lot of the things they'd say would be about my sexuality, so I think that was one of the things*

*that really pulled me back from talking to people about it…I think because it was happening every day and they were saying the same things every day it just kind of got into my head a lot, so when I talked about it in therapy I got really scared- especially group therapy – that someone was gonna respond like they did or say something the same (Lucy)*

In addition to the relentlessness of these experiences, negative cultural influences also seemed to be given more credence than positive therapy interactions. In therapy, participants were therefore faced with a seemingly monumental task of undoing years of ingrained stigma in a relatively short space of time. For Alex in particular, her religious past was one that she found difficult to reconcile with her emerging understanding of her sexuality:

*At the time I started seeing [the therapist] I didn't even like think about my sexuality at all – like that's a new thing for me – so that just came up mid-way through when I was talking with her… cus I grew up in um like a Christian high school and everything, so that was always just something that isn't ok according to a lot of people that I was surrounded by and it wasn't until this year that my perspective changed some and I was like 'oh, wait, like I'm not really straight'… since then I think it's been harder trying to like reconcile that with religious beliefs that I was raised with (Alex)*

The intersection of identities through forms of social categorisation was a recurring topic for several participants. Jerry spoke at length about his experiences of racism within the gay community – highlighting that lesbian, gay, bisexual, transgender and queer (LGBTQ+) culture is not exempt from discrimination and prejudice. This notion was also echoed by Carol, who described a *'hierarchical'* structure of sexual identities when reflecting on her own experiences of bi-erasure. A commonality amongst these experiences was of a burden of

responsibility that participants felt to engender social change. Many participants felt hopeless to address these wider systemic factors and the weight of such responsibility further contributed to their distress. For some, therapy became a space in which they could work through these difficulties and feel supported. For others, therapy only began to address the surface of a much wider problem:

> *I think sometimes it's because the problem I have is a- is a difficult problem to solve, so very often [the therapist and I are] kind of at a standstill where I sort of like (sigh) everything's kind of like a catch twenty-two, you know, it's like I want to feel good about myself but I don't want to lie to myself, and how can I feel good about myself when I know there's like this racial pressure on me, and I can't fix that- I can't fix that because I can't fix the world (Jerry)*

## Discussion

The aims of this research were to develop current understandings of the coming out experiences of SDY in the specific context of therapy. Four themes were discovered, which highlighted processes of questioning and sense-making on various levels of inter- and intra-personal experiences. In the first and second themes (Questioning the self: who am I; and Questioning the therapist: who are you?), these processes included the appraisals that participants made of themselves and their therapists, such as feelings of fear or mistrust, and a sense of reclaiming ownership of suppressed parts of the self. The third theme (Questioning the relationship: who are we?) extended the findings from themes one and two to include the search for a meaningful connection via the therapeutic relationship. Such relationships formed the basis for self-acceptance and were often grounded in participants' previous experiences of coming out. In the final theme (A flawed society), these experiences were framed within a wider social context, in which the SDY participating in this study typically

felt powerless and stigmatised. There was a general sense of immutability regarding these negative experiences, as participants felt that they had limited scope to influence the societal structures around them. Overall, the findings emphasise that heterosexism and homophobia persists despite recent attitudinal changes in Western cultures (Gallup, 2019), and highlight some of the ways in which therapists might mitigate against these issues.

A particularly interesting finding from the present study was that participant experiences of disclosure were dependent on the investment placed in the therapeutic relationship. Fear and apprehension were typically experienced when the therapist was held in high regard and where there was a perceived risk of loss. These findings echo the coming out stories of SDY more broadly, many of whom have experienced a profound fear of disapproval from a close relative (Rossi, 2010). For some of the participants in this study, therapy became an opportunity to revisit these earlier experiences and to address difficulties such as loneliness and isolation. However, this was only achieved when there was a significant investment from both therapist and client, such that both parties were willing and able to devote themselves to the mutual development of a relationship. In this regard, the findings also resonate with existing literature which emphasises the role of the therapeutic alliance in contributing to psychological change (Norcross, 2010).

Beyond the therapeutic alliance, disclosures were also found to be shaped by the participants' external environments. Regardless of their cultural backgrounds, the majority of participants described negative experiences which impacted on the understanding and disclosure of their sexual orientation. However, unique interactions were discovered in the experiences of those participants who possessed additional minority characteristics. For example, Jerry described a *"racial pressure"* which prevented him from forming connections with other SDY. The role of intersectionality is well documented within the literature, which outlines the complexities of reconciling conflicting identities (Gold & Stewart, 2011;

Semlyen, Ali & Flowers, 2018) and uncovers multiple layers of stigma and discrimination within these groups (Ghabrial, 2017). This is particularly important to note, given that traditional coming out narratives "are based largely on white Euro-American experiences, and are underpinned by Western understandings of an autonomous self" (Jordan, 2010, p. 175).

Notions of power were present in all four themes, which echoes the findings of previous research into coming out more generally (Klein et al., 2015). In the first theme (Questioning the self: Who am I?), many participants reported a lack of ownership over an otherwise deeply personal, introspective process regarding their sexual identity. For some participants, this process was felt to be prematurely interrupted or intruded upon by other people. Therapy therefore presented an opportunity for these participants to reclaim a sense of agency over their experiences. However, this was complicated by operations of power within the therapeutic relationship. For example, the therapist's identity as a 'professional' meant that participants typically held them in greater esteem. Due to these power differentials, many participants described feeling unable to challenge their therapist or speak openly about their sexualities.

The significance of power in therapy settings is not exclusive to sexual minority populations (Fors, 2018), but is nevertheless particularly important to consider for this group. As highlighted by the fourth theme (A flawed society), participants were often exposed to cultures in which they were actively oppressed due to their sexual orientation. The harm caused by these experiences was felt to be difficult to repair and particularly when sustained over long periods of time. Participants looked to their therapists for approval of thoughts, feelings and behaviours; many of which were attached to a sense of shame. Therapists were therefore felt to be within in a position of influence, whereby they had the potential to reduce or exacerbate previous harm depending on their responses.

A related factor impacting on power differentials within therapy was of the therapist's knowledge and understanding of sexual diversity. Several authors have commented on the lack of adequate diversity training in mental health professions (Alderson, 2004; Davies & Barker, 2015). In addition, past research has demonstrated the costs of this in terms of subtle enactments of heterosexism within the therapy room (O'Neill, 2002). Interestingly, whilst some of the participants in this study felt burdened to educate their therapists, others felt empowered by imparting their own knowledge and experience. These findings offer an extension to those of Evans and Barker (2010), who suggested that the manner in which the therapist responds to the disclosure may be of more importance than any previous knowledge they might possess.

Regarding therapist self-disclosure of sexual orientation, participant responses were similarly mixed. Some participants indicated a preference for a sexually diverse therapist, as found in previous research (Liddle, 1996). For these participants, there was an expectation that a sexually diverse therapist would possess a deeper insight into their inner world so that they might experience a more profound connection. Of particular importance was an assumed shared experience of confusion regarding one's sexual orientation, which some participants deemed heterosexual therapists unable to comprehend. These findings mirror the experiences articulated by sexually diverse therapists themselves; some of whom may choose to utilise self-disclosure as a deliberate therapeutic intervention when working with sexually diverse clients (Lea, Jones & Huw, 2010; Porter, Hulbert-Williams & Chadwick, 2015).

Contrary to the above studies, however, other participants preferred *not* to meet with a sexually diverse therapist on the basis that they might feel less able to communicate their own experiences. For these participants, the notion of therapist self-disclosure was deemed to be obstructive of their own coming out process. Carol's experience highlights the importance of the therapist's capacity to remain inquisitive in the face of such conversations, and to learn

directly from the client. This notion was shared by all participants, regardless of their preferences for a sexually diverse or heterosexual therapist. Indeed, Stracuzzi, Mohr and Fuertes (2011) spoke to this in their research, in which a more general appreciation of diversity by the therapist was found to contribute more significantly to the therapeutic relationship than the therapist's sexual orientation per se.

**Clinical Implications**

The experiences shared by the participants in this study offer several key considerations for mental health professionals working with SDY. Firstly, it is suggested that sexual minority therapists should carefully consider the use of deliberate self-disclosure as a therapeutic tool. Whilst some SDY may clearly benefit from such disclosures, others may feel inadvertently suppressed from speaking openly about their sexuality. This is particularly useful to hold in mind for SDY who are in the early stages of exploring their sexual identity, or for those who prefer to maintain distance from the wider LGBTQ+ community. If the therapist's appreciation of diversity is indeed of greater importance (as suggested by Stracuzzi et al., 2011), then this can be demonstrated using alternative methods. For example, therapists are advised to utilise gender and sexually inclusive language in their communication (e.g. gender-neutral pronouns) and to avoid making heteronormative assumptions about their clients and their relationships. Symbols of inclusivity, such as the iconic LGBTQ+ rainbow, can also be adopted by individuals and within organisations – as with the UK's National Health Service 'rainbow badge.' These efforts may help to demonstrate a more collective commitment to the acceptance and inclusion of SDY within mental health services.

Unfortunately, evidence continues to suggest that therapists are lacking in LGBTQ+ specific knowledge and skills (see section 1 of this thesis) and these findings are supported by

the present study. Therapists require more than a 'basic' understanding of sexual diversity if they are to adequately support the SDY accessing their services. In addition to an awareness of the terminology used to describe various sexualities, therapists should also possess an understanding of the more subtle factors impacting on identity development, including the intersectionality with other minority characteristics.

As highlighted by Carol, therapy can be enriched when the therapist learns directly from the client and remains inquisitive in the face of difference. Nevertheless, therapists cannot rely solely on their clients to educate them about these issues and so it is suggested that teaching pertaining to sexual diversity is more explicitly included within professional training programmes and through continued professional development. Boroughs et al. (2015) outline some useful recommendations towards achieving this, including the need for an ongoing commitment to self-reflection regarding one's own beliefs and prejudices. Importantly, until such a time that we have a truly LGBTQ+ competent mental health workforce, SDY require the option of a safe environment in which they can feel assured that they will be accepted and understood. In the UK, specialist organisations such as 'Pink Therapy' exist to advocate for such environments and to provide support to sexual minority therapists and clients alike.

**Limitations & Future Directions**

It is important to acknowledge the diversity present within the sample, which may be considered both a strength and limitation of this research. Participants varied in their ethnicity, gender and in the descriptions used to define their sexual orientation. Such diversity was fortuitous to the extent that it allowed for the representation of multicultural experiences within a relatively small sample. In teasing out the commonalities between participants, nuanced discoveries were made regarding the coming out experiences of SDY – such as

specific processes of introspection, comparison and the significance of the therapeutic relationship. The use of IPA also meant that it was possible to retain the essence of each individual within the broader analysis. In doing so, wider contextual influences emerged which prompted the consideration of individual differences and an exploration of how such differences might impact on the experience of coming out in a therapy context.

Despite these strengths, the sample diversity is also a limitation in that it does not allow for deeper understandings of highly specific cultural factors. Whilst the research highlights the importance of intersectionality, for example, less is known about how this intersectionality manifests in therapy for SDY from particular social and ethnic groups. This is especially important for Black, Asian and minority ethnic (BAME) young people, who are underrepresented within mental health services and health research (Kramer, Evans & Garralda, 2000; Smart & Harrison, 2017).

Future research would therefore benefit from extending the findings of the present study by adopting a more targeted approach to recruitment. For example, Semlyen et al. (2018) conducted an IPA investigation of gay, Muslim men and found unique factors affecting the coming out experiences of this population. These included specific perceptions of threat regarding the disclosure of sexual orientation and difficulties integrating sexual and religious identities – as was also the case for Alex in the present study, who experienced difficulties in reconciling her sexuality with her Catholic upbringing. Faith, ethnicity, age, class and gender are but a small selection of factors which interact with the experience and disclosure of sexual orientation (Wallace & Santacruz, 2017). By deepening our collective understanding of the subtle ways in which these interactions take place within the therapy room, we can continue to work towards a more culturally competent mental health workforce.

**Conclusions**

This research has explored the experiences of SDY in disclosing their sexual orientation to therapists and counsellors. It is widely acknowledged that SDY are disproportionately affected by mental health difficulties and are more likely to require support from mental health services. Yet the evidence suggests that many therapists and counsellors are lacking in the knowledge, skills and training required to adequately support people from sexually diverse groups. The findings of this study provide a framework which mental health professionals might draw from to assist in understanding the experience of coming out in therapy, from the detailed perspectives of eight SDY. The findings also illuminate notions of power and structural inequality as they manifest both inside and outside of the therapy room. Moreover, they highlight the value of relationships, connections and acceptance in reducing these inequalities and the mental anguish created by them. For the participants in this research, as much as coming out was a statement, it also represented a series of questions posed indirectly to the therapist – i.e. in revealing ourselves to you, as we are, will you accept us? And, in so doing, can we also come to accept ourselves?

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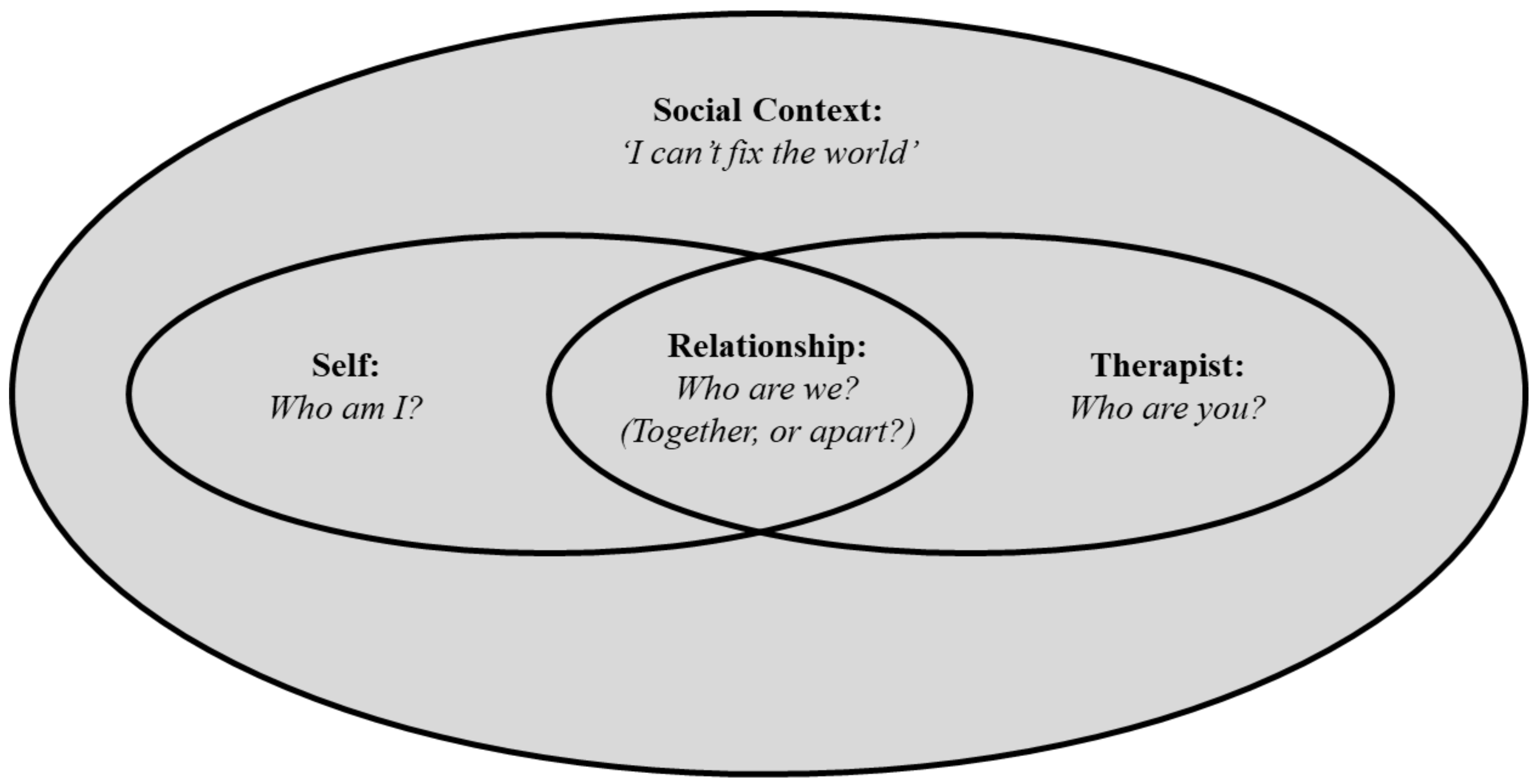


*Figure 1.* Diagrammatic representation of the final four themes.

*Table 1.* Participant Characteristics.

| Pseudonym | Age | Gender* | Sexual Orientation* | Ethnicity | Context of therapy & disclosure |
|---|---|---|---|---|---|
| Alex | 20 | Female | Bisexual | White-American | Alex was studying at a University College in the United States, where she had spoken with two therapists via student support services. Alex did not disclose her reasons for accessing therapy, though she explained that these were initially unrelated to sexual orientation. Her first therapy was brief, having decided that she and her therapist were not a helpful fit. She described her second therapeutic relationship in more positive terms and this therapy was ongoing at the time of the interview. Alex discovered that she was bisexual during her second therapy experience and was not aware of this beforehand. She had since come out to some friends, though her family were unaware. |
| Carol | 24 | Female | Bisexual | White-British | Carol had been meeting with a counsellor for weekly sessions, 3 years prior to the interview. She recalled that her counselling lasted for approximately 3 months. Carol predominately sought counselling due to stress and anxiety, related to events happening at home and in her workplace. She was openly bisexual (though sometimes preferred to define her sexuality as 'queer' or 'fluid'). Prior to speaking with a counsellor, Carol considered herself to be comfortable with and accepting of her sexual orientation. She explained that, through her counselling, she discovered more "deeply rooted" difficulties pertaining to her sexuality. For Carol, counselling became a vehicle for her to work through these difficulties in a safe environment. |
| Hamish | 20 | Female | Lesbian | White-British | Hamish described having spoken with several therapists and counsellors over the past few years. These experiences varied in length, with the shortest being approximately 2 sessions and the longest involving weekly sessions over the span of a year. Hamish described her main reasons for accessing therapy as being related to anxiety and depression, and she considered sexuality to be secondary to her mental health diagnoses. Prior to speaking with her first therapist, Hamish was aware of her sexual orientation. She was 'out' to a few of her friends but had not disclosed her sexuality to her family members at that time. |
| Jacob | 15 | Male | Queer | White-British | Jacob had met with three therapists in total – two of which he had accessed via public Child and Adolescent Mental Health Services (CAMHS) and a third who he described as a private psychologist. His first therapy experience was approximately 3 years prior to the interview and involved weekly sessions over the course of several months. Jacob explained that his main reason for seeking therapy was low mood, however his initial therapist focused on feelings of anxiety. Prior to meeting with his first therapist, Jacob was questioning his sexual orientation and, at that time, identified as bisexual. He had shared his sexual orientation with close friends but not family members. Since disclosing his sexual orientation to his therapist, Jacob also began to share this information with other people in his life, including his parents. |

| | | | | | |
|---|---|---|---|---|---|
| Jerry | 25 | Male | Gay | Taiwanese | Jerry had met with multiple therapists and counsellors over the past few years. His first experience of therapy was at the age of 21, with a therapist who he had accessed via student support services in the United States. Since then, Jerry had met with several other therapists and counsellors – the most recent of which he began seeing in Germany, after moving there to study. On all but one occasion, Jerry had met with gay, male therapists after specifically requesting someone fitting this demographic. He described his reasons for seeking therapy as being related to his mood and experiences of racism within the gay community. Jerry's friends and relatives were aware of his sexual orientation at the time he began meeting with a therapist. |
| Joe | 24 | Male | Gay | Chinese | Joe was an international student, originally from Hong Kong but living and studying in the UK. Joe described having met with three therapists – a psychologist and counsellor in Hong Kong, and a counsellor from his student wellbeing service in the UK. Joe had initially sought therapy due to feelings of anxiety that he wanted to address. He considered his sexual orientation and sexual experiences to be related to his anxiety, but not a central feature of his mental health difficulties. Joe was aware of his sexual orientation prior to seeking therapy and had disclosed this to his friends and relatives. |
| Joshua | 13 | Trans-male | Gay | White-British | Joshua had spoken about his sexual orientation with a school counsellor, who he had been meeting with on a weekly basis until approximately one year prior to the interview. The main difficulties that Joshua wished to address in counselling were low mood and self-harming behaviours. His family and friends were aware of his sexual orientation before the counselling began. |
| Lucy | 15 | Female | Lesbian | White-British | Lucy met her therapist when she was 13 years old, via her local CAMHS. She received individual and group cognitive behavioural therapy and spoke about her sexual orientation within both settings. These experiences went on for approximately 10 months. Lucy conceptualised her sexuality as being related to her mental health difficulties (and her diagnosis of OCD), but not the sole focus of her therapy. The week before Lucy's therapy experience began, she had been forcibly "outed" at her school, due to this information being shared publicly with the other students without her knowledge. Lucy recalled that she was still making sense of her sexuality at the time and so this was a frightening experience for her. Her parents were subsequently made aware about what had happened, and this became a talking point for Lucy in the initial stages of her therapy. |

*Note: Participants were asked to self-define their gender and sexual orientation.

*Table 2.* Participant contributions to each theme.

| Super-ordinate themes | Alex | Carol | Hamish | Jacob | Jerry | Joe | Joshua | Lucy |
|---|---|---|---|---|---|---|---|---|
| *Questioning the Self: Who am I?* | [X] | [X] | X | [X] | X | X | [X] | X |
| *Questioning the Therapist: Who are you?* | X | [X] | - | - | [X] | [X] | [X] | - |
| *Questioning the Relationship: Who are we? (Together, or apart?)* | X | [X] | [X] | [X] | [X] | X | X | X |
| *A flawed society: 'I can't fix the world'* | [X] | - | X | - | [X] | X | X | [X] |

*Note: [Square brackets indicate those participants whose data extracts are provided in the written findings]

**Appendix 2-A**

**Interview Schedule.**

***'Coming out' in therapy: The experiences of young people disclosing their sexual orientation to mental health professionals***

The interview is designed to elicit participants' subjective experience of disclosing their sexual orientation in a therapy context. Some of the domains that might be explored are captured below, with some example questions and prompts. The questions here are intended as a guide only and do not need to be asked in the exact order or form that is presented.

*Pre-amble to orient participants to the process, use of audio recording device and purpose of the interview (participants will also have been presented with the participant information sheet and consent form).*

*Suggested opening question:*

- **As you know, this research is about your experience of speaking with a therapist or counsellor about your sexual orientation. To start with, could you tell me a bit about the person that you spoke to?** (Do you know their professional background/title? – e.g. counsellor, psychologist, CBT therapist; How & when did you come into contact with them?)

*Possible follow-up questions:*

- **Lots of people see mental health professionals for all sorts of reasons. Was sexual orientation the focus of your therapy, or were you seeking therapy because of something else?**
- **What was it like speaking to your therapist?** (How would you describe the relationship?)
- **At what point did you tell them that you weren't heterosexual?** (What did you say? Was this early in the process? Later on? Why do you think this might have been?)
- **How did they respond when you told them?** (Was there anything in particular that was said or done that stood out to you?)
- **How did you feel about telling them?** (Before / During / After; Emotionally, physically)
- **Did you have any expectations about what it might be like to tell your therapist about your sexual orientation?** (Hopes / Fears)
- **Had you told other people about your sexual orientation before?** (If *yes*, how did this experience compare to telling your therapist? If *no*, what was different about this person that meant you were able to tell them?)
- **Was it difficult to talk about your sexual orientation?** (Were there any challenges? Did you manage to overcome these? If so, how? Did your therapist support you with this process?)

- **Did your therapist seem knowledgeable about LGBT issues?** (Were they aware of different labels for sexual orientation? How confident were you that your therapist understood what your sexual orientation meant to you?)

- **Did your therapist seem comfortable knowing that you weren't heterosexual?** (Did you experience any prejudice or discrimination, from your point of view?)

- **How accepting of your sexual orientation did your therapist appear to be?** (Did your therapist ever make you feel like your sexual orientation was a problem, or something that needed to be changed?)

- **Do you think your therapist would have thought any differently about you if you were straight?** (If yes, in what ways? What makes you think that? How might things have been different for you?)

- **Do you think the conversations you had with your therapist might have been different if you hadn't told them about your sexuality?** (If *yes,* in what ways? If *no,* why do you think so?)

- **What advice would you give to other young people who might want to talk about their sexual orientation with a therapist/counsellor?**

- **Is there anything else you would like to add?** (Or ask?)

*Debrief – check-in with the participant to see how they found the interview, thank them for their time and answer any questions they might have. Re-affirm that they are welcome to withdraw their data if they wish to do so, but only up until* ***two weeks*** *from the interview date.*

**Appendix 2-B**

**Transcript Extract (Hamish).**

| Transcript | **Notes** **(Codes / 'Emergent Themes')** |
|---|---|
| I: Erm- was sexual orientation kind of… how did that feature in the reasons you went to therapy in the first place? | |
| P: Erm it wasn't like a main reason, but it was kind of like- I dunno, I guess it comes up when you're talking to somebody for that much a time- when you're trying to vent about everything it always comes up- like saying I'm scared to like tell my family or this person has reacted badly or it just always- it comes up in like *ways* | **Conceptualisation of sexual orientation as a secondary issue...**<br>**...but something that is inevitably opened up in conversation.**<br>**There is a sense of mystery about this process.**<br>**(An inevitable conversation)**<br>**(A secondary issue)** |
| I: Yeah- so it comes up- and I'm wondering how that happens… whether that's something that comes from you or them or just what happens in that process? | |
| P: Erm I feel a lot of therapists will ask you about relationships or partners or whatever and that's just always a gateway to I guess open that- they'll be like 'oh are you in a relationship' or 'is your partner supportive' and that kind of thing- and then it gets into the subjective relationships from there | **Discourse about relationships in a broader sense is a gateway to discourse about sexuality.**<br>**(Gateways to sexuality)** |
| I: Mhmm, right- and erm I'm curious about what that was like for you when you were asked about relationships- and just kind of going into the finer detail of taking you back to that time, when a therapist said 'are you in a relationship?' or words to that effect – what was that like for you, what did that bring up? | |
| P: I think the first few times I found it really like shocking because I was still quite young- I was like sixteen- I think at sixteen everyone is a bit confused about their sexuality, they don't want to talk about it with a stranger very much- especially one that like, you know sometimes my mum was nearby or whatever and she didn't know at the time so that was really awkward, but I don't really care now- if anybody asks I'll happily have a conversation about it, it's fine. | **The "shock" of talking about sexuality with a therapist – perhaps something about externalising an internal sense of confusion?**<br>**(Saying the unsaid)** |

**Appendix 2-C**

**Development of Participant Themes (Hamish).**

| **Participant Theme 1.** ***The Distant Self*** | | |
|---|---|---|
| **Description** | **Emergent Themes** | **Example Quotations** |
| This theme encapsulates an internal process by which Hamish seemed to distance the experience of her sexuality from her broader sense of self. On several occasions throughout the interview, Hamish appeared to give the impression that her sexuality was irrelevant, or such a minor part of her that it didn't warrant thinking about. Upon first coming to realise that she was attracted to other women, Hamish described a process of "compartmentalising" – that is, separating this newfound part of her until she felt ready to pay it more thought. In doing so, Hamish's sexuality seemed to become an unspoken aspect of her identity that she would internally move away from in order to maintain distance.<br><br>Hamish described various strategies which assisted this process of 'moving away.' Some strategies appeared to be conscious decisions, such as avoiding the exploration of her feelings. Other strategies appeared more unconscious in nature. For example, the language used by Hamish to describe diverse sexual orientations seemed dehumanising at times, though I am not sure that this is something that she was actively aware of. In addition, she regularly used language which seemed to reduce or minimise her experiences – referring to herself as "lucky" and "straight passing," in a way which seemed removed from the LGBTQ+ community and her own sense of being a lesbian.<br><br>In a therapy context, this aspect of her identity seemed to become something which was also minimised or avoided. Hamish described her sexuality as a secondary issue and mentioned several mental health diagnoses which took priority in the therapy space. She considered her sexuality to be something unimportant by comparison, despite having some initial fears about her therapist's response. | • The distant self<br>• A shrinking sense of self<br>• A "minor part" of self<br>• Embracing logic & avoiding feelings<br>• Minimising and moving away<br>• Compartmentalising<br>• Dehumanisation<br>• Sexuality as a 'non-issue'<br>• A secondary issue<br>• A process of concealment<br>• A sense of separation<br>• A narrow escape | • "it's really such a minor part of me- it's always been such a minor part of me"<br><br>• "I'm not really a feelings kind of gal- like I'd much rather just laugh at it and move on- I think a lot- so I prefer therapists that do the same- especially with sexuality and stuff, like I don't want to go into it"<br><br>• "even when I first realised it never became this massive part of my personality- it just became something and I was like 'ok I'm going to compartmentalise that for a little bit,' think about it a little bit and then when I'm ready I can think about it properly (laughs)"<br><br>• "Most of my stuff has been removed from sexuality – like I've been really lucky like that"<br><br>• "nobody looks at me and goes '*that* might be a lesbian' – ever – I dunno it's just straight passing privilege isn't it really" |

**Appendix 2-D**

**Development of Super-ordinate Themes.**

| Super-ordinate themes | Contributing participant themes |
|---|---|
| *Questioning the Self: Who am I?* | • Integration & Reconciliation (Alex)<br>• Guided Introspection (Jerry)<br>• Interrupted Introspection (Lucy)<br>• Journey into the unknown (Carol)<br>• Identity oppression (Carol)<br>• The distant self (Hamish)<br>• The illusion of choice (Joshua)<br>• Reclaiming ownership (Jacob)<br>• Forced hiding (Jacob)<br>• A necessary disclosure (Jacob)<br>• Self-acceptance (Joe) |
| *Questioning the Therapist: Who are you?* | • The all-powerful therapist (Alex)<br>• The duality of the therapist (Joe)<br>• The inquisitive therapist (Carol)<br>• The insecure other (Joshua)<br>• The rejected other (Jerry)<br>• Mirrors of the self (Jerry) |
| *Questioning the Relationship: Who are we? (Together, or apart?)* | • Investing in the other (Hamish)<br>• The fear of being seen (Hamish)<br>• The guarded self (Hamish)<br>• Relational risk-taking (Alex)<br>• Unspoken fears of disapproval (Alex)<br>• Risks of rejection (Carol)<br>• Mutual Empowerment (Carol)<br>• Fear of the unknown (Lucy)<br>• Normalising (Lucy)<br>• Conditioned fear (Jacob)<br>• Unity (Jacob)<br>• Inevitable hostility (Joshua)<br>• Building walls (Jerry)<br>• Searching for a connection (Joe) |
| *A Flawed Society: 'I can't fix the World'* | • A flawed system (Joshua)<br>• Fixed hopelessness (Joshua)<br>• A dangerous society (Hamish)<br>• A culture of 'taboo' (Joe)<br>• Outside influences (Lucy)<br>• A social problem (Jerry)<br>• The lingering past (Alex) |

# Section Three: Critical Appraisal

## Reflections on the research journey

Word Count: 3,847

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In this section of the thesis I will detail my reflections on some key aspects of the research. First, I will present a brief summary of the literature review and research project, highlighting the main findings from each paper. I will then share reflections on my relationship with the research, including my reasons for choosing the topic and challenges that I encountered in navigating various personal and professional identities. Finally, I will discuss methodological considerations pertaining to my epistemological stance and factors impacting on research design and recruitment. I will end the section with some concluding thoughts regarding my research journey.

## Research Summary

The broad purpose of this thesis was to investigate experiences of gender and sexual diversity within the context of therapy and/or counselling. The literature review focused on this from the perspectives of therapists and counsellors. It asked questions such as: 'What are the attitudes and experiences of therapists and counsellors working therapeutically with gender and sexually diverse clients?' and 'How competent do therapists and counsellors consider themselves to be in working with this demographic?' The research paper went on to consider these questions from the perspectives of clients. It offered insights into the coming out experiences of eight sexual minority youth, and provided a relational framework from which to understand how this occurs in therapy settings.

The literature review uncovered a process of silencing and erasure of gender and sexually diverse identities within therapy and counselling professions. In many of the reviewed studies, there was evidence of heterosexism and transphobia. Therapists and counsellors acknowledged that these issues were ongoing and problematic in mental health professions, but nevertheless felt that they lacked the sufficient knowledge and skills to make a difference. Additionally, the findings pointed towards an underlying sense of fear – either

of unintentionally perpetuating problems in attempting to address them, or that the therapist themselves might be judged or criticised in being outed as an 'ally.' Despite these reservations, therapists in the reviewed papers demonstrated a commitment to developing their understanding and awareness of gender and sexual diversity. Specific opportunities for self-reflection were cited as particularly important in achieving this, however many therapists and counsellors felt that these spaces were superficial or lacking in their respective training programmes.

The research paper highlighted some repercussions of a mental health workforce that lacks cultural competency pertaining to gender and sexual diversity. Participants described their therapists as possessing a relatively 'basic' understanding of lesbian, gay, bisexual, transgender and queer (LGBTQ+) culture. For some, this was problematic in that it left them vulnerable to enactments of heterosexism and homophobia, or avoidant of heterosexual therapists entirely. For others, the lack of knowledge was surprisingly helpful in that it reduced a perceived imbalance of power. Common to all participants was the significance of the therapeutic relationship, which presented an opportunity to challenge prior experiences of prejudice and discrimination, and to connect through a process of shared understanding and acceptance.

## Choosing a Topic

My interest in this research stemmed from my own experiences as a gay clinical psychologist in training. Prior to submitting the proposal, I was loosely aware of the health inequalities that exist for gender and sexually minorities (King et al., 2007; King et al., 2008; Semlyen, 2016). I was also aware of the historical context, in which gender and sexual diversity was pathologised as a 'mental illness,' resulting in various abusive treatments from mental health professionals over the years (Drescher, 2015). It saddens me to acknowledge

that I bore witness to abusive practice during one of my clinical placements, in which a service user was denied the right to express their identity because they did not fit within a heteronormative framework. I felt strangely alone in challenging this practice as I saw it. My cisgender, heterosexual colleagues seemed to struggle to understand, though not for lack of trying. I began to wonder whether such experiences were commonplace and so turned to the literature to begin my investigation.

Whilst my reading provided me with some valuable insights, it was in seeking out therapy for myself that I developed a more experiential understanding of the relationship between sexuality and mental health. In communicating my sexuality with my therapist, I felt an immediate sense of fear – that I might be judged, pathologised or discriminated against. The intensity of this fear was unexpected and I subsequently became curious about its origins. Whilst therapy provided me with an opportunity to explore this for myself, I also wondered about the experiences of other sexually diverse people. I reflected on work with previous clients, and drew inspiration from my experiences with young people in particular, in order to develop and conduct the research project. In doing so, I hoped to further my own understanding of diversity and to give voice to an important, yet underrepresented group within mental health research.

## Navigating Personal and Professional Identities

The nature of my relationship with this research was multifaceted. As a trainee clinical psychologist, I represented a dual-professional as both a researcher and practicing clinician. I had worked therapeutically with gender and sexually diverse clients – some of whom would have met the inclusion criteria for my research. I had also received therapy myself and was meeting regularly with a Jungian analyst at the time of writing this thesis. My own experiences as a gay male often featured in discussions with my analyst and also with

research/placement supervisors. As such, I feel it necessary to reflect on myself in relation to the work and to disentangle some of these competing aspects of my identity – as a researcher, therapist, client, and advocate of gender and sexual diversity.

**‘Researcher’**

My role as a researcher was to privilege the experiences of the participants and I hoped to achieve this through ongoing reflection. Given my personal relationship with the topic, I encountered various challenges in maintaining the stance of an objective researcher. As stated in the research paper, my aim was not to adopt a position of ‘true objectivity,’ but to recognise my own subjective influence on the design and implementation of the research. To this end, I kept a reflective journal to document my experiences, thoughts and feelings. These written records were particularly useful to hold in mind during interviews, in which I adjusted my questioning style to ensure that conversations remained open and participant-focused. At times, I wondered whether I might be searching for experiences similar to my own – such as observations of malpractice – and so was careful to notice occasions when this might be influencing the questions and make appropriate adjustments. I shared my reflections/interpretations within the wider research team and invited discussion to ensure that these were considered from various perspectives. These discussions enhanced the richness of the findings and evoked reflection on wider themes of identity and diversity.

An additional matter of self-reflection has been of my contributions to the field as an openly gay researcher. Research into gender and sexual diversity tends to be conducted predominately by LGBTQ+ researchers and the validity of heterosexuals applying their knowledge and interpretations to ‘queer theory’ and ‘queer research’ has been put to question. For example, Schlichter (2004) argues that to apply dominant heterosexual narratives onto queer culture is to re-establish heteronormativity and is therefore not

conducive to queer research. Conversely, Allen (2010) adopts a stance more removed from political and ethical considerations. Whilst not dismissing the significance of these factors, Allen (2010) suggests that sexual identity alone does not determine one's knowledge of gender and sexual diversity. Moreover, it is argued that "the production of heteronormative knowledge may be better understood as a consequence of the ongoing power and pervasiveness of heteronormativity" (Allen, 2010; p.161). I believe that my own gay identity does not preclude me from such pervasive heteronormative structures and, as such, does not offer me exclusive protection from re-framing diverse experiences through a heteronormative lens. Therefore, the emphasis on diversity that I hope to have embedded within this thesis represents my attempt to be curious about experiences of gender and sexuality beyond my own, and to learn from these diverse experiences in a research capacity.

**'Therapist'**

As a provider of therapeutic interventions, I was trained to listen to, understand and support people experiencing mental and emotional distress. I had become accustomed to attuning intently to feelings – particularly those which might be experienced as painful or difficult to tolerate. In part, I believe that these skills assisted me during interviews, as I felt comfortable engaging with sensitive conversations and building rapport. However, I was also curious about the extent to which my identity as a therapy provider influenced the discussions which subsequently emerged. Indeed, it has been suggested that researching clinicians often find themselves in a position of deconstructing previous theoretical knowledge so that they might adapt themselves to the research context (Chenail & Maione, 1997). For me personally, this was a process of recognising occasions when I might have become interested in pursuing certain feelings and reminding myself of the research question.

My identity as a gay therapist in particular meant that I was especially interested in the self-disclosure of therapist sexual orientation and this perhaps guided my questioning at times. Similar to other gay therapists (Lea, Jones & Huw, 2010; Porter, Hulbert-Williams & Chadwick, 2015) I had utilised self-disclosure in clinical practice when working with gender and sexually diverse clients. I was curious to learn more about this from the perspectives of the participants and to compare these with my own. That the findings highlighted mixed views about the utility of therapist self-disclosure was particularly interesting to me and I wondered about this in terms of the interviews themselves. Some participants were aware of my sexual identity – either because they had asked me directly, or because I had disclosed during introductions when attending LGBTQ+ youth groups. Given the findings, it is important to acknowledge the possible impact of this self-disclosure on the ways in which participants expressed themselves during interviews. In hindsight, it may have been helpful to spend more time considering this within the design stage of the study and to have taken a more uniform approach to self-disclosure.

**'Client'**

Through my own therapy, I was essentially seeking to deepen an understanding of myself. This is important to acknowledge because, to some degree, this thesis is an extension of my own self-reflective journey. I was aware of the implications of this and therefore approached the analysis cautiously, intending to set aside my personal experiences. Yet the more I attempted to separate myself, the more I realised the impossibility of the task. I concluded that the emerging themes resonated with me not because they were a product of my experiences, but because of a shared understanding between myself and the participants. Throughout this research, I have learnt of the need to strike a delicate balance between privileging the voices of the participants and acknowledging my own interpretations and

experiences as equally valid and representative of the sample. The following is an excerpt from my research journal, which captures some of this interpretative process:

*"During the interview, what stood out to me strongly was an emphasis that Hamish placed on her sexuality being 'not a big deal' and yet I remember feeling confused about this as she spoke with me. I wondered whether my own experiences might have played a part here, or clouded my judgement in some way (as I'm aware that, for me personally, disclosing my sexuality to my therapist felt very emotionally charged and this did not seem to chime with Hamish). Still, my gut feeling was that there was something more to this that I was empathising with or attuning to. She pointed to the hedgehog that she had brought with her, referred to herself as 'weird' and 'bizarre' on occasion, and I was left wondering whether having others believe that she was 'odd' in some way might be protective; particularly if she had any fear or worry that others might judge her based on her sexuality."*

**'Advocate'**

At the heart of this research is a theme of advocacy. This is a position that I have chosen to adopt, regardless of whether I identify as a 'researcher,' 'therapist' or 'client.' Personally, I stand as a member of a gender and sexually diverse community, within which I am all too aware of the impact of stigma and discrimination on mental health and wellbeing. Professionally, I also feel obliged to speak out against injustice as I witness it. The role of applied psychologists in advocating for social justice is becoming increasingly apparent, especially as we seek to extend our practice beyond the therapy room (Ali et al., 2008; BPS, 2017). As such, I cannot deny the influence of this position on the research process. In some cases, I felt surprised – such as when Carol articulated that the therapist's lack of knowledge was in fact to her relief. I have endeavoured to represent these experiences fairly and inclusively throughout this thesis, as to do so is in itself the purpose of advocacy.

In reflecting on myself in this role, I also feel as if I have deepened my understanding of the research findings. Just as the participants questioned their disclosures, I too have found myself questioning. I felt the weight of the risks involved in sharing my thoughts and reflections so openly and wondered whether I was brave enough to release them into the public domain. Yet the collective stories contained within this thesis gave me strength. Through solidarity, we can have courage – and this, I have learnt, is the driving force behind what it means to 'come out.'

## Methodological Considerations

### Research Design

My decision to utilise interpretative phenomenological analysis (IPA) was predominately anchored to my conceptualisation of gender and sexuality as socially constructed and unique to the individual. I considered that coming out experiences would possess similarly unique qualities to them, and felt that this resonated with IPA's idiographic approach of "allowing participants to tell their story, in their own words, about the topic under investigation" (Smith, Flowers & Osborn, 1997, p.68). It was this idiographic style that led me to choose IPA instead of quantitative or alternative qualitative approaches, such as thematic analysis, which are more concerned with aggregating findings at a broader level (Braun & Clarke, 2006). Through bracketing each individual transcript during the analysis, I hoped to draw out more nuanced understandings of each participant's experiences. This approach is in keeping with current theoretical understandings of sexuality as highly personal and fluid, such that they cannot be wholly understood through a group lens (van Anders, 2015). Indeed, IPA is frequently used in the study of sex and sexuality (Coyle & Rafalin, 2000; Jarman, Walsh & De Lacey, 2005), not only because of its idiographic focus, but also

because it combines this with the interpretation of psychological experiences through phenomenology and hermeneutics; both of which are key to the study of sexual identity.

It is interesting that a recurring aspect of the research findings was of identity – whether an introspective understanding of self, others, or self in-relation-to others. Indeed, for participants such as Jacob, introspection was felt to be “the biggest thing about sexuality.” Themes of self and identity are frequently observed in IPA research. For example, in his studies with people transitioning to motherhood, Smith (2004) makes reference to a “relational self” (p.43). By this, Smith (2004) implies that identity is shaped in relation to other people. That this notion was echoed in my own research is unlikely to be a mere coincidence. It may represent something of the IPA method, the process of interviewing (which in itself is a relational process), or it may speak more generally about the ways in which we come to experience ourselves and others. There are various psychological approaches to identity, stemming from a number of theories and ideologies (Crossley 2000). Whilst these approaches differ significantly in their theoretical underpinnings, a commonality between them seems to be the significance of relationships in shaping an individual sense of self. Smith (2004) argues that identity, in all of its various forms, is the “spine” of psychology and IPA. It therefore follows that identity might have provided a similar frame within this research.

**Homogeneity and Sample Diversity**

One of the key features of the IPA method is that it is typically conducted with small, homogenous samples. This is in keeping with its idiographic approach and commitment to investigating the finer details of individual experiences. Smith, Flowers and Larkin (2009) emphasise that there is no ‘correct’ sample size for IPA as such, but that smaller samples allow for more in-depth analyses which preserve the richness of the data. Published IPA

studies interested in experiences of sexuality vary in sample size, with more homogenous samples tending to include fewer participants. For example, Porter et al. (2015) recruited a sample of seven gay male therapists on the assumption that all of the participants would have some shared experience in terms of their sexuality, gender and profession.

However, as highlighted by Murray and Wilde (in press), the notion that participants are required to be similar or identical on various demographic factors in order to be considered homogenous is a common misconception of IPA. Rather, Smith et al. (2009) suggest that homogeneity should be guided by the research aims and the particular experience under investigation. In the present research, this was the experience of young people in disclosing a minority sexual orientation within therapy. During the design stages of the research, I wondered whether to restrict the focus to a particular minority group – such as gay males, or bisexuals. However, in reflecting on my own understanding of sexuality and gender as diverse and fluid phenomena, I felt that to restrict the sample in such a way would be unnecessarily excluding. Essentially, I expected that each individual would have a different experience, regardless of the label used to identify themselves, and that such differences would be appropriately elicited and analysed through the use of IPA.

Similarly, no exclusion criteria were placed on the type of therapy or professional qualification of the therapist. This was to acknowledge that talking therapies are practiced by a range of mental health professionals – including psychologists, psychotherapists and counsellors. Moreover, research consistently suggests that the unique therapist-client dynamic, or therapeutic alliance, is of more influence than the specific therapeutic modality or training (Norcross, 2010). The majority of participants were unaware of the specific therapeutic interventions that they received and few recalled the professional title or training of their therapist(s). As such, it was difficult to determine the impact of these factors on individual participant experiences. It is important to acknowledge this because the findings

represented within this research are unlikely to account for the variation that exists between therapeutic orientations and professional training programmes. Nevertheless, to devise recruitment criteria on this basis would have been to exclude a significant proportion of the sample and so I felt it necessary to adopt a more inclusive approach.

A final area of importance regarding homogeneity is of the diverse cultural backgrounds represented within the sample. Participants described experiences of therapy across four different areas of the world – the United Kingdom, the United States of America, Germany and Hong Kong. In some cases, participants had experienced therapy in multiple countries and were therefore able to compare and contrast their experiences. Despite this variation, it was interesting to note the commonalities that emerged in the descriptions that participants gave of cultural attitudes towards sexual diversity – many of which are captured in the fourth theme: *'A flawed society.'*

Whilst I felt justified in including such a diverse array of experiences, I have since had the opportunity to reflect on this decision. With hindsight, the interview with Jerry in particular helped me to acknowledge the significance of intersectionality, especially where race and ethnicity are concerned. Jerry's coming out experiences seem distinct amongst a group of predominately White-British individuals, in that he seemed to carry a more deeply entrenched sense of hopelessness and futility. In light of these findings, I feel that future research would benefit from a more targeted recruitment approach. For example, this could invite a closer examination of the role of ethnicity in the coming out experiences of sexual minority youth.

In addition to the above considerations, there were also pragmatic factors impacting on the sample diversity. Several months after initiating the recruitment process, only two people had expressed interest in participating. This was despite liaising with various

LGBTQ+ charities, youth groups and organisations at a national level and advertising the study online. I therefore decided to increase the target age range from 13 – 18 years to 13 – 25 years, which prompted discussion and debate within the research team. The main concern was whether the coming out experiences of a 13-year-old would be similar enough to those of a 25-year-old to warrant including both within the sample. To answer this question, I drew from research, theory and policy – such as Cass' (1979; 1996) and Erikson's (1950;1968) theories of identity development, and national decisions to increase the age of provision in child and adolescent mental health services across the UK to 25 years. On balance, I reasoned that there was sufficient justification, given that these groups are thought to overlap in terms of the formation of their sexuality.

I had already factored this decision into the initial ethics application as I was aware of some of the challenges in recruiting young people for research. Previous authors have commented on the tendency to view young people as passive and vulnerable, which can inhibit their participation within research (Powell & Smith, 2009). Issues related to gatekeeping and consent are commonly cited barriers, particularly when the research topic is considered 'sensitive' or related to health and wellbeing (Turner & Almack, 2017). I personally came across such barriers when attempting to liaise with relevant youth groups and organisations – many of whom did not respond to my communication efforts. Those stakeholders who were involved in the design of the study proposal and interview schedule were more actively supportive and this taught me the value of networking and relationships within the research process. In hindsight, I would have hoped to have had more time available to build and sustain such relationships as I believe that this was a crucial aspect of recruitment.

## Conclusions

This thesis represents a significant milestone in my personal and professional development. Professionally, I have critically engaged with the design, implementation and evaluation of research pertaining to sexual minority mental health. I have valued the opportunity to learn from the participants and to reflect on issues which have informed my clinical practice. The findings have also moved me to recognise the wider potential of psychologists, therapists and mental health professionals in supporting the health and wellbeing of gender and sexually diverse people. This has been enriched by my own personal association with the topic, as a gay recipient of therapy. Above all, I have cultivated a greater appreciation of relationships – both within therapy and research. I have learnt that it is through these relationships that we operate in the world around us, and develop more nuanced understandings of who we are.

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# Section Four: Ethics Application

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**Faculty of Health and Medicine Research Ethics Committee (FHMREC)**

**Lancaster University**

**Application for Ethical Approval for Research**

## Guidance on completing this form is also available as a word document

**Title of Project**: 'Coming out' in therapy: The experiences of young people disclosing their sexual orientation to mental health professionals

**Name of applicant/researcher**: Chris Hunt

**ACP ID number (if applicable)*:**

**Funding source (if applicable)**

**Grant code (if applicable):**

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

**Type of study**

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

**SECTION ONE**

**1. Appointment/position held by applicant and Division within FHM** Trainee Clinical Psychologist

**2. Contact information for applicant**:

**E-mail**: c.hunt@lancaster.ac.uk **Telephone**: [redacted] (research phone)

**Address**: Department of Clinical Psychology, Furness College, Lancaster University, Lancaster, LA1 4YG

3. **Names and appointments of all members of the research team (including degree where applicable)**

Dr Clare Dixon (Clinical Psychologist & Clinical Tutor, Lancaster University)

Dr Craig Murray (Senior Lecturer in Health Research, Lancaster University)

Dr James Porter (Counselling Psychologist, [redacted])

**3. If this is a student project, please indicate what type of project** by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

**4. Project supervisor(s), if different from applicant**: As above – see research team

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**: As above

**SECTION TWO**

**Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants**

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

**Data Management**

*For additional guidance on data management, please go to* Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms' ☐

4c. If yes, where relevant has permission / agreement been secured from the website moderator? ☐

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? ☐

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain? ☐

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

**8. Confidentiality and Anonymity**

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? ☐

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

**SECTION THREE**

**Complete this section if your project includes *direct* involvement by human subjects**

1. **Summary of research protocol in lay terms (indicative maximum length 150 words):**

The aims of this research study are to explore the experiences of young people in disclosing a minority sexual orientation to therapists or counsellors. Adolescence is often a time of great confusion and identity change, especially for people who might be questioning their sexual orientation. Despite this, many young people who realise that they are not heterosexual are unable to communicate this with their family members or the people around them due to a fear of discrimination. Therapy should ideally be a space in which people can explore their feelings freely and without judgement, however stigma remains a barrier for many young people accessing services. It is important that we understand the experiences of young people accessing therapeutic interventions so that we can offer support to those who might otherwise be struggling in silence.

Therefore, this study aims to recruit approx. 8 – 12 young people, who will be interviewed about their experience of 'coming out' in therapy. Once transcribed, the research team will look for patterns or themes in the participants' responses. The findings will be written up into a report which will tell the stories of those who contributed.

2. **Anticipated project dates (month and year only**)

Start date: October 2019 End date: May 2020

**Data Collection and Management**

*For additional guidance on data management, please go to* Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. **Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):**

Interviews will take place with between 8 and 12 young people who identify as having a minority sexual orientation (i.e. non-heterosexual), and who have previously disclosed their sexual orientation to a therapist or counsellor. The target age range of participants will be between 13 – 18 years, however this may be increased to 25 years depending on recruitment (please refer to more detailed recruitment strategy below).

4. **How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).**

Initially, contact will be made with regional and national LGBT+ youth groups and charities within the North-West of England and the West-Midlands. The lead researcher and field supervisor will be responsible for distributing recruitment posters and attending relevant meetings to promote the study. Advertisement will also take place via social media (e.g. LGBT Facebook groups and Twitter), whereby the group administrators will be requested to share posters and information on behalf of the research team. This will avoid the use of personal social media accounts. If fewer than eight participants have been recruited after a two-month period then recruitment will be expanded from 13 – 18 years to 13 – 25 years for both online and face-to-face recruitment. In this instance, posters (with an amended age-range) will be distributed within local Universities, LGBT groups and online.

5. **Briefly describe your data collection and analysis methods, and the rationale for their use.**

The data will be collected via face-to-face semi-structured interviews with participants, lasting approximately 45 minutes – 1 hour. Interviews will take place in person or via Skype video chat if the participant is unable to meet at a convenient location. Possible meeting locations might include private rooms at centres where LGBT+ group meetings usually take place, or interview rooms at Lancaster University. To ensure safety, the interviewer will carry a 'SkyGuard' device, which the interviewer will be responsible for activating in case of emergency. Interviews were chosen as the method of choice as they will allow for the collection of rich, in-depth service user narratives. The data will be analysed by interpretative phenomenological analysis (IPA). The IPA approach has an emphasis on personal lived experience and sense-making; both of which were considered relevant to sexual identity and the aims of this research. In accordance with the IPA approach, transcripts of the interviews will be read thoroughly and annotated by the research team who will note down significant points and begin drawing out themes from the interviews. Throughout this process, the

transcripts will be continuously re-examined by the research team to ensure that the essence of the participant's experiences are captured appropriately within a final thematic map.

6. **What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.**

Interviews will be tape-recorded and stored initially on an encrypted USB and later transferred to the University network (see below). The interviews will be transcribed manually using Lancaster University computer equipment and Microsoft Word software. Transcripts will be saved onto the University H: Drive, which is also password protected for secure storage. The analysis of the transcripts and construction of themes will also be completed using computer software and any resulting documents will be saved electronically onto the University network. Paper versions of consent forms will be given to participants at the interview for signing (in the case of Skype interviews, consent will instead be obtained verbally). Immediately after the interview has taken place (or once the completed consent form has been received by the research team) the paper consent forms will be scanned into electronic format. The paper versions will be subsequently disposed of in a confidential waste bin. In situations where the electronic consent forms cannot be immediately upload to the University network, they will instead by transferred onto an encrypted USB and uploaded to the H: Drive at the earliest opportunity.

Once the project has been successfully published in a peer-reviewed research paper, electronic recordings and pseudonym codes will be destroyed. The electronic consent forms and transcripts will be stored securely in separate password protected files by the Doctorate in Clinical Psychology Course at Lancaster University's for 10 years. These will be accessible by the Research Coordinator and Research supervisors (Craig Murray & Clare Dixon) who will act as custodians of the data. After 10 years the Research Coordinator will be responsible for destroying the data under instruction from the research supervisors.

7. **Will audio or video recording take place?** ☐ **no** ☒ **audio** ☐ **video**

**a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.**

Interview recordings will be immediately transferred onto an encrypted USB drive and removed from the recording device. At the earliest available opportunity, the recordings will be transferred from the encrypted USB drive to the University network (H: drive) for secure storage.

**b. What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?**

Audio data will be retained on the University network until the final written assignment as been examined and/or published in a peer-reviewed research journal. This will ensure that the researchers have access to the data in case it needs to be checked or re-evaluated. Following publishing, the data will be deleted from the University network.

**Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder**

**8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?**

Full data will only be accessible to the research team and the Research Coordinator for Lancaster University's Doctorate in Clinical Psychology. After 10 years the Research Coordinator will be responsible for destroying the data under instruction from the research supervisors (Craig Murray & Clare Dixon).

**8b. Are there any restrictions on sharing your data ?**

Due to the small sample size, even after anonymization there is a small risk that participants could be identified by their comments. Supporting data will not be shared outside of the research team. The research supervisor holds responsibility for overseeing access to this data.

**9. Consent**
**a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law?** yes
**b. Detail the procedure you will use for obtaining consent?**

Participants will be presented with a participant information sheet in paper form prior to commencing the interview. The participants will be given time to read and digest the information and ask any questions so that they can make an informed choice about whether to participate. Should they wish to continue with the interview then they will be asked to sign their consent in writing. Participants who are interviewed via Skype will be asked to provide the consent verbally. Participants will also be informed that they have the right to withdraw from the study, without any negative consequences if they choose to do so. They will be given a time limit of two weeks following the interview, during which time they may contact the research team to withdraw their participation.

**10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.**

Whilst there are not any anticipated risks in participating in this study, it is acknowledged that participants may have some difficulty speaking openly about their experiences, or may feel a pressure to present their therapist/counsellor in a positive light. It will therefore be emphasised that information shared during the interview will remain anonymous and will not have any impact on the participant's future care. Should participants become distressed during the interview then they will be given the opportunity to pause or stop the interview if they wish to do so. The participant information sheet also contains contact details for organisations that participants are able to contact in the event that they become distressed following the interview (i.e. Childline, Samaritans, Stonewall and local LGBT organisations depending on the participants' locality). If a participant becomes significantly distressed, or should risk issues be disclosed during the interview, then a discussion will be arranged between the lead researcher and research supervisors. Relevant safeguarding professionals will also be contacted should there be any risk concerns reported and, where possible, the participant will be made aware of this decision.

As stated above, participants may withdraw their consent up to two weeks after the interview has taken place. This should be sufficient time for participants to decide whether they would like to retract any of their comments, whilst ensuring that the project can be completed in an appropriate time frame.

**11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).**

When conducting interviews, the lead researcher will ensure to adhere to Lancaster University and Lancashire Care NHS Foundation Trust guidance on fieldwork and lone working. The lead researcher will be supplied with a SkyGuard device to protect them in case of emergency. It will be the lead researcher's responsibility to create a SkyGuard account prior to borrowing one of the devices from the Faculty of Health & Medicine. The lead researcher will then be responsible for activating the device in case of emergency, so that relevant authorities can be alerted. It is not anticipated that the interviews will evoke any distress, however it will be the responsibility of the lead researcher to approach members of the research team for supervision & support should this be the case.

**12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.**

Although there are no expected direct benefits, participants will hopefully have an opportunity to reflect on their experiences and have these validated through the interview process. The participants will also be contributing to research which aims to indirectly improve the mental health and wellbeing of other young people from sexual minority groups.

**13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:**

Incentives are not intended to be used as these might be interpreted as coercive. We will offer to reimburse travel expenses for participants who take part in face-to-face interviews (i.e. the cost of public transport tickets or a 45p/mile rate for those who travel by car – up to a maximum of £20 for each participant).

**14. Confidentiality and Anonymity**

**a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?** yes

**b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.**

Participant identities will be kept anonymous and recordings/transcripts saved under a pseudonym, which the participant can choose. If any personal contact details are shared by the participants when enquiring about the study then these details will be securely stored electronically on the University H: drive and destroyed when contact is no longer required (i.e. once the work has been examined and/or published, or as soon as a participant withdraws their consent). Participants will be made aware that there are some circumstances in which confidentiality must be broken – i.e. if a disclosure is made which might indicate risk to self or other people. In these circumstances, the

participants would be made aware that the information would need to be shared with research supervisors and appropriate safeguarding professionals.

**15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.**

Stakeholders were consulted regarding the research question and design of the study (e.g [redacted] [redacted], CEO of [redacted] – a group of mental health professionals working with gender and sexual diverse clients). Local LGBT charities and youth groups have also been consulted regarding the design of materials such as the participant information sheet, consent form and interview schedule.

**16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.**

The findings will be written into a thesis for completion of the Doctorate in Clinical Psychology at Lancaster University. In addition, the findings are likely to be submitted for publishing in a peer-reviewed journal, such as *The Journal of Gay and Lesbian Mental Health* or *Journal of LGBT Issues in Counselling*. Participants will also be supplied with a copy of the findings, should they wish to receive one.

**17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?**

I can confirm that the lead researcher has enhanced DBS clearance, as this was required prior to acceptance on the doctorate in clinical psychology programme.

*Parental consent:* Due to the sensitive nature of the research topic, parental consent will not be sought for this study, despite the age range of the target sample. This is because participants may not have disclosed their sexual orientation to family members and in some cases doing so may place them at risk of harm. In addition, research has demonstrated that requiring parental consent for LGBT youth under the age of 18 years has the potential to alter study findings and increase participants' appraisals of any risk or discomfort which might be associated with their participation. Research with LGBT youth is typically conducted without parental consent for this reason, with no known negative implications.

*Follow-up interviews:* In some circumstances, it may be appropriate to arrange a follow-up interview with a participant. This can be instigated by either the participant, should they have any further information which they had forgotten or omitted from their initial interview, or by the researcher, should there be a need for clarity in any of the participant's statements. Participants will be made aware of the potential for a follow-up interview prior to taking part in the study and this will be stated clearly on the information sheet. Participants will be under no obligation to take part in a follow-up interview and have every right to refuse this if instigated by the researcher. If participants do agree to a follow-up interview, then the process will be the same as the initial meeting.

**SECTION FOUR: signature**

**Applicant electronic signature**: C.Hunt Date 04/10/19

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☒

**Project Supervisor name** (if applicable): Clare Dixon & Craig Murray Date application discussed 21/08/2019

**Submission Guidance**

1. **Submit your FHMREC application by email to Becky Case (fhmresearchsupport@lancaster.ac.uk) as two separate documents:**
    i. **FHMREC application form.**
    Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*
    ii. **Supporting materials.**
    Collate the **following materials for your study, if relevant, into a single word document:**
        a. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
        b. Advertising materials (posters, e-mails)
        c. Letters/emails of invitation to participate
        d. Participant information sheets
        e. Consent forms
        f. Questionnaires, surveys, demographic sheets
        g. Interview schedules, interview question guides, focus group scripts
        h. Debriefing sheets, resource lists

    **Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.**

2. Submission deadlines:
    i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Becky Case **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:

   a. existing documents/data only;
   b. the evaluation of an existing project with no direct contact with human participants;
   c. service evaluations.

**3. You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**

# Research Protocol

## *'Coming out' in therapy: The experiences of young people disclosing their sexual orientation to mental health professionals*

**Principal Researcher:** Chris Hunt, Trainee Clinical Psychologist, Lancaster University

**Research Supervisors:** Dr Clare Dixon, Clinical Psychologist, Lancaster University;

Dr Craig Murray, Senior Lecturer in Health Research, Lancaster University

**Field Supervisor:** Dr James Porter, Counselling Psychologist,

## Introduction

Research suggests that people from sexual minority (SM) groups are more likely to experience mental health difficulties and are often at greater risk of suicide than heterosexuals (Haas et al., 2011; King et al., 2008; McDermott et al., 2017). These findings exist in a context of widespread homophobia and the mistreatment of individuals identifying as a SM (Smith, Bartlett & King, 2004). Unfortunately, there are several barriers which may prevent people who identify as a SM from accessing services in the first instance. These may include fear of discrimination from staff (Burgess et al., 2008) and/or traditional narratives of sexual orientation, which paint SM individuals as ‘sexual deviants,’ requiring ‘treatments’ for their pathologised behaviour (Drescher, 2015; Friedman & Downey, 1998). In order to better support people from SM groups, clinicians require a wider understanding of the factors affecting their engagement with mental health services and the outcomes of psychotherapy, yet research is relatively scant (King et al., 2007).

The existing literature highlights that many SM individuals actively seek out SM therapists and, in some cases, achieve better outcomes than with therapists who identify as heterosexual or who choose not to disclose their sexual orientation (Brooks, 1981; Green, 2011; Jones, Botsko & Gorman, 2003; Liddle, 1996). One potential explanation for these findings is the minority stress model (Meyer, 2003). This model states that people from SM groups may conceal their identities from others to protect them from stigma and discrimination. However, it is suggested that this concealment comes with a considerable cost to the person’s wellbeing – perhaps due to the cognitive and psychological burden of suppressing such a significant aspect of one’s identity (Smart & Wegner, 2000). A therapist who openly identifies as a SM themselves may be perceived as less threatening to the SM client, due to an assumption of some shared understanding or experience (Beutler et al., 1991). As such, the client may feel more able to talk openly with the therapist about their

sexual identity, freeing them from the potential stress otherwise induced by concealing their sexual orientation or other related aspects of themselves.

It appears that many therapists and counsellors feel ill-equipped to work with SM clients and research has highlighted significant gaps in training regarding issues of gender and sexual diversity (Boroughs et al., 2015; Evans & Barker, 2010; Garnets et al., 1991; Owen-Pugh & Baines, 2013). Furthermore, despite a societal shift in attitudes regarding sexual orientation and a movement towards 'gay-affirmative' therapeutic interventions (Davies, 1996), many SM individuals continue to report experiencing negative or mixed reactions when openly expressing their sexual orientation with mental health professionals (Department of Health, 2006). To some, these findings may sadly be unsurprising, especially given the continued practice of 'conversion' or 'reparative' therapies which aim to modify a person's sexual orientation in favour of heterosexuality (Beckstead & Morrow, 2004). Whilst there has certainly been an increasing regulation of these approaches over the years (Drescher et al., 2016), recent research has suggested that as many as 17% of therapists have attempted to assist clients in 'reducing homosexual feelings' in their past practice and that a minority (4%) would still attempt to change their client's sexual orientation (Bartlett, Smith & King, 2009).

Despite the above findings, little investigation has taken place into the experiences of SM clients disclosing their sexual orientation in the therapy room. One study has explored the experiences of self-disclosure for lesbian, gay and bisexual clients in counselling by way of a postal survey (Evans & Barker, 2010). However, research has tended to focus more generally on the 'helpful and unhelpful experiences' of SM clients (Israel et al., 2008) or experiences of self-disclosure from the position of the therapist, rather than the client (Harris, 2015; Porter, Hulbert-Williams & Chadwick, 2015).

The issue of self-disclosure of sexual orientation is perhaps especially relevant for young people, who might be considered at a key stage of identity development (Floyd & Stein, 2002). Various models have been proposed to conceptualise the development of sexual identity – one of the most frequently cited being the Cass (1979) model. Cass (1979; 1996) suggested that SM individuals progress through a series of developmental 'stages,' beginning with the questioning of one's sexual orientation and moving through periods of peer comparison, tolerance, acceptance and ideally successful integration of the person's sexuality with their wider sense of self. Whilst this process is likely to be affected by a range of contextual factors, there is an assumption that the earlier stages tend to begin in adolescence.

Current research into therapy with SM youth tends to focus on work with parents and families (Saltzburg, 2007; Tanner & Lyness, 2002). However, many young people may choose not to disclose their sexual orientation within a family setting for a variety of reasons, including a fear of being made an outcast from the family due to homophobia. It is therefore especially important that mental health professionals are equipped to support SM clients who may be coming to terms with their developing sexual orientation and are able to reach out to those individuals who may otherwise be struggling in silence. As such, the aim of the proposed study is to explore the experiences of young people in disclosing their sexual orientation to mental health professionals within the United Kingdom. It is hoped that the findings of this research will contribute to a wider understanding of the process of 'coming-out' in the current socio-political climate and how this can be supported in a therapeutic setting.

# Method

## Design

A qualitative approach is proposed for this research study as qualitative approaches seek to understand the *experiences* of individuals and groups, which is applicable to the research question (Teherani et al., 2015). The scarcity of research in the topic area was also a justification for choosing a qualitative rather than quantitative approach. Semi-structured interviews will be conducted with participants who volunteer to take part. It was felt that 1:1 interviews would be more appropriate than surveys or focus groups due to the potentially sensitive and personal nature of the topic. Whilst the interviews will ideally take place in person, video technology such as Skype may also be considered where distance/travel might be an issue – this approach is becoming increasingly used in qualitative research as an alternative to conventional face-to-face interviews (Janghorban et al., 2014).

### Proposed analysis

The proposed method of analysis for interview transcripts is Interpretative Phenomenological Analysis (IPA). IPA was deemed the appropriate method of choice due to its emphasis on personal lived experience and sense-making (Smith, Flowers & Larkin, 2009) – both of which were considered relevant to the topic of sexual identity and the aims of this research. More specifically, IPA has foundations in three key theoretical principles which were considered important in meeting the research aims. These principles are: phenomenology, which refers to the study and conscious perception of lived human experience; hermeneutics, which refers to the process of interpretation of these experiences; and idiography, which emphasises the uniqueness of the experience to the individual. Previous studies investigating similar research questions have also made use of the IPA approach for these reasons (Porter, Hulbert-Williams & Chadwick, 2015).

**Participants**

Approximately 8 – 12 participants will be recruited for interview. Whilst there is no definitive guidance for the number of participants required for qualitative research (Pietkiewicz & Smith, 2012), it was decided that this approximation would be appropriate given the relative homogeneity of the target sample and the chosen method of analysis. Inclusion criteria for participants will be as follows:

- Identify as having a minority sexual orientation (i.e. non-heterosexual)
- Experience of disclosing their sexual orientation to a therapist or counsellor
- Between the age of 13 – 18 years at the time of recruitment (the upper age limit may be extended to 25 years, depending on the number of participants who come forward – please refer to 'procedure' for more details regarding the staged recruitment strategy).

Due the broad nature of the research question and the lack of literature in the topic area, no restrictions will be placed on the modality of the therapy received by participants or their presenting difficulties. This information will nevertheless be collected during the interview process in order to contextualise the findings.

**Procedure**

**Recruitment strategy**

A staged recruitment strategy is proposed to ensure that an adequate number of participants can be recruited whilst balancing the sample homogeneity required by an IPA approach. Two stages are proposed, as follows:

*Stage 1* - Contact regional and national LGBT+ youth groups and charities (target sites are likely to be within the North-West of England and within the West-Midlands). The lead

researcher and/or field supervisor will be responsible for distributing recruitment posters (Appendix A) and attending relevant meetings to promote the study. Advertisement will also take place via social media (e.g. Facebook groups & Twitter), whereby the group administrators will be requested to share posters and information on behalf of the research team. This will avoid the use of personal social media accounts. If fewer than eight participants in total have been recruited after two months, proceed to stage 2.

*Stage 2* - Expand age criteria from 13 – 18 years to 13 – 25 years for both online and face-to-face recruitment. In this instance, posters (with an amended age-range) will be distributed within local University institutions, LGBT+ groups and online.

**Data collection**

Individuals who make contact with the research team and volunteer to participate will be supplied with an additional information sheet (Appendix B) and given opportunity to ask any questions about their participation. Should they still wish to participate then the lead researcher will arrange a date and time to meet face-to-face at an agreed location. As an employee of [redacted] the lead researcher will adhere to the [redacted] lone worker policy. Suggested locations for interviews will depend on where the participant was recruited from, but may include: interview rooms at Lancaster University, youth group meeting spaces or school/college classrooms. If it is not convenient for the participant to meet in person then a video-based interview will be arranged via Skype. In this instance, the participant information sheet and consent form (Appendix C) will be sent to the participant's preferred e-mail address.

Prior to commencing the interview, participants will again be presented with the participant information sheet (or asked to read over their e-mailed copy if the interview is being conducted via Skype). The participants will be given time to read and digest the

information and a second opportunity to ask any questions. Should they wish to proceed with the interview then participants will be asked to sign their consent in writing and complete a demographic information record (Appendix D). In the case of Skype interviews, this information will instead be obtained verbally, rather than in writing. The interview itself will take a semi-structured form, with the aid of a pre-designed interview schedule (Appendix E). Interviews will be recorded for the purposes of transcribing and participants will be asked to select a pseudonym to preserve their anonymity. This pseudonym will be used in place of the participant's name within the transcripts and any written material emerging from the study.

Participants will also be informed that they have the right to withdraw from the study, without any negative implications if they choose to do so. It will be requested that participants let the research team know of their decision to withdraw within two weeks after the date of the interview so that the findings can be written up within an appropriate time frame.

**Data analysis**

Recordings of the interviews will be transcribed for analysis by the lead researcher. Initial transcripts will be read by members of the research team and feedback given. The lead researcher will analyse the transcripts in accordance with an IPA approach, and members of the research team will supervise this process, checking for intercoder agreement. This will involve making some initial notes regarding observations and reflections about the interview process and transforming these notes into a series of emerging themes which will be incorporated within a written report. As an *inductive* approach, IPA seeks to explore the meanings that participants assign to their experiences (Reid et al., 2005). Therefore, the development of these themes will be conducted directly from the 'bottom-up,' as opposed to imposing a pre-existing hypothesis on the data.

## Practical Issues

### Expenses

Participants will not be offered a financial incentive or reward for taking part in this study. We will offer to reimburse travel expenses for participants who take part in face-to-face interviews (i.e. the cost of public transport tickets or a 45p/mile rate for those who travel by car – up to a maximum of £20 for each participant).

### Data management

Interviews will be audio recorded and immediately transferred onto an encrypted USB drive, to be transported securely onto the Lancaster University network at the earliest opportunity (University H: Drive, via the VPN if away from campus). As soon as the dataset has been transferred to the USB, it will be deleted from the audio recorder. The data will then be immediately removed from the USB once transferred to the network. Paper consent forms will be immediately scanned into electronic format after the interview has taken place. The paper versions will subsequently be deposited in a confidential waste bin. In situations where the electronic consent forms cannot be immediately upload to the University network, they will instead by transferred onto an encrypted USB and transferred at the earliest opportunity. All data analysis will be conducted electronically (including transcription and development of themes) to ensure safe data storage on the lead researcher's University H: Drive.

Once the project has been examined and published in an appropriate peer-reviewed journal, electronic recordings and pseudonym codes will be destroyed. The electronic consent forms and transcripts will be stored securely in separate password protected files by the Doctorate in Clinical Psychology Course at Lancaster University for 10 years. These will be accessible by the Research Coordinator, who will be the data custodian. After 10 years, the

research coordinator will be responsible for destroying the data under instruction from the research supervisors (Craig Murray & Clare Dixon).

## Ethical Issues

### Informed consent

Consent is a key ethical consideration for this study due to the age range of the target sample. Due to the sensitive nature of the research topic, parental consent will **not** be sought. This is because some participants may not have disclosed their sexual orientation to family members and in some cases doing so may place them at risk of harm. In addition, research has demonstrated that requiring parental consent for LGBT youth under the age of 18 years has the potential to alter study findings and increase participants' appraisals of any risk and discomfort associated with research (Mustanski, 2011). Research with LGBT youth is typically conducted without parental consent for this reason, with no known negative implications (D'Augelli, Hershberger & Pilkington, 2001; Mclaren, Schurmann & Jenkins, 2015).

### Risk to participants

Whilst there are not any anticipated risks in participating in this study, it is acknowledged that participants may have some difficulty speaking openly about their experiences or may feel a pressure to present their therapy experience in a positive light. It will therefore be emphasised that information shared during the interview will remain anonymous (through use of a pseudonym, which the participant may choose) to reduce the likelihood of their identity being recognised.

Should participants become distressed during the interview then they will be given the opportunity to pause or stop the interview if they wish to do so. The participant information sheet also contains a list of resources/contact details for the participant to make use of in the

event that they experience any distress. If a participant becomes significantly distressed, or should risk issues be disclosed during the interview, then research supervisors will be contacted for discussion. In the instance of any safeguarding concerns arising then it will be the responsibility of the research team to pass on any necessary information to the relevant professionals. The participant will be made aware of this decision where possible and will be aware of the limits of confidentiality from discussions prior to the interview and after reading the participant information sheet. In cases where disclosures are made regarding the malpractice of a mental health professional, this information will also be brought to the attention of the research supervisors.

### Risk to researchers

There are no anticipated risks for the researcher conducting interviews, however the lead researcher will ensure to adhere to [redacted] lone working policy. The lead researcher will carry a SkyGuard device during interviews, which they will take responsibility for activating in case of an emergency. Should any concerns arise during the interviews that the lead researcher requires additional support or guidance with (such as escalating a safeguarding concern), then research supervisors will also be approached for debriefing.

## Proposed Timescale

*September 2019* – Submit Ethics application

*September – October 2019* – Receive confirmation of ethics (amend/resubmit)

*November 2019* – Begin recruitment stage 1

*December 2019* – Proceed to recruitment stage 2 if additional participants are needed

*January 2020* – Proceed to recruitment stage 3 if additional participants are needed

*January – February 2020* – Data analysis

*February – May 2020* – Write-up & Submission

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**Appendix 4-A – Recruitment Poster**

Doctorate in Clinical Psychology | Lancaster University

# 'Coming out' in counselling or therapy –

## Can you help us with our research?

- **Are you 13 – 18 years old?**
- **Do you think of yourself as lesbian, gay, bisexual, pansexual, asexual or any sexual orientation besides straight?**
- **Have you spoken about your sexuality with a therapist or counsellor? (please note: it doesn't matter whether or not this was your main reason for seeking therapy or counselling)**

**We would love to hear from you!**

**We are looking to speak with young people about what it is like to talk with therapists and counsellors about sexual orientation. Taking part is voluntary and should take no more than 45 minutes – 1 hour. Please get in touch to find out more by contacting a member of the research team using the details below.**

**All of your information will be kept anonymous and your help could make a real difference to improve the mental wellbeing of young LGBT people.**

**Thank you!**

Chris Hunt
Coming out in counselling study
**07508375658 (call or text!)**
**E-mail: c.hunt@lancaster.ac.uk**

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Coming out in counselling study
**07508375658 (call or text!)**
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Chris Hunt
Coming out in counselling study
**07508375658 (call or text!)**
**E-mail: c.hunt@lancaster.ac.uk**

**Appendix 4-A – Recruitment Poster (online version)**

'Coming out' in counselling or therapy –

Can you help us with our research?

- Are you 13 – 18 years old?
- Do you think of yourself as lesbian, gay, bisexual, pansexual, asexual or any sexual orientation besides straight?
- Have you spoken about your sexuality with a therapist or counsellor? (please note: it doesn't matter whether or not this was your main reason for seeking therapy or counselling)

We would love to hear from you!

We are looking to speak with young people about what it is like to talk with therapists and counsellors about sexual orientation. Taking part is voluntary and should take no more than 45 minutes – 1 hour. Please get in touch to find out more by contacting a member of the research team using the details below.

All of your information will be kept anonymous and your help could make a real difference to improve the mental wellbeing of young LGBT people.

Thank you!

Lead researcher: Chris Hunt

CALL OR TEXT 07508375658

E-Mail c.hunt@Lancaster.ac.uk

***please note: the above telephone number is a research phone supplied by the Lancaster Doctorate in Clinical Psychology and is not intended for personal use.**

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**Appendix 4-B – Participant Information Sheet**

***'Coming out' in therapy: The experiences of young people disclosing their sexual orientation to mental health professionals***

My name is Chris Hunt and I am conducting this research as a student on the Clinical Psychology Doctorate programme at Lancaster University, Lancaster, United Kingdom.

## What is the study about?

We are asking young people about what it is like to talk with a therapist or counsellor about having a sexual orientation that isn't 'straight' (e.g. gay, lesbian, bisexual, pansexual, asexual, queer, questioning, or unsure). We hope that this will help us to better understand what it is like to come out in therapy so that we can help improve the mental health and wellbeing of young LGBT people.

## Can I take part?

We would like to invite you to take part if you:

- Are between 13 and 18 years old.
- Think of yourself as having a sexual orientation that isn't 'straight' (e.g. gay, lesbian, bisexual, pansexual, asexual, queer, questioning, or unsure).
- Have spoken with a therapist or counsellor and told them about your sexual orientation (it doesn't matter if this wasn't your main reason for seeking therapy/counselling).

## Do I have to take part?

No. It's completely up to you to decide whether you would like to be interviewed. If you do decide to take part, you are free to stop the interview at any point. You can also decide to withdraw your information, up until two weeks after the interview has taken place.

## What will I be asked to do if I take part?

If you decide you would like to participate, you would be asked to take part in an interview (approximately 45 minutes to 1 hour in length) about your experiences. The interview will take place with Chris Hunt, the lead researcher for the project, at a location that is convenient for you. It may also be possible to arrange a video-chat through Skype if it is not possible for you to meet in person. Sometimes it can be helpful to arrange a follow-up interview to clarify our discussions from the initial interview. You are welcome to contact the research team after your interview has taken place for this to be arranged. Please note that you are under no obligation to take part in a follow-up interview if you do not wish to do so.

## Will my data be Identifiable?

The information you provide during the interview will be anonymous and pooled together with information provided by other participants. The data collected for this study will be stored securely and only the researchers conducting this study will have access to your responses:

- Audio recordings will be destroyed and/or deleted once the project has been submitted for examination.
- The files on the computer will be encrypted (no-one other than the researcher will be able to access them) and the computer itself is password protected.
- At the end of the study, electronic copies of the anonymised interview transcripts will be kept securely on Lancaster University's computer network for 10 years. At the end of this period, they will be destroyed.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them.
- All your personal data will be confidential and will be kept separately from your interview responses.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to the research team about this. If possible, I will tell you if I have to do this.

## What will happen to the results?

The anonymised results will be summarised and reported in a piece of academic work for the Doctorate in Clinical Psychology. The results may also be published in a research paper. You may request a copy of the findings by contacting the lead researcher (Chris Hunt), should you wish to receive one.

After the interview, you will have a period of **two weeks** in which to withdraw your data, if you decide that you no longer wish for your information to be used. After this time, it may not be possible to withdraw your data so please do contact the researcher within the allotted time if this is the case.

## Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this information sheet.

**Are there any benefits to taking part?**

Although we cannot guarantee any direct benefits of taking part, we hope that you will find your participation interesting and worthwhile, and it may help you to think about your experiences. Your contributions may also help us to understand how best to support and work with LGBT people in therapy.

**Will my travel costs be reimbursed?**

We are happy to provide reimbursement for travel costs that you have incurred by attending your interview (up to a maximum of £20). If you travel by public transport, please bring your travel tickets/receipts with you to the interview and we will compensate you for the ticket price. You will also be able to claim return tickets via post if necessary. If you travel by car then we are happy to reimburse you for your mileage at a 45p/mile rate.

**Who has reviewed the project?**

This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

**Where can I obtain further information about the study if I need it?**

If you have any questions about the study, please contact the main researcher or one of the research supervisors below.

Chris Hunt - c.hunt@lancaster.ac.uk Tel: 07508375658
Dr Clare Dixon – c.dixon3@lancaster.ac.uk
Dr Craig Murray – c.murray@lancaster.ac.uk
Dr James Porter - james.porter@mpft.nhs.uk

**Complaints**

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Prof. Bill Sellwood Tel: 01524 592970
Chair in Clinical Psychology; Email: b.sellwood@lancaster.ac.uk
Doctorate in Clinical Psychology
Lancaster University
LA1 4YG

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Professor Roger Pickup Tel: +44 (0)1524 593746
Associate Dean for Research Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine (Division of Biomedical and Life Sciences)
Lancaster University
LA1 4YG

Thank you for taking the time to read this information sheet.

## Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of help to you:

**Childline:**
Tel: 0800 1111 (Freephone)
Or contact them online for a 1 to 1 chat with a counsellor.

Childline is a free counselling service for young people up to their 19th birthday. It is provided by the NSPCC. Childline deals with any issue which causes distress or concern. Some common issues include child abuse, bullying, mental health problems, parental separation or divorce, teenage pregnancy and substance misuse.

**Samaritans:**
Tel: 116 113 (Freephone)
Email: jo@samaritans.org

Samaritans is a registered charity aimed at providing emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide throughout the United Kingdom and Ireland, often through their telephone helpline.

**Stonewall:**
Tel: 08000 502020

Stonewall is an LGBT rights charity in the United Kingdom. They provide advice and support about human rights for anyone under the LGBT+ umbrella.

Depending on where you live, there may also be more local LGBT+ groups or drop-in centres which you can attend. Feel free to ask the research team if you would like to receive some contact details.

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**Appendix 4-C – Consent Form**

**Study Title:** ***'Coming out' in therapy: The experiences of young people disclosing their sexual orientation to mental health professionals***

We are asking if you would like to take part in a research project where you will be interviewed about your experiences of talking with a therapist or counsellor about your sexual orientation.

Before you consent to participating in the study, we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Chris Hunt.

| | **Please initial each statement** |
|---|---|
| 1. I confirm that I have read the information sheet and fully understand what is expected of me within this study | ☐ |
| 2. I confirm that I have had the opportunity to ask any questions and to have them answered. | ☐ |
| 3. I understand that my interview will be audio recorded and then made into an anonymised written transcript. | ☐ |
| 4. I understand that audio recordings will be kept until the research project has been examined and/or published. | ☐ |
| 5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. | ☐ |
| 6. I understand that I may choose to withdraw my data, up until **two weeks** after the interview has taken place, by contacting a member of the research team. I am aware that it may not be possible to withdraw my data after this time. | ☐ |
| 7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published. | ☐ |
| 8. I consent to information and quotations from my interview being used in reports, conferences and training events. | ☐ |
| 9. I understand that the researcher will discuss data with their supervisors as needed. | ☐ |
| 10. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will need to share this information with their research supervisor. | ☐ |
| 11. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished. | ☐ |
| 12. I consent to take part in the above study. | ☐ |

**Name of Participant**________________________________________

**Signature**______________________ **Date** ______________________

**Name of Researcher** _______________________________________

**Signature** ______________________**Date** ______________________

Should you have any further questions or queries about the research then please contact a member of the research team via the details below:

**Principal investigator:**

Chris Hunt

E-mail: c.hunt@lancaster.ac.uk
Tel:

Doctorate in Clinical Psychology
Lancaster University
Lancaster
LA1 4YG

**Supervisors:**

Dr Clare Dixon – c.dixon3@lancaster.ac.uk
Dr Craig Murray – c.murray@lancaster.ac.uk
Dr James Porter -

Doctorate in Clinical Psychology | Lancaster University

**Appendix 4-D – Demographic information record**

**Participant Pseudonym______________________________**

**Study Title:** ***'Coming out' in therapy: The experiences of young people disclosing their sexual orientation to mental health professionals***

Thank you for agreeing to participate in this research study. Before we begin the interview, there are a few demographic details that we would like to ask of you. Please could you fill out the following form using the spaces provided.

Many thanks for your participation.

1. **How old are you? ____________________________**

2. **How would you describe your ethnicity (e.g.** ***White British, Black, Asian, Mixed, Other*****)______________________________________**

3. **How would you describe your gender? __________________________**

4. **How would you describe your sexual orientation? _________________________**

## Appendix 4-E – Interview Schedule

***'Coming out' in therapy: The experiences of young people disclosing their sexual orientation to mental health professionals***

The interview is designed to elicit participants' subjective experience of disclosing their sexual orientation in a therapy context. Some of the domains that might be explored are captured below, with some example questions and prompts. The questions here are intended as a guide only and do not need to be asked in the exact order or form that is presented.

*Pre-amble to orient participants to the process, use of audio recording device and purpose of the interview (participants will also have been presented with the participant information sheet and consent form).*

*Suggested opening question:*

- **As you know, this research is about your experience of speaking with a therapist or counsellor about your sexual orientation. To start with, could you tell me a bit about the person that you spoke to?** (Do you know their professional background/title? – e.g. counsellor, psychologist, CBT therapist; How & when did you come into contact with them?)

*Possible follow-up questions:*

- **Lots of people see mental health professionals for all sorts of reasons. Was sexual orientation the focus of your therapy, or were you seeking therapy because of something else?**
- **What was it like speaking to your therapist?** (How would you describe the relationship?)
- **At what point did you tell them that you weren't heterosexual?** (What did you say? Was this early in the process? Later on? Why do you think this might have been?)
- **How did they respond when you told them?** (Was there anything in particular that was said or done that stood out to you?)
- **How did you feel about telling them?** (Before / During / After; Emotionally, physically)
- **Did you have any expectations about what it might be like to tell your therapist about your sexual orientation?** (Hopes / Fears)
- **Had you told other people about your sexual orientation before?** (If *yes*, how did this experience compare to telling your therapist? If *no*, what was different about this person that meant you were able to tell them?)
- **Was it difficult to talk about your sexual orientation?** (Were there any challenges? Did you manage to overcome these? If so, how? Did your therapist support you with this process?)
- **Did your therapist seem knowledgeable about LGBT issues?** (Were they aware of different labels for sexual orientation? How confident were you that your therapist understood what your sexual orientation meant to you?)

- **Did your therapist seem comfortable knowing that you weren't heterosexual?** (Did you experience any prejudice or discrimination, from your point of view?)

- **How accepting of your sexual orientation did your therapist appear to be?** (Did your therapist ever make you feel like your sexual orientation was a problem, or something that needed to be changed?)

- **Do you think your therapist would have thought any differently about you if you were straight?** (If yes, in what ways? What makes you think that? How might things have been different for you?)

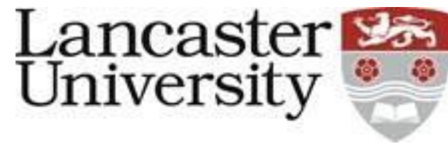
- **Do you think the conversations you had with your therapist might have been different if you hadn't told them about your sexuality?** (If *yes,* in what ways? If *no,* why do you think so?)

- **What advice would you give to other young people who might want to talk about their sexual orientation with a therapist/counsellor?**

- **Is there anything else you would like to add?** (Or ask?)

*Debrief – check-in with the participant to see how they found the interview, thank them for their time and answer any questions they might have. Re-affirm that they are welcome to withdraw their data if they wish to do so, but only up until **two weeks** from the interview date.*

**Ethics Approval**




Applicant: Chris Hunt
Supervisor: Claire Dixon and Craig
Murray Department: Health Research
FHMREC Reference: FHMREC19004

14 October 2019

Dear Chris

**Re: 'Coming out' in therapy: The experiences of young people disclosing their sexual orientation to mental health professionals**

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further

information. Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

R·E·Case

Becky Case
Research Ethics Officer, Secretary to FHMREC.