‘This dance between hope and hopelessness’: Queer and/or trans clinical psychologists’ experiences of bringing their lived identities into their practice

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

This thesis explores the experiences of queer and/or trans clinical psychologists in the United Kingdom (UK). It is set out in three parts. Part One is a Conceptual Introduction, which reviews research as it relates to the following topics: (1) Clinical psychology and the development of 'personhood'; (2) Psychology, violence and professional exclusion; (3) Queer and/or trans subjectivities in clinical psychology; and (4) Moving beyond disclosure – the self as resource. Finally, the rationale is made for the empirical paper that follows in Part Two, and the use of Interpretative Phenomenological Analysis (IPA) as its chosen methodology.

Part Two is a qualitative empirical paper using IPA to explore how self-identified queer and/or trans clinical psychologists in the UK bring their lived experiences into their practice. Analysis of the transcripts from eight semi-structured interviews generated five superordinate themes: (1) Queering practice; (2) Queer euphoria; (3) Living in threat mode; (4) 'A punch in the guts': profession as hostile; and (5) Living and working in community. The paper's discussion will conclude with a review of its limitations, and implications for training, research and clinical practice.

Part Three is a critical appraisal comprised of a summary of reflections that were noted throughout the writing of the conceptual introduction and the empirical paper. It reflects on three themes: (1) the 'novelty of being asked', (2) 'lost stories', and (3) the ethics of researching one's own community.

Impact Statement

This thesis has implications both inside and outside academia. The research contributes to literature on personal and professional development within clinical psychology, as well as piecing together a comprehensive history of the profession's evolving treatment of sexual and gender minorities. Uniquely, this thesis weaves these two topics together, to newly consider how the profession's legacies of queer- and transphobia might affect the personal and professional development of queer and/or trans psychologists.

Existing research on the lived experiences of queer and/or trans people tends to report from either a minority stress deficit perspective, or formulating research questions within a positive psychology framework. This thesis uses an open-ended qualitative methodology, allowing participants to speak to their lived experiences in a relatively non-directed way. This generates results that are nuanced, complex and dialectical, rather than one-dimensionally addressing queer and/or trans 'suffering' or 'pride'.

The findings of this thesis point to a crisis within the profession. Though positive shifts towards diversity, equality and inclusion are noted, the reality remains that queer and/or trans clinicians regularly experience queer- and transphobia directed towards themselves and their clients. Furthermore, queer and/or trans people are still overrepresented in mental health services, and report poorer experiences within them. This points to a lack of reckoning with psychology's violent past and cis-heteronormative present on an institutional level. The findings and implications of this research may serve as a small step towards 'holding up a mirror' to a profession that does not reflect on itself. Future researchers may use these findings as a springboard into thinking about *how* institutional change might take place. Queer and trans voices must lead on and be centred in the

development of any such guidance. Change should begin on a pedagogical level, with training courses first critically and meaningfully engaging with the profession's legacy before further efforts are made to 'include' minoritised perspectives in the curriculum.

Drawing on findings around the empowering or damaging potential of supervision of queer and/or trans clinicians, this research may be used to inform critical consciousness training for clinical supervisors. Further research should develop a fuller understanding of how supervision and clinical tutoring can empower clinicians with lived identities that psychology has historically pathologised.

This thesis contributes to multiple intersecting social, cultural and political discourses on the role of sexual and gender diversity in public life. Stepping beyond the confines of psychology, it may be used by activists, legal professionals and historians in considering how the taken-for-granted rules of living are *queered* by minoritised communities.

Perhaps most importantly, this thesis may empower queer and/or trans clinical psychologists to engage in their own reflexive relationship to their profession, and to ask themselves the question – *"what can psychology learn from us?"*.

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Part 1: Conceptual Introduction

Attending to our queer and/or trans selves: Navigating personhoods in clinical psychology

Abstract

This conceptual introduction explores the institutional practices and psychological processes that may impact the development of a queer and/or trans 'personhood' as a clinical psychologist in the UK. It situates the profession's approach to personal and professional development in the context of psychology's underpinnings, and provides an overview of the profession's historical pathologisation and violent treatment of sexual and gender minorities. The impact that these legacies of oppression have left on queer and/or trans psychologists are considered, as well as the structural processes that lead to queer and/or trans clinicians having to 'risk assess' whether it is safe to bring their subjectivities into their clinical work. The literature around therapist 'disclosure' of sexual orientation and gender identity is reviewed, before setting out the argument that this debate ought to be abandoned in order to consider how else queer and/or trans clinicians might employ a whole-person self-reflection as a potential location of empathy and connection.

There is currently no research which addresses how queer and/or trans clinical psychologists bring their lived identities into their practice. Further research is needed to understand what might be 'opened up', and what might be 'closed down' through these lived experiences.

Introduction

We have all been programmed to respond to the human differences between us with fear and loathing and to handle that difference in one of three ways: ignore it, and if that is not possible, copy it if we think it is dominant, or destroy it if we think it is subordinate (Lorde, 2007, p.115)

Whilst there is increasing recognition of the importance of personal development within the profession of clinical psychology, constructions of 'personhood' and how it is used in clinical practice are largely based on cisgender, heterosexual, middle-class, neurotypical, non-disabled and white assumptions and privileges (Adetimole et al., 2005; Ahmed, 2006; Ahsan, 2020; Clarke et al., 2010; Davidson & Patel, 2008; Goodbody & Burns, 2011; Haritaworn, 2008; Riggs, 2004; Turpin & Coleman, 2010). The profession has a history of classifying non-normative gender and sexual identities as deviant and pathological, and there has been a lack of curiosity as to how queer and/or trans clinical psychologists make sense of, integrate or use their identities in clinical practice. This conceptual introduction outlines the context for the experiences of queer and/or trans clinical psychologists, for whom embodying a 'reflective scientist practitioner' stance may go beyond intra-psychic reflection to negotiate experiences of gender- and heteronormativity or queer- and transphobia in their work.

Becoming a 'reflective scientist practitioner' and considering how the personal meets the professional is seen as integral to the professional development of therapists (Aponte, 1994). Whilst it is compulsory for trainees in many of the psy-professions (psychology, psychiatry, psychotherapy and related disciplines) to engage in personal

therapy, there is no such requirement for clinical psychologists (Marecek & Lafrance, 2021; Willets, 2018). In clinical psychology, the personal and the professional are conceptualised as distinct entities in relationship to one another (Gillmer & Marckus, 2003; Walsh & Scaife, 1998; Hughes & Youngson, 2009). The British Psychological Society and the Health and Care Professions Council, the two accrediting bodies for clinical psychology, have both issued guidance emphasising the importance of personal development in demonstrating self-awareness and sensitivity whilst working within ethical practice frameworks (BPS, 2015; HCPC, 2012). However, the extent to which the 'personhood' of clinical psychologists is enabled in practice may differ according to a number of variables, including the values of individual Doctorate of Clinical Psychology (DClinPsy) training programmes, philosophical underpinnings of the therapeutic models used in practice, and wider-NHS or team-specific organisational culture.

This conceptual introduction sets out the institutional practices and psychological processes that may impact on the development of a queer and/or trans personhood within the profession. After a short reflexivity and note on language, section two will situate clinical psychology's approach to personal therapy, personal and professional development and reflective practice in the context of the discipline's historical underpinnings. Section three will consider psychology's background of pathologisation and violence towards sexual and gender minorities, and will consider the legacy this has left on queer and/or trans clinicians in the profession. Section four considers the structural processes of power and privilege that lead to queer and/or trans clinicians having to 'risk assess' whether it is safe to bring their subjectivities into their clinical work. Section five will review the literature around therapist 'disclosure' of sexual orientation and gender identity, and will consider why this debate

ought to be left behind in order to consider how else the queer and/or trans clinician might employ a whole-person self-reflection as a location of empathy and connection. Finally, section six will introduce the rationale for the qualitative research paper that follows this conceptual introduction, and the use of Interpretative Phenomenological Analysis (IPA) as its chosen methodology (Smith et al., 2022).

Language

A complex issue in research with gender and sexually diverse communities is that of which language to use to appropriately capture those it concerns itself with. Historically, 'lesbian and gay' has attempted to capture those that exist outside the lines of heteronormativity, but have failed to include bisexual or trans people (Clarke et al., 2010). The term 'LGBT' (lesbian, gay, bisexual, trans) or 'LGBTQ' (lesbian, gay, bisexual, trans, queer) has also been critiqued for being a Eurocentric term that is used less readily by racialised communities, who may favour the term 'QTPOC' (queer and/or trans people of colour) (Davis, 2017). The term 'queer' is a word that has been historically used as a derogatory slur but was reclaimed in the late 1980s in a radical re-appropriation by those it described (Barker, 2017). 'Queer' is contemporarily used as a noun or adjective to encompass a range of sexual orientations and gender identities that are minoritised (Czyzselska, 2022). 'Trans' is an umbrella term denoting someone's gender identity or expression that transgresses social norms and does not conform with that assigned (assumed) at birth.

Whilst there are important differences between the experiences of everyone who falls under these umbrellas, the shared experiences of living outside dominant gender, sexual and relationship norms merit an inclusive approach to using a common term (Clarke

et al., 2010). Whilst acknowledging that there is no perfect terminology, the umbrella terms 'queer and/or trans' will be used in this research to as broadly as possible speak to people of minoritised sexual orientations and gender identities. Using the conjunction 'and/or' includes both queer and trans people, whilst also indicating that queer people may have gender identities that are expansive, and *vice versa*.

Reflexivity - A note on the author

It is important to acknowledge the social location and world view from which this paper is written in order to render visible the positionality held in this paper. Willig queries the notion that the research practitioner ought to remain *"detached, neutral and unbiased"* (2013, p.25), as this could limit the potential for certain specific insights only available to that specific person as the researcher in that specific research environment. In this vein, I do not claim to have an objective voice throughout this conceptual introduction, nor the qualitative research paper that follows. This paper concerns itself with the subjectivities of queer and/or trans clinical psychologists. The term 'subjectivity' refers to our lived experiences; it is the way *"the voices in our heads and the feelings in our bodies are linked to political, cultural, and historical contexts"* (Ellis & Flaherty, 1993, p.4). My own subjectivity is inextricably linked with the research topic. I am a queer feminist scholar, activist, woman and trainee clinical psychologist. I am a clinician who, because of the discipline's historical underpinnings and active legacy that remains, often finds myself feeling at odds with the values embedded in the profession.

This paper was initially written about the experiences of queer and/or trans clinical psychologists, referring to *them* with the plural pronoun 'they' throughout. Academic writing socialises scholars into using apparently neutral, objective and distant language to

disguise the identity of the author and deal exclusively with 'the facts' (Hyland, 2002). However, writing this paper is inevitably a profoundly personal and political exercise. Reviewing literature that is bound up with my own experiences of homophobia, marginalisation, violence and risk-taking has been a simultaneously emotionally draining and powerful process. Separating the subjugated parts of myself for the sake of academic respectability has often felt performative and inauthentic, and an exercise in precisely what this paper seeks to critically examine. As a point of resistance to leaving my queerness at the door of professionalism, I have chosen to write about the context of *our* experiences as queer and/or trans clinicians, the way that power has been used against *us* as queer and/or trans people, and the complex systems of power that *we* have to negotiate in our decisions to risk bringing our whole selves into our practice.

1. Clinical Psychology and the development of 'personhood'

This section will consider the extent to which the development of 'personhood' is encouraged in clinical psychology, and the means through which this is facilitated.

Development of 'personhood': personal therapy

Personal therapy is mandated for psychotherapy, counselling, and counselling psychology trainees by all of their accrediting bodies (e.g. British Association for Counselling and Psychotherapy, 2023; British Psychological Society, 2022; UK Council for Psychotherapy, 2022). Some psychotherapeutic training routes, for example psychoanalytic psychotherapy and psychoanalysis, even have requirements for their prospective trainees to have spent a certain amount of 'hours' in therapy before they are considered eligible to apply for a training course (British Psychoanalytic Council, 2022). Clinical psychology, however, has no

such requirements for its applicants, trainees, or accredited members (Wilson et al., 2015). The BPS, which accredits both clinical and counselling psychology courses, maintains that the difference in expectation between the two training trajectories is rooted in the historical foundations of the profession - with clinical psychology situating itself as a logical positivist approach within behavioural science, where emphasis on notions of subjectivity and personhood are seen to be at odds with its empirical underpinnings (Hanley, 2017; Wilson et al., 2015).

Furthermore, accessing personal therapy or being a service user of NHS psychological services as a clinical psychologist has even carried a stigma, confronting the 'noble us and troubled them' duality, where the 'idealised psychologist' and the 'impaired practitioner' are constructed as mutually exclusive (Aina, 2015; Good et al., 2009; Pope & Tabachnick, 1994; Rhinehart et al., 2019). Wilson et al.'s (2015) study found that nine out of ten participants experienced shame for accessing therapy during training, feeling as though they ought to be *"more sorted"* (p.42) as trainee clinical psychologists. Whilst some training courses in the UK provide stipends for personal therapy, Wilson's study found that trainees felt concerned about applying for this funding, in case it became *"just another thing"* (p.38) that could be used for monitoring and evaluating their performance. This uniquely positions clinical psychology as the only 'talking therapies' profession where accessing one's own therapeutic support reflects poorly on the therapist themselves (Tay et al., 2018). The BPS (2020) recently published guidance to support and value the lived experience of mental health difficulties in clinical psychology training. It remains to be seen whether this guidance helps to bring about change to the way a new generation of clinical psychologists will integrate the vulnerabilities of their personhoods in their practice.

A wealth of research has demonstrated a link between personal therapy and the development of self-awareness, reflexivity, and personal development of therapists (Grimmer & Tribe, 2001; Lavendar, 2003; Rizq & Target, 2008; Timms, 2010; Wigg et al., 2011; Wilson et al., 2015). Accessing therapy, then, is not just for working through distress or accessing an 'intervention' for a mental health diagnosis, but can be a valuable space for intra-psychic exploration and building of 'personhood'. Orlinsky et al. (2015) found in a systemic review that 88% of psychotherapists reported positive outcomes from personal therapy, including experiences of emotional support, enhanced self-awareness, and professional development.

Very little research has been conducted with clinical psychologists, and even less with those in the UK, though research has shown that UK clinical psychologists engage in their own personal therapy at lower rates than their American counterparts (Nel et al., 2012). However, a finding from the same study showed that when clinical psychologists do engage in their own therapy, they experience this as having a positive effect on their practice. Only 26% of the 357 UK clinical psychologists surveyed had accessed personal therapy during training, with 88% reflecting this as important in their personal and professional development. In a narrative analysis of 10 interviews with trainee clinical psychologists in the UK, Wilson et al., (2015) also found that personal therapy can provide valuable support and stress management during training, and had positive impacts on participants' clinical work.

Simply put, one of the key arguments for clinical psychologists to engage in personal therapy is this: we sit with people, we should sit with ourselves. Norcross (2005) emphasises

that this process supports clinicians to acquire personal awareness and psychological maturation in order to better help their clients do the same.

Development of 'personhood': Reflective practice and PPD

Research in the area of personal development has demonstrated that personal therapy is not the only way to develop reflection on one's 'personhood' (Cushway & Gatherer, 2003; Lavender, 2003; Stedmon et al., 2003). Malikiosi-Loizos (2013) noted that trainee counselling psychologists who engaged in a 'personal development group' reported increased self-awareness, development of insight and intra-personal as well as inter-personal growth. Aponte & Kissil (2016), in their book of the same name, recognised the importance of locating 'The Person of the Therapist'. They argue that, through the use of reflexivity, clinicians develop access to their own humanity in a profession which is at its crux a human-to-human encounter, thereby becoming more effective, conscious practitioners.

In 1987, Donald Schön developed the 'reflective-practitioner' model, making space for a new potential direction for the epistemology of clinical psychology, shifting away from the scientist-practitioner identity as gold standard (Frank, 1984). Schön's model emphasised the importance of reflecting on the professional, practical and personal in clinical practice, and bringing these into the expected competencies of clinical psychology training. Building on Schön's model, but staying true to its empiricist foundations, recent shifts in UK clinical psychology training courses have embraced a hybrid reflective-scientist-practitioner identity by building opportunities for reflective practice into the core curriculum (Hanley, 2017; Knight et al., 2010; Binks et al., 2013; Shah et al., 2012).

The BPS' accreditation criteria for UK clinical psychology training courses specifies that courses should teach the 'reflective scientist practitioner' model as standard (BPS, 2015), though the extent to which the reflexivity of trainees is facilitated and encouraged in reality varies across training courses and has been critiqued as underdeveloped (Paulraj, 2016). The BPS (2017) describes personal and professional development (PPD) as the way in which clinicians develop knowledge about their personal and professional selves. The PPD agenda is reinforced on a national level (Department of Health, 2004), a professional level (BPS, 2015), and on an employer level, with NHS Trusts incorporating PPD into their Knowledge and Skills Frameworks (Youngson et al., 2009). However, a review of PPD across UK DClinPsy training courses by Horner, Youngson and Hughes (2009) found huge variation in its application and engagement. One specific reported finding was that although there is movement towards an integrated approach, the 'personal' in PPD is less well defined and emphasised. Furthermore, as Paulraj (2016) notes, the emphasis on PPD in the profession appears to be on transferable skills, employability, and leadership competencies within a changing NHS context, rather than on the reflective development of individual 'personhood' and 'subjectivity'.

This begs the question: for a profession that cloaks itself in the neutrality of science (Paulraj, 2016), what does that mean for the neglected 'personhood' of clinical psychologists? In a focus group of service user perspectives on personal development of clinical psychologists, it was remarked *"If they don't know themselves, they can't help you find yourself, can they really?"* (Youngson et al., 2009, p.62). Furthermore, when the lived experiences of the 'personal' fall outside of the margins of a profession steeped in normative assumptions in general, and cis-heteronormativity in particular, how are clinical psychologists with minoritised experiences expected to bring our 'selves' to work?

Power, subjectivity and 'reflection'

Influential critical psychologists have argued that PPD is crucial to facilitating ethical clinical practice, via continual commitment to raising internal awareness of the way clinical psychologists address power and its consequences (Davison & Patel, 2009). This process may be experienced differently by those in a dominant group(s), and those in the 'other(s)'. Where models of reflective practice are emphasised in clinical spaces, a negotiation takes place of how much of oneself to bring to the group in a process that can leave clinicians feeling exposed and vulnerable (Woodward, 2014). For clinicians with minoritised experiences and identities, this negotiation can feel especially loaded, and there may be a pressure to minimise our subjugated selves in order to feel part of the homogenous group (Shah et al., 2012). This process positions non-conforming parts of the self in opposition to the 'single-axis group', meaning that they cannot 'mesh' without 'erasure or distortion' (May, 2015).

It has been argued that the lack of self-reflection as a built-in core competency has led to the profession's lack of reflection with itself - the insufficient awareness of clinical psychology's socio-political history and context (Paulraj, 2016). The following section will consider the history and context of queer and trans exclusion in clinical psychology, the construction of normative 'personhoods', and how this has reinforced the subjugation of the lived experiences of queer and/or trans clinicians.

2. Psychology, clinical violence and professional exclusion

This section will outline psychology's history of pathologisation and 'treatment' of sexual and gender minorities, and the move towards professional recognition of queer and trans perspectives.

Professional context – diagnostic pathologisation

In 1952, the American Psychological Association (APA) included 'homosexuality' in the first edition of the Diagnostic Statistic Manual of mental disorders (DSM) as a 'sociopathic personality disturbance' (APA, 1952). In its second edition, 'homosexuality' retained its pathological status, but was reclassified as a 'sexual deviation' (APA, 1967). Not only did the APA's stance both reflect and reinforce larger societal views and treatment of queer people at the time, but also those of the profession. A study by Morin in 1977 showed that 70% of psychological research on 'homosexuality' prior to the study's publication was centred around three key questions: 'Are homosexuals sick?', 'How can homosexuality be diagnosed?' and 'What causes homosexuality?'. It was not until 1973, after queer activists disrupted the annual general meetings of the APA and demanded attention be paid to the psy-professions' contribution to prevailing homophobic stigma, that the APA voted for 'homosexuality' to be removed from its third edition (Drescher, 2015a). Notably, 'homosexuality' remained in the World Health Organisation's (WHO) International Classification of Diseases (ICD), the diagnostic manual used more frequently in the UK and mandated for use across the NHS, until 1993 (Clarke et al., 2010).

Before any diagnostic label related to 'homosexuality' was scrapped altogether, the DSM, under pressure from some of its more conservative psychoanalytic members, as a compromise held onto the new diagnosis of 'sexual orientation disturbance' – later 'ego-dystonic homosexuality' – legitimising the practice of conversion therapies to alleviate the

distress that the client's 'homosexuality' caused them (Moleiro & Pinto, 2015). Against the tide of 42% of its membership voting for 'ego-dystonic homosexuality' to retain its categorisation under 'psychosexual disorders', the remaining 58% of APA membership voted for this revised label to ultimately also be removed from the DSM-III-R in 1987 (Drescher, 2015b).

Those deviating from normative gender expressions have fared a similar pathologising trajectory in the psy-professions. Psychiatric interest in gender variance started in the 19th century, though forms of gender non-conformity were conflated with 'homosexuality' and were not seen as a distinct pathology (Drescher, 2015b). In 1965, 'transvestitism' made its debut in the ICD-8 under the category of 'sexual deviation' (WHO, 1965), which the ICD-9 changed to include 'trans-sexualism' (WHO, 1975). The ICD-10 (WHO, 1990) revised these labels to include 'transsexualism', 'dual-role transvestism', and 'gender identity disorders' under the new category of 'sexual and gender identity disorders'. To date, the final change in the ICD-11 (WHO, 2017) was to recategorise 'gender incongruence' under 'conditions related to sexual health'. The APA largely mirrored the WHO in its positioning of gender identity diagnoses. The diagnosis of 'transvestitism' was added to DSM-II (APA, 1967) as a 'sexual deviation', followed by 'transsexualism' as a 'psychosexual disorder' in DSM-III (APA, 1980), and later 'gender identity disorder' under 'sexual and gender identity disorders' in DSM-IV (APA, 1994). To date, the DSM-5 (APA, 2013) and DSM-5-TR (APA, 2022) codes 'gender dysphoria' in its own section.

Unlike those relating to 'homosexuality', the retention of diagnoses relating to gender dysphoria is still a contested issue. Whilst many advocate for the removal of any inherent association between a trans experience and mental illness, diagnoses such as

gender dysphoria allow for some trans people – primarily in a privatised healthcare context - to access gender-affirming healthcare options under insurance plans that require diagnosis in order to fund treatment. Even in the NHS, services designed to provide support to trans people, such as Gender Dysphoria Clinics or GDCs (previously Gender Identity Clinics or GICs) need to justify their existence to NHS commissioners in their bid for public funding. Whilst the British Association of Gender Identity Specialists acknowledge that gender diversity is simply a part of normal human diversity (BAGIS, 2022), they acknowledge that gender dysphoria, the distress that an individual experiences as a result of dissonance between their assigned sex and their gender identity, is a distress that is rooted in social stigma, which may be addressed through supportive gender-affirming healthcare options. The World Professional Association of Transgender Health, in their 'Standards of Care' note that not all health care systems require a diagnosis of gender dysphoria for treatment, however in many contexts this diagnosis facilitates access to medically necessarily healthcare (WPATH, 2022). At the time of writing, a diagnosis of gender dysphoria is also required for an adult to legally change their gender in the UK (Benson et al., 2022). As diagnosis remains a gateway to accessing equitable legal recognition and healthcare options for trans people in the UK, the dilemmas around its removal from diagnostic manuals and application in clinical context are complex.

From pathologisation to intervention

Researchers have noted the effects of decades of theoretical pathologisation of queer and/or trans lives and discourses that followed by the world's most influential clinical bodies (Anderson & Holland, 2015; Feinstein et al., 2012; Herek, 2010; Meyer, 2003; amongst many others). The effect that this coding had in clinical practice, though, is even

more devastating. The United Nations Office of the High Commissioner for Human Rights (UNOHCHR, 2020), in a statement condemning conversion practices as torture, pointed to a century of peer-reviewed British and North American psychological and psychiatric journals publishing research into 'homosexual aversion therapy' as recently as 2000.

Behavioural conditioning techniques have included electric shock therapy (Freeman & Meyer, 1975); the use of nausea-inducing chemicals (McConaghy, 1975); pairing disturbing imagery, such as that of rotting corpses, with arousing imagery (Freund et al., 1973; Herman, 1974); fading (McGrady, 1973); and controlled hunger paired with painful electric shocks (Fookes, 1960). Cognitive techniques have included hypnosis (James, 1978); eye movement desensitisation and reprocessing (UNOHCHR, 2020); and dream therapy (Gershman, 1971). Psychodynamic approaches have included individual (Nicolosi et al., 2000) and group therapy (Bieber & Bieber, 1979). Other medical interventions used in psychiatric study have included lobotomies (Zlotlow, 1959), surgical removal of sexual organs (Hackfield, 1935), organotherapy (1944), prescribed anti-psychotics (Bartholemew, 1968), and hormone therapy (Dörner, 1988). Whilst most psychology textbooks may at most, if at all, acknowledge this violent history as a 'thing of the past', a study from 2009 showed a significant proportion of psychiatrists and therapists in the UK were still willing to provide conversion therapy to their lesbian and gay clients (Bartlett et al., 2009).

It was not until 2015 that the majority of British psy-professions, co-signed by the NHS, released a Memorandum of Understanding committing to ending the practice of sexual orientation conversion therapy in the UK, later updated in 2017 to include gender identity (BPS, 2017). As of 2023, it is still not illegal to practice conversation therapy in the

UK, and contemporaneous politically charged debates have seen pressure to remove protections against gender identity conversion from the 2017 Memorandum (Dyer, 2022).

There are large bodies of research noting the negative effects of societal stigma and shame on the mental health of queer and/or trans communities, which psychology's pathologising history has no doubt reinforced. This research generally focuses on mental health with a deficit perspective, drawing on the minority stress model (Brooks, 1981; Meyer, 1995). This model points to stigma-related prejudice experienced by minoritised populations that culminate in chronic stress responses, leading to negative psychological and physical health outcomes. As is the case with any intersectional identity, vulnerability increases when one minoritised identity is 'layered' upon another. Studies have found minority stress responses linked to higher rates of psychological distress and higher rates of suicide attempts across the lifetime (Fingerhut, 2010; Lewis et al., 2003; Meyer, 2003; Ross et al., 2018), especially for trans people (Turban et al., 2019), people of colour (Cyrus, 2017; Sutter & Perrin, 2016), those with a lower socioeconomic status (Shangani et al., 2020), those with religious conflict (Gibbs & Goldbach, 2015), those with intellectual disabilities (Bennet & Coyle, 2007), physical disabilities (Eliason et al., 2015); adolescents (Fish, 2020; Kelleher, 2009) and older adults (Fredriksen-Goldsen et al., 2014).

Experiences within the profession

Setting out this relatively recent historical context is pertinent not to make claims that there has been no progression in the profession, or that queer and/or trans people are still overtly viewed as perverts and deviants in mainstream clinical thinking. The BPS' official stance that conversion therapies are unethical, harmful and unsupported by evidence, demonstrated through the 2017 Memorandum of Understanding, should offer some

reassurance to prospective queer users of NHS mental health services, though contemporaneous 'debates' in the UK have signalled to many trans people that mainstream mental health and transition-related provisions are still unsafe to access due to the 'gender critical' views held by the many in the profession (Mollitt, 2022). Psychology's violent history raises questions around the lived experiences of queer and/or trans people within the discipline. What does it mean to belong to a profession that has sought to erase queer and/or trans ways of 'being in the world' through violent and oppressive means? What does it mean to go through psychology training from undergraduate to doctorate level when higher education in general and psychology in particular remains a site of *"thundering heteronormativity"* (Barker, 2007, p.95)? There has been a notable absence of research giving voice to these experiences.

Though American counterparts established an APA division for lesbian and gay psychology in 1984, it took much longer for colleagues in the UK to follow suit. The 'Lesbian and Gay Psychology Section' - now 'Psychology of Sexualities' - was established in the BPS in 1998, but only after its fifth proposal (Clarke et al., 2010). The opposition from other BPS members was predictably hostile - in response to the first application, the BPS even changed its rules to make it more difficult to form a section (Wilkinson, 1999). Before it was finally ratified, the BPS experienced the highest 'anti' member vote in its history, with many members of the section's working group receiving abusive hate mail from other BPS colleagues (Coyle & Kitzinger, 2002; Hodges & McManus, 2006).

The move towards establishing a 'section' of the BPS – and the opposition that was ultimately overcome – was significant to queer clinicians for several reasons. In a profession that is still *"riddled with heterosexist assumptions"* (Clarke et al., 2010, p.21), the formation

of a representative section allowed for its members to promote and publish research and practice guidance that challenged dominant heteronormative assumptions, gave queer clinicians and academics a legitimised 'voice', and put forward a curiosity into the psychological lives of queer people beyond pathology.

However, significant qualitative accounts of the lived experiences of minoritised clinical psychologists give weight to May's (2015) scepticism of *"claims that we have fully disaffiliated from pathologising mindsets or wholly broken from past discriminatory practices"* (p.12). Research demonstrates that aspiring and qualified clinical psychologists from minoritised backgrounds still face additional barriers in the profession (Ahsan, 2020; Hsueh, et al., 2021; Odusanya et al., 2018; Paulraj, 2016; Ragavan, 2018; Shah et al., 2012).

Clinical psychology, with its tendency to privilege 'objective' knowledge over lived experience, consequently *"de-authoris[es] other ways of knowing"* (Beetham & Pope, 2019, p.183), particularly those lesser-heard voices that may be dissonant to the norm (Fricker, 2007). Given what has been outlined in this section about the history of the profession's stance, this is an important omission in the curiosity of the subjectivity of clinical psychologists. The following section will consider the importance of reflecting on the subjectivity of queer and/or trans clinical psychologists in more depth.

3. Queer and/or trans subjectivities in clinical psychology

Prominent research psychologists Clarke & Peel (2007) comment on the resistance they faced from their colleagues when embedding queer and/or trans perspectives in their teaching curricula, facing frequent feedback that *"sexuality is not a workplace issue"* (p.2). They note that mainstream psychology as a profession is at best ambivalent, and at worst

ignoring, excluding and marginalising of queer and/or trans experiences (Peel, 2001). This paper has already made the case for increasing the depth and practice of personal reflexivity within clinical psychology. Hodges & McManus (2006) make the direct assertion that reflexivity is fundamental in allowing the discipline to move beyond its ambivalent stance towards queer and/or trans experiences and subjectivities. They challenge their colleagues to candidly explore their own values and biases towards sexual and gender diversity, and contend that it is no longer acceptable for clinicians and academics in the field to engage with queer and/or trans experiences without first conducting thorough investigations into their own role in the processes that subjugate them.

Challenging normative 'personhood'

Neutrality as being 'free' from a sexual orientation or gender identity is a deeply entrenched and socialised privilege only afforded to cis-heterosexual individuals (Thomas, 2002). This makes it difficult for psychologists without minoritised experiences to appreciate the relevance of their own sexual orientation and/or gender identity to the therapeutic process (Richards, 2003). Rather than the queer and/or trans selves of psychologists being something to 'other', they may be seen as something to 'add'. This is supported by Burnham's (2017) concept that each of our social 'GGRRAAACCEEESSS', the aspects of personal identities that relate variably to power and privilege, can be both potential resources and restraints. By valuing and developing reflexivity around these societally subjugated parts of our 'selves', it is argued, queer and/or trans clinical psychologists can come to be *"more aware, reflective/reflexive and skilled"* in our work (Burnham and Nolte, 2019, p.135). Furthermore, by embracing what can be learnt from those of us who have had to negotiate our subjugated selves at the margins, it brings into focus how queer and/or

trans subjectivities challenge psychology's fundamental theories, and the transcendental gaze of middle-class, ableist, cis-heteronormative Whiteness that they conceal (Evzonas, 2021).

Whilst the profession is becoming more aware of the importance of diversity and representation, research suggests that trainee psychologists experience cultural competency teaching on human sexuality in general and sexual and gender minorities in particular to be uncomprehensive and inadequate (Abbot et al., 2023; Mollen and Abbott, 2022), and studies on the experiences of clinical psychologists with minoritised identities are sparse. Paulraj (2016) explored how black trainee clinical psychologists negotiated their identities whilst on training. Three themes were identified: (1) that power relations within clinical psychology and wider society influenced participants' construction of their own Blackness, (2) that participants felt simultaneously hyper-visible and invisible within the profession, and (3) that the journey of being a black trainee was cyclical and lonely, and without support from training programmes.

Similar research looking at the experiences of queer and/or trans clinical psychologists is strikingly absent (Hsueh et al., 2021). Considering the profession's violent treatment of queer and/or trans people, including its clinicians, this seems glaringly neglectful. Given this lack of research, it is no surprise that cis-heteronormativity in teaching and practice prevail (Barker, 2007), but raises questions about how we as queer and/or trans clinicians manage our identities in our work, process our experiences in supervision, and feel supported by active cultural responsiveness in teams and wider Trusts (Autret & van Eeden-Moorefield, 2022). Some research exists on queer therapists' experiences of sexual orientation disclosure in therapeutic practice, and the variety of factors that

influences this decision (Danzer, 2018; Evans & Barker, 2010; Porter et al., 2015). This research will be engaged with in the next section. However, no research has explored how the profession itself impacts the 'sense of self' of queer and/or trans clinicians, or how this particular subjectivity is used in practice.

It is no surprise that clinical psychology's historical context of pathologising queer and/or trans lives has led to many with minoritised sexual orientations and gender identities to feel excluded or unwelcome in professional spaces because they are not regarded as 'neutral'. In these situations, queer and/or trans clinicians may feel conflict about how much to share of the parts of themselves that make them 'different' (Twist, 2017). This may lead us to having to choose between foregrounding our queer and/or transness and remaining outsiders, or 'covering' (Goffman, 1963, Yoshino, 2007), adapting and leaving the 'self' at the door of respectability (Higginbotham, 1994; Joshi, 2011; Odusanya et al., 2018; Ragaven, 2018; Shah et al., 2012). As Toki and Byrne (2002) contend, *"everyone reflects, but some reflections are more risky than others"* (p.61).

Lizette Nolte uses the concept of 'uninvited selves' to consider the idea that not all parts of the self are welcome or seen as useful in clinical psychology. She links the competitive entry into the profession with a prevailing culture of perfectionism, imposter syndrome and preoccupation with desirability – leading clinical psychologists to conclude that they need to leave their personal selves at the professional door (Burnham & Nolte, 2019). This mechanising pressure has been described as a loss of one's own narrative (Dera, 2019), viewing parts of the personal self as potential obstacles to be observed and assessed in the process of deciding what is included in the attainment of a professional identity (Burnham & Nolte, 2019).

Attending to our queer and/or trans selves

Burnham and Nolte (2019) ponder the question of what might happen if clinicians *"took the plunge"* (p.133) to resist breaking up our personhoods to present a professional self, and rather considered all 'parts' as welcome and appropriate in our professional identities? What would it mean for queer and/or trans clinical psychologists to not have to choose between "*public justice and private happiness?"* (Faludi, 1991, p.xxiii). It has been argued that in order to sustain the self, the multiple parts of our subjectivities must be wholeheartedly embraced (Beetham & Pope, 2019). The act of attending to and sustaining the self, whilst risky, can also lead to potential experiences of connection and meaning-making.

Whilst the positive contribution of research around minority stress has been enormous in its efforts to highlight the psychological and physiological consequences of discrimination towards minoritised communities, the framework within which this research is located has been criticised for its reliance on a biomedical model, and calls have been made to study the wellbeing and resilience of these communities with a positive psychology lens (Meyer, 2014). Riggle and Rotosky (2011) put forward 'A Positive View of LGBTQ' – a large scope thematic analysis which set out eight positive themes common to queer and/or trans lived experiences: (1) living an authentic life; (2) increased self-awareness and insight; (3) feeling free to create flexible rules around gender and its expression; (4) strong emotional connections and the creation of 'families of choice'; (5) exploring sexuality and intimacy with 'new rules'; (6) unique life perspectives with empathy and compassion for others; (7) being positive role models for social justice; and (8) belonging to a community.

Riggle and Rotosky's findings offer a refreshingly celebratory view of what it means to be queer and/or trans. They also raise questions about the meaning that queer and/or trans clinical psychologists make about their specific experiences in the profession – both those stemming from potential marginalisation and cis-heteronormativity, but also those arising out of potential connection, intimacy, resilience, and joy. The next section will consider ways in which queer and/or trans clinicians might go beyond considering whether we should disclose our identities in our work, to consider how reflecting on our lived experiences might open up possibilities for relational depth and human connection, and fundamental shifts in psychology's deeply held assumptions.

4. Moving beyond self-disclosure – the self as resource

This section will first outline debates in the literature around therapist disclosure of sexual orientation and gender identity, before considering what might be gained by abandoning this debate entirely to look for new possibilities in the therapist use of self.

Disclosure debates: safeguarding cis-heteronormative 'neutrality'

Where attention has been paid towards queer and/or trans experiences in the psy-professions is in academic debates about disclosure of sexual orientation by sexual minority clinicians. A study by Henretty and Levitt (2010) reported that 90% of therapists use some form of self-disclosure in general in their practice, however, the topic of sexual orientation disclosure remains controversial (Harris, 2015). It is notable that the debate around therapist disclosure of sexual orientation has not had the same attention in research for heterosexual clinicians. This disparity reinforces the idea that it is only the queer sexual orientation of therapists that is considered a sensitive topic of debate, safeguarding

heterosexuality as the normative 'neutral' assumption that does not need disclosing. Similarly, gender organises the process of all interpersonal interactions (Shipman & Martin, 2017), including therapeutic ones, however the question as to whether or not a clinician ought to disclose their gender identity is not a question posed to cisgender psychologists.

The disclosure of (non-normative) sexual orientations and gender identities is a particularly controversial issue, precisely because, for queer and/or trans clinicians, disclosing ruptures the cis-heteronormative assumptions laden within the profession and the therapy room. Harris (2015) brought together research on therapist-disclosure of sexual orientation in a systematic review. Several themes emerged as facilitative or preventative to the use of disclosure: (1) therapists' work culture, (2) client sexual orientation, (3) the therapists' own internalised homophobia, (4) the perception of their client's reaction, and (5) therapists' own experiences of being queer community members. Harris (2015) highlights that an absence of queer perspectives within therapists' training added a further barrier, as minoritised therapists were left unsure of how and what to disclose of themselves, feeling unsupported by dominant heteronormative discourses in teaching and supervision. Whilst recognising the potential benefits of thoughtful and nuanced disclosure of sexual orientation in clinical practice, Johnsen and Ding (2023) add that a lack of recognition and adequate training and supervision on this issue leaves queer therapists with only their intuition to guide them.

Research on the disclosure of trans identities in clinical practice is strikingly sparse. At the time of writing, only two articles were found on this topic, both in the field of social work in an American context. Kahn (2021), in a personal reflection on the use of disclosure as a trans social worker, notes the positive and negative ways that the therapeutic alliance

may be influenced by the clinician's gender identity, and that this may at times be due to 'visible disclosures' that the therapist has no control over. Shipman and Martin (2017) call for the trans therapist to develop rigorous reflexivity around their own social location before using self-disclosure, and emphasise the need for supportive, informed supervision of trans therapists when navigating these decisions.

The concept of 'disclosure' of sexual orientation or gender identity is in itself problematic. These debates are at best cis-heteronormative and at worst queer- and transphobic, continuing to centre discussion on the appropriateness of queer and/or trans subjectivity in the therapeutic space. To disclose – the act of making secret information known – carries the weight of a confession, perpetuating the notion that those who disclose require explanation (Barker, 2006). The prevailing discourse that encourages the view that therapists ought to convey 'neutral' personhoods carries with it assumptions about the 'neutral' – that is – compulsory cis-het subjectivity and expression of the therapist. When cis-heteronormativity constructs ideas of 'normal' and 'professional', to express oneself as queer and/or trans at work is to be perceived as 'abnormal' and 'unprofessional' (Beagan et al., 2022; Kelly et al., 2021).

The queer and/or trans 'self' as resource

As has been argued, continuing to debate whether or not queer and/or trans people should self-disclose as clinical psychologists perpetuates the narratives that uphold cis/heteronormative assumptions. Instead, it is important that the profession 'moves on' to develop curiosity about queer and/or trans perspectives as clinical psychologists beyond disclosure. To ask how queer and/or trans people might reflect on what our identities might 'open up' as well as 'close down' for us in our professional roles, and how meaning is made

from experiences of marginalisation within the profession – as well as potential experiences of connection, joy and solidarity. Starting to 'thicken' these narratives (White, 1995) may also help queer and/or trans clinicians develop our personal and professional subjectivities in our work, create more robust cultural responsiveness for supervising queer and/or trans clinicians through these challenges (Autret & van Eeden-Moorefield, 2022), and may support aspiring psychologists from minoritised backgrounds to enter the profession without feeling the need to 'cover' (Goffman, 1963; Yoshino, 2007). Centring curiosity around these questions may 'open up' wider possibilities for psychology as a whole. By troubling the *a priori* knowledge that the profession holds in relation to what is 'healthy' and 'normal', fundamental understandings around family, intimacy, creativity and expression are expanded.

Psychologists with minoritised identities are able to offer their unique vantage points to the profession, as well as lived experiences of marginalisation and 'otherness', potentially bridging the 'us and them' gap that can reinforced between the therapist/service user dyad (Thomas, 2002). Furthermore, Thomas argues that clients from minoritised backgrounds benefit from a therapeutic relationship with someone who is open with them about their similarities on key characteristics, as the therapist is more likely to formulate in a way that is meaningful for both them and their client, drawing on a similar cultural worldview.

In the 'Person of the Therapist Training Model', Aponte and Kissil (2016) propose that therapists' connection with their own 'woundedness' allows empathy and resonance with the 'woundedness' of our clients. They argue that by connecting to the heart of our woundedness, we are able to selectively and judiciously use our vulnerabilities to connect with our clients' difficulties. By accepting our own vulnerabilities, we are able to empathise

with our own selves. This facilitates reaching from our personal 'wounds' to those of our clients, allowing for the cognitive and emotional identification that enables us to better understand *"the hurt from within"* (p.3). This argument echoes those in this paper's second section around the importance for therapists to deepen their self-awareness in order to facilitate their clients in doing the same. Baldwin (1952) wrote that considering the subjectivity of his own blackness was paramount as the *"gate* [he] *had to unlock"* before he could examine the subjectivity of the other (p.5).

Burnham's (2017) Problems-Possibilities and Resource-Restraints (PPRR) model allows clinicians to develop reflexivity around what is 'opened up', as well as what is 'closed down' when navigating complex situations, such as the implicit or explicit use of self in therapy. Whilst the historical context of the profession outlined in this paper gives weight to how queer and/or trans subjectivities in the profession could be 'closed down' and 'restrained', Riggle and Rostosky's (2012) eight positive themes raise questions about what might be 'opened up' as possibilities and resources. Ahmed (2017) posits that the vulnerable parts of our selves can be sites of relational depth. In a fundamentally relational profession, this may encourage marginalised clinicians to draw on the *"history that stands behind"* the ways we wish to live our lives as therapists and as people (White, 1997, p.81).

Integrating a queer and/or trans personhood into professional life as a clinical psychologist can therefore be a profound act of resistance. Our lived experiences are given meaning by the social, institutional and cultural contexts that we live in (Andrews, 2006). Given what has been highlighted about the profession's reciprocal role of constructing and mirroring societal queer- and transphobia, to embrace the subjugated self as a queer and/or

trans clinician is to make visible that the personal, the professional and the political are inseparable (Beetham & Pope, 2019).

How we, as queer and/or trans clinical psychologists, make use of our identities in our work remains an unexplored area. The relevance of this topic is far-reaching and goes beyond a discussion around the appropriateness and limits of disclosure. It focuses on the queer politics of recognition (Joshi, 2012), and does not debate whether or not queer and/or trans clinical psychologists 'should' come out in academia or the therapy room. It does not address whether there is enough diversity and representation woven into the DClinPsy curriculum, and it does not seek to weigh in on current divisive controversies around best practice in working therapeutically with gender non-confirming young people. Instead, it concerns itself with the nuances in between all of these conversations – how these debates around the appropriateness of our existence affects the lived experiences of queer and/or trans clinical psychologists, the ways in which we feel we *can* bring our whole selves to our profession, and furthermore, the extent to which we *do.*

5. Why Interpretative Phenomenological Analysis?

Interpretative Phenomenological Analysis (IPA) is an approach developed from Husserl's early philosophical phenomenology, and is informed by three key theoretical underpinnings: phenomenology, hermeneutics and idiography (Smith et al., 2022). Phenomenology can be characterised as the study of experience, and how humans experience the 'essence' of given phenomena. Hermeneutics is concerned with how humans interpret the world around them, and how meaning is made. Idiography attends to the individual and the particular, emphasising the unique and subjective nature of the human meaning making experience. Taken together, IPA becomes an approach that focuses

on an individual's meaning making of their lived experiences. As such, IPA does not seek to generalise findings to a general population, and but instead is suitable to amplify lesser-heard narratives, complex topics and under-researched areas (Smith & Osborn, 2008). Using purposive sampling and small, appropriately homogenous sample sizes, IPA emphasises the depth rather than breadth of analysis, allowing researchers to both 'give voice' and 'make sense' of their participants' personal experiences in detail (Noon, 2018).

IPA's epistemological stance assumes that researchers can access the 'essence' of the internal worlds of their participants through careful, thorough analysis of their narratives, and makes no claim that this is an objective process (Smith et al., 2022). Instead, the intersubjective – the fundamental layering and overlapping nature of our shared experiences – is rendered a visible and contributing factor in the analytic process (Laverty, 2003). Furthermore, IPA aims not only to gain understanding of the meaning-making processes of participants, but also that of the researcher. The 'interpretative' part of IPA refers to the way in which the researcher interprets the internal worlds of their participants (Smith & Osborn, 2008).

This project aims to explore the many possible ways in which queer and/or trans clinical psychologists in the UK make sense of, use, and bring lived experiences into our work. As has already been discussed in this conceptual introduction, the profession's history of privileging the 'neutrality' of science over reflection, its legacy of queer- and transphobia, and its normative understandings of 'neutral' personhood, can amalgamate to create environments where minoritised clinicians can feel conflicted about how much of our 'selves' we are able to bring to work. Simultaneously, engaging with the sites of our

woundedness as people with minoritised experiences might allow us to connect more deeply with the woundedness of others in therapeutic relationships.

Using semi-structured interviews and a qualitative methodology allows participants to give voice to their own experiential worlds, rather than trying to locate the 'objective' reason behind their experiences (Willig, 2013). This is particularly important when conducting psychological research with marginalised groups, whose voices are normally reduced to subaltern and excluded on the premise of 'outlying' cis-heteronormative, Eurocentric and patriarchal experience (Mattos, 2015). The topic under investigation concerns itself with how legacies of institutional oppression can exclude non-normative narratives from being voiced and celebrated. As such, choosing IPA as a methodology that assumes innate truth in each individual's account of their own experience is vital in approaching psychological research with a focus on social justice. Attending in detail to the texture and meaning making of each participant's narrative is in itself an act of resistance and solidarity.

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Part 2: Empirical Paper

‘This dance between hope and hopelessness’: Queer and/or trans clinical psychologists’ experiences of bringing their lived identities into their practice

Abstract

Aims: Clinical psychology has a history of constructing and reinforcing queer- and transphobic social stigma through diagnostic pathologisation and aversive treatments. Though these practices are now widely condemned in the United Kingdom (UK), their legacies remain through cis-heteronormative teaching and practice. However, there is a lack of research on how these legacies affect queer and/or trans people within the profession. This study explored how queer and/or clinical psychologists in the UK bring their lived experiences into their practice.

Method: Semi-structured interviews were conducted with eight clinical psychologists who self-identified as queer and/or trans. Transcripts were analysed using Interpretative Phenomenological Analysis (IPA).

Results: Five superordinate themes were identified: (1) Queering practice; (2) Queer euphoria; (3) Living in threat mode; (4) 'A punch in the guts': profession as hostile; and (5) Living and working in community.

Conclusions: Participants' queer and/or trans lived identities 'opened up' and 'closed down' experiences as clinical psychologists. Drawing on their own marginalisation, participants incorporated liberatory frameworks into their practice, and experienced greater empathic connection with clients. The euphoria of belonging to queer and trans communities was simultaneously met with vigilance, exhaustion and burden from challenging queer- and transphobia within clinical psychology. The profession was perceived as concurrently resourcing and wounding, and was overwhelmingly identified as transphobic. Participants perceived a lack of role models and spoke to the complexities of working therapeutically with members of their own queer and trans communities.

Introduction

Clinical psychology as a profession has made recent commitments towards acknowledging the importance of diversity and inclusion of trainees, clinicians and supervisors (British Psychological Society [BPS], 2015). However, whilst efforts towards 'cultural competence' mark a positive shift in professional teaching and practice, the profession continues to construct a particular type of 'personhood' as normative (cisgender, heterosexual, middle-class, neurotypical, non-disabled and white), thereby othering 'difference and diversity' as existing outside of this construction (Adetimole et al., 2005; Ahmed, 2006; Ahsan, 2020; Clarke et al., 2010; Davidson & Patel, 2008; Goodbody & Burns, 2011; Haritaworn, 2008; Riggs, 2004; Turpin & Coleman, 2010).

Furthermore, whilst movement towards diversifying clinical psychology are welcome, there is perhaps insufficient acknowledgement and accountability of the profession's problematic legacies in its treatment of minoritised groups (Paulraj, 2016). In particular, psychology has not reckoned with its history of classifying non-normative gender and sexual identities as deviant and pathological (Anderson & Holland, 2015; Feinstein et al., 2012; Herek, 2010; Meyer, 2003), and 'treating' these identities through peer-reviewed violent interventions as recently as 2000 (United Nations Office of the High Commissioner for Human Rights [UNOHCR], 2020). It was not until 2015 that the NHS co-signed a Memorandum of Understanding committing to ending the practice of sexual orientation conversion therapy in the UK, later updated in 2017 to include gender identity (BPS, 2017). As of 2023, it is still not illegal to practise conversation therapy in the UK, and contemporaneous politically charged debates have seen pressure to remove protections against gender identity conversion from the 2017 Memorandum (Dyer, 2022).

Psychological research has noted the negative effects of societal stigma and shame on the mental health of queer and/or trans communities, which the profession's pathologising history has played a large part in constructing (Drescher, 2015). The minority stress model (Brooks, 1981; Meyer, 1995) points to stigma-related prejudice experienced by minoritised populations, culminating in chronic stress responses that lead to negative psychological and physical health outcomes. Queer and/or trans people are generally over-represented in mental health services (Fish, 2020), and report poor experiences within them due to cis-heteronormativity and culturally incompetent practice (Bettergarcia et al., 2021; Bishop et al., 2022). Ultimately, this results in higher treatment attrition rates (Pereira et al., 2019; Utamsingh et al., 2016), leaving the mental health disparities of these communities unmet or reinforced.

To a lesser extent, the positive aspects of a queer and/or trans lived experience have been noted (Meyer, 2014; Riggle et al., 2008; Riggle et al., 2011; Robinson & Schmitz, 2021; Rosenkrantz et al., 2016). In a large-scale thematic analysis, Riggle & Rotosky (2011) put forward 'A Positive View of LGBTQ', which set out eight positive themes common to being queer and/or trans: (1) living an authentic life; (2) increased self-awareness and insight; (3) feeling free to create flexible rules around gender and its expression; (4) strong emotional connections and the creation of 'families of choice'; (5) exploring sexuality and intimacy with 'new rules'; (6) unique life perspectives with empathy and compassion for others; (7) being positive role models for social justice; and (8) belonging to a community.

Psychology's problematic history raises questions around the lived experiences of queer and/or trans people within the discipline. Whilst there is a considerable body of work on how to therapeutically navigate a client's minoritised sexual or gender identity as a

psychologist (Kort, 2018; Moon, 2014; Neves & Davies, 2023; Nichols, 2014; Tilsen, 2021), there is a gap in research on how minoritised clinical psychologists themselves navigate their own identities in their work.

Research demonstrates that aspiring and qualified clinical psychologists from minoritised backgrounds still face additional barriers in the profession (Ahsan, 2020; Hsueh, et al., 2021; Odusanya et al., 2018; Paulraj, 2016; Ragavan, 2018; Shah et al., 2012), though there is a notable lack of data on the experiences of queer and/or trans clinicians specifically. This lack of attention allows for cis-heteronormativity to prevail in teaching and practice (Barker, 2007), and raises questions as to the meaning that queer and/or trans clinicians make of their experiences in the profession. Considering the contributions of minority stress as well as positive psychology research, the complex 'being in the world' for queer and/or trans psychologists may include experiences of marginalisation as well as those of potential connection, intimacy, resilience, and joy.

This given, I am curious to explore how clinical psychologists with non-normative sexual/gender identities make sense of their subjectivities within the context of their work. Using qualitative semi-structured interviews with self-identified queer and/or trans clinical psychologists, this study will use Interpretative Phenomenological Analysis (IPA) in its aim to understand how this minoritised group of clinicians navigate their particular subjectivities in their clinical practice.

Rationale

Research aims:

1. To understand queer and/or trans people's experiences of their roles as clinical psychologists
2. To understand how they bring their lived experiences of being queer and/or trans to their practice

Situating the research

Owning one's own perspective is a primary marker of the quality of qualitative research (Elliot et al., 1999). My interest in how the lived experiences of queer and/or trans people dance with their experiences as psychologists is a direct result of my personal and professional experiences as a queer woman. These contexts cannot be separated from the research, nor should they have to be for the research to be of value (Sharville, 2019). I acknowledge my role in co-producing, not simply reflecting, a reality with my research participants (Stanley & Wise, 2002). In line with this, I have chosen to write in the first person throughout this study. A full reflexivity is included in the methodology.

Method

This section will explain why Interpretative Phenomenological Analysis (IPA) was chosen for this study, and will outline the process for recruitment, ethical considerations, data collection and the process of analysis. Finally, some thoughts will be offered on the validity and quality of the research before the discussion.

Interpretative Phenomenological Analysis

Qualitative methodologies allow psychology researchers the opportunity to develop idiographic understandings of their participants: that is – what it means to be them, with their positionality, to 'be in the world' (Willig, 2013). IPA, one such qualitative method, was

developed by Jonathan A. Smith to allow the rigorous exploration of subjective lived experiences (Biggerstaff & Thompson, 2008; Smith et al., 2022). It is characterised by three main tenets: phenomenology, hermeneutics and idiography (Smith et al., 2022). Phenomenology involves the study of experience, hermeneutics concerns itself with meaning-making and interpretation, and idiography with the specific and personal (Ahmed, 2006; Smith et al., 2022). Taken together, IPA's primary focus is the lived experience of the participant, and the meaning they make of their own experiences (Smith & Shinbourne, 2010). The 'interpretative' aspect of IPA involves what Smith et al. (2022) term the 'double hermeneutic', whereby the researcher attempts to make sense of the participant's own sense-making process. Rather than attempting to exclusively reduce researcher subjectivity in the analytic process, IPA seeks to capture the unique and valuable insights that can be offered in the inter-subjective double hermeneutic process (Chan & Farmer, 2017). In order to aid transparency and accountability in the research, researchers can render visible their predispositions through reflexivity (Finlay & Gough, 2008). This is included as its own section later in the methodology.

The epistemological underpinnings of IPA are particularly appropriate for this study which seeks to explore how queer and/or trans clinical psychologists bring their lived experiences into their practice. IPA is most suitable for research questions that centre a curiosity around personal meaning-making experiences of specific groups experiencing a particular phenomenon (Smith et al., 2022). It allows psychology researchers to make implicit 'taken-for-granted' elements of the human experience explicit (Biggerstaff & Thompson, 2008). Queer and trans communities have a steeped history of being categorised through assumptions laden in the cis-heteronormative gaze. It has therefore been argued that IPA is useful when conducting research with minoritised groups, and sexual and gender

minorities in particular, due to IPA's intention to counter assumptions about the lived experiences of communities of interest, and the shifting nature of queer and trans lives as objects within social, temporal and political contexts (Ahmed, 2006; Chan & Farmer, 2017; Griffith et al., 2015). IPA's idiographic approach gives voice and value to the unique diversity and nuances inherent within and between minoritised identities, in order to create a more holistic understanding of the phenomenon under investigation (Callary et al., 2015; Griffith et al., 2017).

Undertaking ethical research with queer and trans communities requires an understanding of queer theoretical approaches (Chan & Farmer, 2017; Griffith et al., 2015; Lugg & Murphy, 2014). Queer theory lends us the flexibility to trouble normative categorisation along the lines of sexual orientation, gender expression, and layers of multiple identities (Ahmed, 2006). Similarly, IPA has the power to challenge hegemonic systems of power by foregrounding the voice and experience of the individual participant, without seeking to mute idiosyncrasies in order to generalise findings (Larkin et al., 2006). This given, choosing IPA as a methodology that attends to the innate truth in the texture of each individual's experience is vital in approaching psychological research with a liberatory lens.

Participants and Recruitment

IPA requires a 'homogenous' sample in order to examine the convergence and divergence of how given phenomena are made sense of (Smith et al., 2022). For the purpose of this study, this was defined as being a queer and/or trans clinical psychologist in the UK. Participants were recruited through a research advert (Appendix 1), posted on three private Facebook groups for clinical psychologists in the UK.

Purposive sampling was used to ensure a fairly homogeneous sample of respondents that could speak to the phenomena under investigation with personal relevance and significance. Participants could be included in the study if they were qualified clinical psychologists in the UK that self-identified as queer and/or trans. The rationale for only including qualified, rather than trainee clinicians, was to guarantee that participants had at least three years of working as clinical psychologists in the NHS in a variety of settings, with substantial experience of navigating the interplay of their subjectivities as queer and/or trans people and professions as clinical psychologists.

The research advert invited interested participants to follow a link to a short screening questionnaire, which collected their contact details, chosen pseudonym, and asked participants to self-certify that they met the inclusion criteria. The intended sample size was eight participants. Due to the detail and depth of IPA analysis, a sample size of between four and ten participants is recommended for professional doctorate research (Smith et al., 2022). Eighteen people expressed an interest, and the first eight to respond were contacted with information sheets (Appendix 3), consent forms (Appendix 4), and a suggested interview time. Six of those who were initially contacted did not respond, and so subsequent interviews were offered to participants in chronological order of expressed interest until eight interviews had been completed. This recruitment method was chosen due to pragmatism, and what seemed to be the fairest and most unbiased way of selecting participants for interview.

Participants were asked to choose a pseudonym and state how they self-defined their sexual orientation, gender identity and pronouns. The participants' details are presented in Table 1.

Table 1

Overview of participant information

Pseudonym	Sexual orientation and gender identity	Pronouns
Steve	Gay cisgender man	He/him/his
Cleo	Queer agender femme	They/them/theirs
H	Pansexual cisgender woman	She/her/hers
Dominic	Gay cisgender man	He/him/his
Kate	Homoromantic pansexual neuroqueer	She/her/hers
Sage	Queer, non-binary	They/them/theirs
Elle	Late-blooming lesbian, cisgender woman	She/her/hers
Jay	Gay cisgender man	He/him/his

Ethical Considerations

The study received ethical approval from the UCL Research Ethics Committee (Appendix 2). Guidance by Griffith et al. (2017) on conducting research with sexual and gender minorities was closely consulted throughout the research process. It was made explicit in the information sheet and consent forms that data would be pseudo-anonymised in publication but that participants were being sought from a specific minoritised demographic, which included a small risk of becoming identifiable. In order to offer participants a greater sense of control of their voice in the research process, participants were asked to choose their own personal pseudonym.

A complex issue in research with gender and sexually diverse communities is that of which language to use to appropriately capture the identities of those it concerns itself with. Identity descriptors are extremely personal, and language has been instrumental in the historical oppression, discrimination and pathologisation within the field of psychology (Griffith et al., 2017). Whilst acknowledging that there is no perfect solution to the problems posed by using 'catch-all' terminology to describe diverse communities, the umbrella terms 'queer and/or trans' was used in this research to as broadly as possible speak to people of minoritised sexual orientations and gender identities. This was decided in consultation with my supervisor and the two community stakeholders named in the ethics application, Dr Lorna Hobbs and Dr Siri Harrison, both clinical psychologists that self-identify as queer and/or trans. Importantly, the first question in the interview schedule (Appendix 5) was *"Can you tell me in your own words how you identify in terms of your sexual orientation and gender identity?"*, allowing participants to self-define from the outset. From that point in the interview and write up, and in line with Griffith et al.'s (2017) guidance, only the participants' own language was used in reference to themselves.

Another difficulty with access and representation when working with sexual and gender minorities is that many people who have the lived experience of being queer and/or trans are not 'out', making it difficult to represent those who may not feel comfortable speaking about their experiences for a variety of social or cultural reasons. Whilst this is unavoidable due to the self-selecting nature of the sample, the pseudo-anonymising process was guaranteed to participants at every stage of recruitment and participation. It was hoped that this would encourage participants with a variety of experiences to participate.

Furthermore, Griffith et al. (2027) encourage researchers working with queer and/or trans populations to use sampling strategies that enable them to reach as diverse a sample as possible. As such, three Facebook groups representing diverse but overlapping groups were used to advertise the study: 'LGBTQ+ Psychologists UK', 'Minorities in Clinical Psychology Group' and 'UK based Clinical Psychology Group'. By posting in the latter two groups, rather than just relying on the LGBTQ+ group, it was hoped that a sample more diverse in multiple intersecting identities could be reached, as well as those with varying degrees of 'outness', who may not have been members of the LGBTQ+ group (Meyer & Wilson, 2009).

It was possible that asking participants to reflect on their minoritised identity could cause distress, especially when recounting difficult experiences of marginalisation or discrimination. The aims of the study were clear in the information sheets provided; therefore, potential participants were forewarned of the content. Participants were reminded that they had total control over what and how much they share and could decline to answer questions and withdraw at any time. Participants were also signposted to additional sources of support in the debrief. As will be expanded upon in the Discussion, the majority of the participants made explicit and unprompted reference to how relieving it felt to talk about their experiences. It is hoped that receiving a copy of this thesis upon completion will go further to distil their experiences of validation.

Data Collection

Data was collected through the use of semi-structured interviews, conducted online to promote equitable access for participants, irrespective of their geographical location. An interview schedule comprised of ten open-ended and non-directive questions was used to

structure the interview (Appendix 5). The interview schedule was generated in consultation with my supervisor and the two community stakeholders, Dr Lorna Hobbs and Dr Siri Harrison. Occasionally, focused questions were used in follow-up in order to prompt further detail or query the participants' use of language. After the final question, participants were asked if they had anything else they wanted to add or if they felt there was anything else significant to their experience that had not yet been captured.

Analysis

The process of analysis closely followed recently developed guidance from Smith et al. (2022) on using IPA, including: (1) reading and re-reading, (2) exploratory noting, (3), constructing experiential statements, (4) searching for connections across experiential statements, (5) naming personal experiential themes (PETs), (6) continuing the analysis of cases, and (7) developing group experiential themes (GETs).

Reading and re-reading

Interviews were transcribed verbatim, with all identifiable information obscured or redacted by the researcher. Rigorous attention was paid to verbal and non-verbal utterances, so as to preserve the participants' voice as much as possible. Transcripts were then read and re-read whilst listening to the accompanying original interview audio, enabling a 'slowing down' of the analysis and preventing a 'quick and dirty' reduction and synopsis (Smith et al., 2022). Listening to the audio at the same time as reading the transcribed interview allowed for a more active engagement with the participants' voices before exploratory noting began. Given IPA's idiographic commitment, each transcript was analysed in full before moving on to the next.

Exploratory noting

Exploratory notes were written in the right-hand margin of each page for the first stage of analysis, using italic, underlined or plain text to distinguish between linguistic, descriptive or conceptual comments. Any words or phrases in the transcript that stood out as particularly meaningful were underlined.

Constructing experiential statements

The second stage of analysis involved noting experiential statements, in the left-hand margin of the transcript, labelling them according to the experiential quality of what was being described (Willig, 2013).

Searching for connections, naming personal experiential themes

Once experiential statements had been noted, the next step involved drawing together these statements to produce a mapping structure of how they fit together. This was done following Smith et al.'s (2022) guidance on abstraction, subsumption, polarization, contextualisation, numeration and function. For example, Jay's transcript initially had 48 experiential statements, which were then clustered into a table to create nine personal experiential themes (Appendix 6). Using *in vivo* keywords to return to the voice of the participant, each PET was labelled to describe its characteristics. Bold upper case was used to reflect the superordinate themes, and lower-case bold writing was used to label sub-themes within each PET. Each experiential statement was identified with the transcript's page number and accompanying quote which prompted it.

Repeating the process and developing group experiential themes

Each transcript was analysed at individual depth, allowing for new experiential statements to emerge with each case before moving on and repeating with the next

transcript, therefore maintaining the idiographic commitment of IPA. Finally, each participant's table of PETs was compared on a macro-level to showcase both idiosyncrasies between participants and connections for the group. These were captured in a table of GETs which represented the PETs that were the most potent across the whole data set and showed convergence in the participants' experiences, without losing the variety of experiences contained in the individual cases (Smith et al., 2022). Each GET was then labelled according to the themes it represented. A full table of group emergent themes can be found in Appendix 7.

Validity and Quality

Yardley (2007) proposes four criteria with which to assess the validity and quality of qualitative methodologies: (1) Sensitivity to context, (2) commitment and rigour, (3) transparency and coherence, and (4) impact and importance.

Sensitivity to context

Qualitative researchers can demonstrate sensitivity to context through awareness of previously published theory and literature that is relevant to the research topic, through conducting rigorous analysis that is sensitive to the data, and through the awareness of the sociocultural locus and power dynamics in which the research is played out (Yardley, 2007). These aspects are attended to through the summary of the relevant existing and gaps in research in the introduction to this paper, and the detailed steps of analysis outlined in the methods. The sociocultural setting of this research is uniquely familiar to me, as I as researcher am also a queer (trainee) clinical psychologist, and therefore have a lived experience of the normative, ideological, historical, linguistic and socioeconomic factors influencing many of the participants' narratives. These experiences, and the resulting

interplay with power dynamics in the research context will be expanded upon in the critical appraisal.

Commitment and rigour

In-depth engagement with the topic and methodological competence was demonstrated through regular meetings with my supervisor, with whom I cross-referenced every stage of the research process, from developing an interview schedule to the final group experiential themes and how these linked back to the data. Though I had previously completed academic work using IPA, I sought further training through workshops, videos and extensive reading on how to utilise the 2022 iteration of Smith et al.'s guidance. I was careful to demonstrate the commitment to thorough data collection by creating as exhaustive an interview schedule as possible, attending to unexpected divergences in the experiential data as well as convergent themes, and allowing myself plenty of time for analysis to enable the depth of reflection required for an IPA study (Yardley, 2007).

Transparency and coherence

A commitment to transparency is demonstrated by the clear detailing of the study's methodology, from participant recruitment to final stages of analysis, and the inclusion of examples of each stage of the analysis in the appendices. The regular consultation with my supervisor at each stage of analysis also ensured that I was not the only 'set of eyes' on the data or the interpretative process. I have been careful to ensure the data analysis and discussion is in line with the theoretical assumptions of IPA.

Impact and importance

Yardley's (2007) final principle on assessing the validity and quality of qualitative methodologies concerns itself with the usefulness of its application in community, policy

and practice. I have included an impact statement on the relevance of this study in the discussion to speak to this point in detail.

Reflexivity

Reflexivity is both a concept and a process in qualitative research, and a good starting point is a critical reflection on the ways our personal and professional roles are tethered to the research context (Dowling, 2006; Durdella, 2019). Willig (2013) acknowledges the potentially enriching effect of the inter-subjective on qualitative study, and queries the positivist canon that research practitioners should be detached, neutral or unbiased, as this could limit unique insights only available to that researcher in that given research context. Following, Willig's (2008) recommendation, I will now consider three types of reflexivity: personal, epistemological, and critical language awareness.

Personal reflexivity

This study concerns itself with subjectivities: the way that *"the voices in our heads and the feelings in our bodies are linked to political, cultural, and historical contexts"* (Ellis & Flaherty, 1992, p.4). My own subjectivity is inextricably linked to my choice to pursue this research question, as well as the adopted methodology and epistemology. I am a white, neurotypical, non-disabled, middle class, cisgender, British citizen. I am a woman in a field that, at least until senior management level, is dominated by women that look just like me. At the same time, interrupting the orbit of my privilege (Schmitz, 2010), I am a queer woman who has experienced violence because of my sexual orientation, has experienced conversion therapy as an adolescent, and has felt disorientated in a training programme that only brought in perspectives on queer and/or trans lives on the days that the assumed cis-het cohort learnt about working with 'difference'. I have experienced and/or witnessed

direct queer- and transphobia whilst in training - on clinical placements, from clients, supervisors, and colleagues alike.

I have had to ride the waves of self-criticism throughout this thesis process, though those waves went far beyond the feelings of imposter syndrome that I have experienced in writing other pieces of academic work. I have felt the weight of exceptionally high self-imposed standards in this write-up, feeling concerned that if my work is not exceptional that it might be considered unbelievable (Paulraj, 2016), or that its appropriateness as a DClinPsy thesis would be questioned. Additionally, I have at times become incapacitated by self-doubt around the validity of my own interpretations, wondering whether I was exaggerating dynamics that I myself had experienced, feeling the pressure to sanitise certain aspects of my participants' voices or my own analysis for it to be taken seriously. I have worried about raising eyebrows if I am critical of my own academic institution. This reflexivity in particular is a section that I have procrastinated over and rewritten multiple times, concerned that I might highlight my work as self-indulgent 'me-search' if I disclose just how self-relevant this topic is.

This given, I do not claim to be objective, nor do I attempt to speak on behalf of my participants. Their narratives are their own, and I have handled them with great care, even when I experienced discomfort with the ways in which their lived experiences were dissonant to my own. In this research context, I am accountable to my work, my community, and future queer and/or clinical psychologists if I am using my voice to disrupt the cis-heteropatriarchal (re)production of psychological knowledge. Keeping a research diary, conducting a bracketing interview and bringing this journey into my own therapy helped me to refine which of these aspects I ought to include in this reflexivity.

Epistemological reflexivity

Willig (2008) encourages qualitative researchers to reflect upon how their epistemological position may have defined and limited what could be 'found' in the phenomena under examination. As discussed at greater length in the critical appraisal, I at times experienced discomfort when I questioned the ethics of interpretation as a tool of analysis. Going further than 'holding my participants in mind', throughout the process of analysis I was repeatedly drawn back to imagining how my participants would feel about how I had interpreted their very real lived experiences and narratives about matters as personal as identity.

This preoccupation was partly due to the great respect and positive regard I held for my participants and the generosity with which they shared their stories. It was also due to the ways in which my own lived experiences often felt similar or overlapping with theirs, causing me to think critically about how much I might project meaning onto their words. A final concern was the ethical impact of interpreting my participants' narratives using dominant psychological concepts and theories that are cis-heteronormative at their core, potentially losing the nuances of queer phenomena, and perpetuating misrepresentations of communities that have an oppressive history with the researcher's gaze (Edwards & Ribbens, 1997). As such, it is possible that this anxiety led my interpretations to follow pre-existing discursive realities, rather than creating new ones. This epistemic injustice (Fricker, 2007) occurs when a person from a marginalised group lacks the interpretative resources to counter the dominant narratives that are presented to them about their own experiences. Throughout the process of analysis, I was heartened by Morris et al.'s (2022) reminder that contributing to queer pedagogy is in itself a destabilisation of hierarchies of expertise.

Critical language reflexivity

Critically engaging with language is vital when working with communities that have historically had language chosen for them for pathologising or criminalising means. I am aware that using the term(s) 'queer and/or trans' may not have captured the embodied sense of all my participants' identities, may have led participants to foreground certain parts of themselves, or may have prohibited some participants expressing an interest to begin with.

Critical language reflexivity does not just require thoughtfulness about the words that are used, but also how they make up the questions that are asked. Brannen (1988) cautions against too closely defining the research 'problem' in sensitive research contexts, emphasising that this should be done by the participants themselves. Many participants expressed relief and gratitude to be given the space to speak about an aspect of their lives that had not previously been directly asked about. As such, and especially with the use of the second question in the interview schedule, *"what does the experience of that identity mean to you?"*, many participants spoke about their coming out stories, which for most of them were rooted in suffering. This question was meant to elicit an idiographic answer and set the tone from the outset about what the participants' preferred language was, and how salient their sexual orientations and/or gender identities felt in their personal and professional lives.

I anticipated the interviews would be emotional and might elicit narratives that went beyond the scope of the research question, and struggled to find the balance between using language that was direct enough to get at the 'essence' of the question, whilst also wanting to create a space for participants to speak about what felt aspects of the broader research

question felt salient to them. This led to a wider experience of feeling that I at times 'lost control' of the interview, switched from researcher to therapist mode, and resultingly felt enormous guilt at having to omit highly emotive and generously shared aspects of my participants' narratives that went beyond the scope of the research question, but were all directly tied to the experiences of queer/transphobia. These included stories of grief, widowhood, ambiguous loss, addiction, family break-up, sexual abuse, bullying, exclusion, and chronic illness relating to stress and intimate partner violence. This consideration is explored at greater depth in the critical appraisal.

Results

Introduction

Five superordinate group experiential themes were identified from the analysis, each with a set of subthemes. An overview of these is presented in table 2 along with their patterns of occurrence according to each participant, with 'x' identifying which participants' quotes were used in the final write up.

Table 2

Overview of group experiential themes for all eight participants

Superordinate Themes	Subthemes	*Dom*	*H*	*Cleo*	*Sage*	*Elle*	*Jay*	*Steve*	*Kate*
Queering practice	The psychological is political	x							x
	Troubling compulsory storylines						x		x
	Freedom to break the rules			x					x
	Sitting alongside					x		x	
Queer euphoria	Joy in belonging					x	x		
	Finding refuge							x	x
	Freedom to flourish		x		x		x		
Living in threat mode	Covering & vigilance		x				x		x
	Battle fatigue			x		x			
	Responsibility & burden		x		x				
A punch in the guts: profession as hostile	Profession as performative			x	x				
	Profession as wounding					x		x	
	Psychology has a transphobia problem						x	x	x
Living & working in community	The loss of elders			x	x				
	Overlapping lives				x		x		
	Solidarity			x			x		

Each of these superordinate themes is explored along with their sub-themes in the following sections. The following notations are used in the transcript excerpts that illustrate each theme:

Omission of unnecessary material	…
Anonymised information	[supervisor's name] *helped me*
Amended for grammatical correctness	*it [was] a significant burden*
Explanatory information	(*the Facebook group*)
Non-verbal communication	*sighs*
Speech emphasis	<u>underlined</u>

1. Queering practice

"But there is something about that, like queer as a verb, you know?" (Kate, p.17:9)

All participants shared this superordinate theme across their interviews. It captures the experience of queering dominant frameworks of clinical practice to include a deconstructed and critically expansive view of 'how things are done'. This theme is divided into four subthemes: *'The psychological is political'*, *'Troubling compulsory storylines'*, *'Freedom to break the rules'*, and *'Sitting alongside'*.

a. The psychological is political

Dominic, Jay, Steve and Kate all spoke of a sense that their queer and/or trans lived experiences had led them to queer their psychological practice in an overall effort to expose the material injustices of the world. As Kate (she/her) states: *"So I think that's the queerness of my practice, it's nothing to do really with sexuality. Or relationships. It's about queering as*

a kind of political act almost" (p.18:13-23). Here, Kate invites us to resist being distracted by the queerness of her practice having anything to do with the way 'queer' is usually used – as a noun to describe a collective of minoritised sexual and/or gender identities. Instead, the queerness of her practice is an act of inherent political resistance.

This is echoed by Dominic (he/him), who makes meaning of his own coming out experiences as an *'unstifling'* (p.19:8), which influenced his view on the role that psychology can play in people's lives:

> Psychology should be about…making it a lot more transparent where injustice occurs…There's something, there's something about that stifling that, that kind of, um, emerges out of injustice. And so the two things are linked together, people don't stifle themselves…for no reason. Um, they do so because they're operating and living in a world which is stifling them. And that that is, and that largely, that's an act of injustice (p.11:14-22)

Like Kate, Dominic sees psychology as serving a liberatory, or unstifling purpose. By exposing the injustice of the world, his practice allows people to externalise their own stifling, locating the root of the suffering in their social contexts rather than in themselves. At a later point in the interview, he rephrases this with candour: *"when people can see how shit the world is, they can stop blaming themselves for their problems"* (p.15:12-13).

b. Troubling compulsory storylines

H, Cleo, Elle, Jay and Kate all spoke to the idea of queering their practice as having something to do with troubling prescribed normative storylines for living.

> I feel quite free to be overtly political about the assumptions that are made, the stories that the world tells us what a happy ending looks like, you know, what's okay and what's not okay, how girls ought to behave, how boys are allowed to behave, the kind of compulsory heterosexuality, these kinds of things (p.17:20-25)

Kate speaks to her own outspoken or *"overt"* disruption of taken-for-granted social rules in the queering of her practice. At the start of the excerpt, Kate tells us what she feels free to do in therapy, however her choice of language also lets us into her own internal sense of herself in relation to the very rules that she seeks to trouble for others: *"I feel quite free to be".* It is in having liberated herself from compulsory cis/het narratives that she feels motivated to help her clients do the same.

Jay (he/him) also speaks to the purposeful unshackling of cis/het normativity in his interview: *"I think kind of being, not being 'shackled' is the word I want to use, but like, to a kind of cis/het sort of framework"* (p.16:11). The purposeful choice of the word *"shackled"* evokes images of chains, servitude, restraint and imprisonment. Like Kate, Jay uses this evocative language to tell us what he feels unshackled from in his practice, a freedom he only knows because he has done the same for himself growing up as a gay man in a cis/het world. He elaborated on what this means for him:

> And I think yeah, being a queer psychologist does just mean that, yeah, I kind of, er, like whatever people are, whatever they bring, then I kind of am open to that. I suppose it's about, I don't know, being, still holding on to being curious, which is a sort of, I suppose fundamental value in the profession. Without making everything a curiosity, you know? (p.17:21-p.18:2)

Here, Jay queers the principle of curiosity, the value of disrupting *a priori* assumptions, relating it back to one of the most fundamental values in the profession. Being playful with language, he shows us how curiosity as a principle embodies openness, but treating people as curiosities, as the profession has a long history of doing towards those it does not understand, violates the values in his queer worldview. By ending his sentence with a question, Jay demonstrates his own curiosity about his statement, allowing multiple responses with the openness he has just named as being central to his practice.

c. Freedom to break the rules

Dominic, Cleo and Kate all spoke directly to the idea that their lived experiences as queer and/or trans people gives them permission to break the rules of dominant taught psychology. Kate starts by referencing what she imagines my own experiences are of being taught on training, and contrasts it with what she has come to realise about therapeutic practice in the 'real world' as an experienced queer psychologist:

> I don't know, this thing that you probably hear on training all the time: 'be warned', you know, 'be wary of therapeutic drift'. And I sort of think, well, actually, this compulsory model, this compulsory fidelity to one particular way of thinking and working and speaking is actually not in line with my queerness. It's not in line with my worldview. It's not in line with how queer I think everyone is, you know, I think it's how queer pain is, how queer joy is, it doesn't work like that. And I think so many of the models are structured on this idea of there is a right way to be human (p.21:4-12)

Kate is naming the freedom to break from the rules in several respects: those taught by the training institution, the protocols built within particular therapeutic modalities, and

the rules that dictate that there are particular ways of thinking, working and speaking to begin with. The queerness of her practice allows her to formulate differently. Having already broken social rules as a person who identifies as neuroqueer, she feels free to rewrite them in a way that captures the lessons of queer and autistic life. She refers to the *"right way to be human"* as being inherently tied to neurotypical cis-heteronormativity within taught psychology, and chooses to abandon these inherent values for those that more thoughtfully capture the diversity of human experience. By specifically engaging with ideas of how inherently *queer* human experiences of pain and joy are, Kate once again reminds us that her use of the word 'queer' goes beyond the collective noun to mean expansive, interhuman, relational, intimate and intense.

Cleo's (they/them) description of queering their therapy practice breaks conventional rules around the therapist-client dyad by disrupting what they experience as unnecessary power dynamics:

> I think- I guess I think part of it is probably coming down to, like, hierarchy is real, but also doesn't have to be real…And I think one of the things I tell- I end up telling most of my clients, at some point, is to say, you know, 'Sure, I'm here as the psychologist, and you're here as the patient who's been referred to see me, but ultimately we are two humans in a room, in relation to each other. And that means that the stuff that happens between us, as two humans, is often a mirror of what happens more broadly in society' (p.42:5-16)

Cleo's therapeutic stance is one that centres the human relationship between themselves and their client for exploration, rather than positioning themselves as observer and their client as observed. Cleo troubles the taken-for-granted idea of the psychologist-

patient hierarchy being 'real', and instead privileges the possibility of a (more) interconnected relationship, which might bring to light learning for the outside world.

Cleo expresses their frustration with structural power elsewhere in the interview. Whilst discussing their frustration at being met with NHS bureaucracy when advocating for trans clients to have their correct names and pronouns reflected on their electronic patient records, they point to the absurdity of being met with resistance by their Trust: *"But times where I'm just like, 'but I just don't understand why this has to be a bureaucratic barrier.' Like, 'That's made up. We could just not do that'*laughs*"* (p.11:6-p.11:8). The humorously adolescent questioning that Cleo uses in this statement is reminiscent of realising that the way the world is organised and rule-bound by adults makes absolutely no sense. Cleo points to the ease with which the apparently impossible bureaucratic barrier could be overturned, by simply choosing to do it differently. Cleo's incredulous response mirrors their own experience of growing up queer and agender in a world full of barriers. Their oppositionality to those barriers showed them that they did not have to accept those rules in their own life, that they *"could just not do that".*

d. Sitting alongside

This sub-theme is the only one in the analysis that every participant spoke to, and captured strong sentiments that the lived experience of being queer and/or trans allowed participants to respond to their clients with greater empathy. To sit with someone and hold space for them is a powerful part of therapy. But to sit *alongside* someone offers a shared human vulnerability. Elle (she/her), who self-identifies as a late blooming lesbian, named the *"softness"* (p.24:13) that she feels able to bring to her clients' experiences of shame since she experienced the *"significant shame"* (p.16:28) of coming out at forty:

> It brings a softness to, a softness, an awareness of working with shame in a very, er, and, erm, aware, an ability to hold and discuss that in a different way than, than other people can… and yeah, and, er, just, yeah, openness and listening around it. Just being able to be present for those conversations (p.24:6-13)

Elle is able to meet her clients' shame with softness because she too is well acquainted with shame's harshness. This allows her to hold softness for others in a way that is a lived, embodied experience. She distinguishes herself from *"others"* in her ability to do this, which, within the context of our conversation, could refer to others who have not experienced the particular shame and hard-fought joy of coming out at a stage in life that does not typically reward the *"turmoil"* (p.2:15) and sacrifice involved in living authentically. It could also be a reference to Elle's former self, who had not yet experienced this turmoil, and therefore was not yet bringing this *"softness"* to others.

Steve (he/him), who self-identifies as a gay man, spoke about directly naming his lived experience of not fitting in when working with young people that experience health conditions that make them feel 'different':

> And so at least my experience of difference gives me some hook with – 'you know what? I know what it's like to not fit in. I know what it's like to not be the same. I mean, my experience isn't your experience, but actually at least I have some experience of that' (p.27:13-20)

Steve spoke with exuberance about the way he makes meaning of *"not being the same".* Steve is candid with the young people he works with, and recognises that life will be different for them. He speaks to their pain around this, whilst acknowledging his own

experience is not the same as theirs, but that he does have a sense of what it feels like. He twice uses the expression *"at least"* to express that although he cannot make their distress disappear, there is some value in offering them the hope that they are not alone in experiencing an 'otherness'. Steve thereby sits alongside his clients as another 'other'.

2. Queer euphoria

> *"You know, to be queer is like, wonderful"* (Sage, p.2:29)

All participants contributed in some way to the shaping of this superordinate theme. Queer and trans experiences carry at their core early messages of shame, stigma and social undesirability. All participants spoke to growing up with schemas of shame attached to their developing personhoods. As this data did not correspond directly to the research question '*How do queer and/or trans clinical psychologists bring their identities into their practice?*', it was not included in the results, however a discussion can be found in the critical appraisal. More pertinent to the research question was the experiences of queer joy that participants expressed, as this became a form of active protest or collective resourcing in their lives as psychologists. This sense, that there is something rich to be gained through the queer and/or trans lived experience, is captured in the three sub-themes in this section: *'Joy in belonging'*, *'Finding refuge'* and *'Freedom to flourish'*.

a. Joy in belonging

All participants described in some way feeling a sense of collective joy in belonging to a larger queer and trans community, which resourced their practice in various ways. Jay, who works in a service that supports trans and gender expansive adults, described a sense of belonging to his particular service, as well as to his colleagues and the area of work in general:

> Um, and, yeah, I think that this is definitely where I want to be working. Um, and I feel where my, my experience and skills and things are best used. So, I think just that in itself, you can't ask for much more than that, really, can you? (p.34:23-25)

Jay refers to *"definitely"* wanting to be working in his service because he feels he belongs there. He speaks with a sense of having found his purpose. When he refers to his *"experience"* being well placed where he is, he is not just speaking to his clinical experience, but his own lived experience as a queer person in the world. He feels this experience is *"best used"* in working with others who experience minoritisation because of who they are. Overall, this gives Jay a sense of belonging. Elsewhere in the interview, he describes the experience of working with and belonging to a larger queer and/or trans community as dialectically *"incredibly joyful"* (p.10:6) and *"difficult"* (p.10:8), but overall *"something really powerful"* (p.10:9), descriptions that are mirrored in Jay's overall meaning-making of his own lived experiences as a gay man. Ultimately, Jay's question *"you can't ask for much more than that, can you?"* is a rhetorical one, that leads my own inner dialogue to respond *"no, Jay, you really can't".*

Elle spoke directly to a sense of joyful belonging whilst describing her majority queer-identified team: *"That just feels like a gorgeous family of, erm, warmth and acceptance and absolute com-comfort almost reminiscent of my old straight days, Jess *chuckle*"* (p.11:3-14). The gorgeous family that Elle refers to are the non-biological kinship bonds that queer and trans communities forge by choice belonging. The warmth, acceptance and absolute comfort that Elle experiences from this chosen family complements, and for some queer and/trans people, replaces the kinship and care that are mandated of families of origin in a cis-heteronormative framework. Elle references this

absolute comfort as reminiscent of the taken-for-granted acceptance she experienced in her *"old straight days"* before she came out as a late-blooming lesbian. By using my name and chuckling quietly at the end of her sentence, my sense was that she gently invited me in to prod at the privilege she used to experience for never knowing what it felt like to not belong in the first place. Though she speaks to the loss and turmoil of coming out elsewhere in the interview, she is clear about the queer euphoria she experiences with statements such as *"there's a kind of joyfulness in that, you know?"* (p.15:23). Like Jay, Elle ends her statement with a rhetorical question that recognises that I might too have an understanding, or perhaps even a similar experience, of this joyfulness.

b. Finding refuge

Overlapping slightly with feeling a sense of belonging with other queer and/or trans colleagues, Cleo, Elle, Steve and Kate all referred to the *"places of refuge"* (Kate, p.31:16) or sense of safety that they experience within their wider felt belonging. For Steve, this became most clear for him after experiencing the anguish of losing his partner, and realising that finding a fellow gay therapist was instrumental in his sense of safety to process his grief:

> Again, [the therapist] being gay, was really - has been really instrumental in my mental health, because one of the reasons I struggled so much when my partner died was that his mother totally invalidated me as his partner. But she was a massive bigot (p.46:14-47-10)

Steve started his sentence in the past tense, referencing his historic decision to start therapy after his bereavement, but immediately corrects himself from *"was"* to the verb form *"has been"*, almost as if his grief stopped him from referring to it as something that is

not still ongoing. Steve evokes his gay-identified therapist as the counterbalance to his *"bigot"* mother-in-law. Later in the interview, Steve clarifies this further: *"So, you know, again, being gay has been an integral part of feeling invalidated, that I lost my partner. And sometimes I don't feel entitled to use the word widow, or widower"* (p.48:17-18). Relating to another gay man in therapy allowed Steve to know that he could safely process the loss of his life partner with someone who would validate his position as a widower without question. This choice allowed Steve to find a small pocket of refuge in his grief process.

Whilst Steve sought refuge from the hostility of those in his personal life, Kate invoked the idea of finding refuge with other queer and/or trans psychologists from the point of view of having a home-base to return to in order to refuel before returning to the hostility of mainstream psychology:

> The main kind of clinical psychology Facebook group…but also sort of trying to swim against the tide of, of anti-trans propaganda, that can show up in there sometimes. And then scurrying off to the kind of little tiny, safe LGBT psychologist group and going, 'oh, my God, they're doing it again'. It's been really nice to find that and kind of move backwards and forwards between the two again…you can have this sense of like, a secret side conversation where we're like, 'okay, who's ready? I'm going in. Does anyone want to come in with me?' (Kate, p.26:24-25:6)

Kate is referring to a particular UK clinical psychology Facebook group that has over six thousand members, which is a forum that has seen regular posts from clinicians sharing trans-critical and transphobic content. With these discourses making many queer and/or trans members of the group feel unsafe and hurt, a new private Facebook group was formed for any UK clinical psychologist that self-identified as LGBTQ+. Kate speaks to the

experience of viewing *"anti-trans propaganda"* on the main group, and then *"scurrying off"* to find refuge amongst her queer and/or trans colleagues in the LGBTQ+ group, to share her frustration and resource herself. The small group allows Kate to feel a sense of comradery and refuelling for *"going [back] in"*. The question she poses to her community at the end of her sentence, *"does anyone want to come in with me?"* signals an invitation for safety in numbers. This solidarity with one another provides a sense of refuge and erodes some of the exhaustion and hopelessness that can come with having to *"swim against the tide"* of reading propaganda about your own community within your own profession.

c. Freedom to flourish

Dominic, H, Sage and Jay all spoke in different ways about experiencing a flourishing where the professional meets the personal in their lives as queer and/or trans people. H (she/her) described starting her current role in a very supportive team, after spending a number of years post-qualified in a *"hugely homophobic"* (p.2:17) and *"very, very hostile"* (p.2:19) service:

> And it was just a whole different experience there. Um very, very warm, very welcoming, and I've just grown in confidence in terms of identity just, I guess, in my personal life through a very long-term relationship, but also a very, very supportive workplace (p.2:22-25)

H's references elsewhere in the interview that her positive identity development was not able to start until she found herself in a workplace that affirmed her. She emphasises the change from a *"very, very hostile"* to a *"very, very supportive"* workplace as having equal importance alongside her *"very long-term relationship"* in her confidence growth specifically relating to her pansexual identity. Moving into a team that extended warmth and welcome

to the parts of H that she historically kept vigilantly hidden at work allowed her the freedom to flourish.

Similarly, Jay speaks directly to the experience of being invited to bring together the personal and the professional at work:

> And that was a real game changer for me actually having a kind of queer supervisor, and, um, essentially, because I wouldn't have necessarily thought it would have, but it really did make a massive difference, just bringing together the kind of personal and professional and thinking about the work and how, yeah, how it affects you, how you affect the work, um, was really helpful (p.5:11-16)

For Jay, the surprising *"game changer"* of having a queer supervisor allowed him to be his whole self at work without compartmentalising. Furthermore, he describes the difference that he didn't know he was missing in being able to reflect with a queer supervisor about how aspects of his lived identity dance with *"the work"*. The significance of the expressions *"massive difference"* and *"game changer"* allude to a sense that Jay has discovered that this is an essential aspect of feeling able to flourish at work moving forward.

For Sage (they/them), the freedom to flourish in their identity as a self-identified queer non-binary person is affirmed through their professional accolade in practical terms: *"I like my 'doctor' title, rather than Mr or Miss or Mx, because, you know, again, it doesn't prescribe any clue to what is going on necessarily, other than that you are different *laughs*"* (p.3:3-5). For Sage, their professional prefix allows them a freedom in a number of regards. Firstly, it allows for a gender-neutral address, which as a non-binary person they are not usually afforded. Secondly, it gives them a freedom to queer and subvert any

attempt to gender them, which their expression of laughter seemed to communicate they enjoy as a mischievous revolt against cisnormativity. The title of 'doctor' also confers a power that Sage had not had access to previously in their life as a person with a subjugated identity. Importantly, though, Sage does not imply that their gender-neutral professional title is important to them as a way of covering their difference. Instead, they revel in their difference, and place an emphasis on remaining opaque and uncategorisable to the cis-het eye, whilst flourishing enigmatically.

3. Living in threat mode

I still don't always feel safe within the profession for a number of reasons (H, p.19:17-18).

This superordinate theme was developed out of a shared expression of at times overwhelming stressful apprehension that participants experienced in regards to their lived identities of being queer and/or trans. These experiences are broadly categorised in three sub-themes: *'Covering and vigilance'*, *'Battle fatigue'* and *'Responsibility and burden'*.

a. Covering and vigilance

H, Elle, Jay and Kate all spoke in different ways about the felt need to cover aspects of their queer and/or trans selves at work. For H, the uncertainty about how her supervisor would respond to her bringing aspects of her personal life to supervision has meant that she had tentatively mentioned but never gendered her partner:

> I've definitely consciously known I've wanted to go there, and maybe hence referencing my partner, um, but never gendered her. Um, and then I've just been led by him. And I guess, I think his focus is very much sort of formal, there's never been any - I've brought emotions, I brought countertransferences, I've brought things like

> that when I needed to talk about them, but it's not something he willingly goes towards. It's not his area of comfort, I feel (p.16:14-19)

H describes this dynamic with tension and contradiction. She both consciously knows she wants *"to go there",* but stops short of actually going there, waiting to be led by her supervisor, who does not take her up on the clue of the ungendered term *"partner"*. Whilst her supervisor's focus is *"formal"* and subject-specific, H has made her supervisor step outside of his comfort zone before by bringing *"emotions"* and *"countertransferences"* when she has felt the need to talk about them. However, exposing herself as being in a queer relationship is positioned as one risk too far in H's supervisory relationship.

Similarly, Jay describes a sense of never feeling fully seen in mainstream services, as he feels his queer self is either totalised or erased: "*There's something about wanting that part of me to be seen, but not wanting it to be the only part of me that's, that's seen"* (p.9:12-14). For Jay, the never-quite-right way in which some of his cis-het colleagues approached his queerness in his former service led him to feeling tokenised and *"really only [seen] through that lens"* (p.9:2). Knowing that he was never fully seen in the richness of his complexity by these colleagues made him feel his queerness was essentialised or covered up by others.

Kate also spoke to an imperative to cover her identity in her work, but unlike H and Jay, spoke of doing so in a deliberately playful way in order to influence discourse around sexual and gender diversity in professional spheres:

> I've honed my disguise over the years as a kind of straight neurotypical, professional, middle-aged person, who's kind of just normal…But you know, I'm a parent, have done the decent thing, you know, and to almost come into a space kind of passing as

straight, passing as neurotypical, and then to kind of come out once I'm in there, do you know what I mean? There's something in that, I'm kind of getting into a conversation because I can, I'm not masking anything particularly well at the moment, but I can, I'm quite capable.

INT: A Trojan horse?

Keeping a lid on it, absolutely the Trojan horse, open the doors, I'm full of queers, they'll come bursting out and burn your houses down *laughs*! (p.30:1-12)

This excerpt captures a moment in the interview where my own researcher mask slipped, and I found myself in conversation with Kate. Though I suggested the analogy of a 'trojan horse' to capture Kate's experience, she readily and emphatically agrees this is an accurate way of describing it. Kate purposefully covers the nonconforming aspects of her lived experience in order to gain respectability as a *"straight, neurotypical, professional, middle-aged person"*, defining these characteristics as the perceived *"normal"*. Once 'inside' the conversation, Kate unleashes an army of queer soldiers, *"bursting out"* to burn down the structures upheld by neurotypical cisnormativity.

Kate is making two concurrent meanings of this analogy: she is both referring to *"bursting"* with an army of queer influence, as well as herself being *"full of queers",* as her four children all identify as queer and/or trans in various expansive ways. Finally, Kate makes reference to the safety that exists between us, by naming *"I'm not masking anything particularly well at the moment, but I can, I'm quite capable".* Here, Kate is letting me know that the freeness with which she allows her felt sense of being neuroqueer to be unmasked in our conversation is not the way in which she normally would amongst those she covers around, and I wonder if my own mask slipping is what allowed for hers to do the same.

b. Battle fatigue

Cleo, Sage, H and Jay all spoke in various ways to the toll of confronting queer- and transphobia within the profession. Elle speaks directly to this sense of overwhelm at the idea of challenging queer- and transphobia every time she experiences it at work: *"God, I can't challenge it <u>all</u> the time"* (p.18:17). The exclamative use of *"God"* and emphasis placed on "*<u>all</u>"* gives a sense of the overwhelming frequency with which Elle would have to take up the battle against micro- and macroaggressions if she chose to every time they occur. She continued: "*The bravery, the energy required. It just, sometimes it's easier to be like, this isn't my battle today"* (p.22:9-10). Though Elle alludes to her lack of bravery, her choice not to engage in an incessant daily battle can also be seen as an act of agency and resistance against unsafe spaces and conversations. The exhausting reality that Elle confronts is one that occurs with or without her challenge. In Elle's experience of battle fatigue, she reminds us that self-care in a context that seeks to denigrate her identity at an individual and collective level is *"self-preservation, and that is an act of political warfare*" (Lorde, 1988).

c. Responsibility and burden

H, Cleo, Elle, Sage and Jay contributed to this theme, which speaks to a sense of responsibility to make things better for other queer and/or trans people, based on the exclusion that participants themselves experienced within clinical psychology. This variously included experiences of wanting to better mental health services to become more equitable for minoritised service users, improving workplace culture for other queer and/trans clinicians, and feeling responsible to challenge queer-and transphobia towards clients in teams. Whilst this sub-theme overlaps somewhat with *'battle fatigue'*, it uniquely captures

the experience of carrying the responsibility to advocate for others in positions of less power.

H explains this in the context of looking to support a trans supervisee in a workplace that did not have structures in place to protect them:

> They didn't have a policy or anything, because I turned to HR for some support with the, um, individual's consent and they had nothing, and they literally said "oh well as, as the LGBT person would you like to do the uh, would you like to write the policy?" I was like, "you can't just use me as the token gay for like, every policy there is!"…And I had to really take a lead, because I felt so passionate, that, wow, this really is archaic here (p.10:1-6)

H's expressed frustration in this extract is multiple. She is disappointed to find that her human resources (HR) department, the team that she expects to carry expertise, have no resources to support her colleague. Rather than this being rectified by HR, she is instead burdened with the proposition of writing the employment policy as the token *"LGBT person"* within her organisation. The responsibility placed on H to *"write every policy there is"* implies that no policies protecting queer and/or trans people already existed in H's workplace. Though she ended up stepping outside of the remit of her role and volunteered her passion to help reform her *"archaic"* service, H speaks about this with a sense of incredulity and exhaustion, as if she has had to do this many times before. Though burdened by the responsibility placed on her in the battle towards progress, H references elsewhere in the interview the close bond that this created between her and her trans supervisee.

Sage spoke to the dialectical privilege and burden at having the felt responsibility to use their voice to advocate for the queer and gender-nonconforming young people they work with in a dialectical behaviour therapy (DBT) service:

> I felt dialectically both privileged and burdened to be in those spaces where like, you know, I was, I'm so glad I'm able to have a voice and even if my voice is shaky, because I'm so enraged by what you're saying, but like, I can advocate for it (p.13:23-26)

Sage is burdened by the exposure to enraging narratives, and being the person with a sense of responsibility to challenge these narratives on behalf of those who are more vulnerable. Their sense of rage is deeply rooted in their own ability to identify with the young people they work with, as Sage mentioned elsewhere in the interview feeling drawn to work in an adolescent DBT service as it helped them understand their own experiences. Their sense of privilege and being *"so glad"* to be able to use their voice, *"even if [their] voice is shaky"*, is perhaps a reference to the uncertain future that Sage once experienced themselves, and the parallels they draw between themselves and the young people they work with, who are disproportionally at risk of suicidality as young queer and/or trans people (Williams et al., 2021).

4. 'A punch in the guts': Profession as hostile

> *"I felt very alone, actually, in the, during the difficult times"* (H, p.22:1)

H, Cleo, Sage, Elle, Jay, Steve and Kate all expressed a sense of injury sustained from within the profession because of their queer and/or trans identities. These experiences varied between examples of direct personal encounters with queerphobia (H, Elle, Steve);

implications that being a gay man carried a paedophilic threat to clients (Jay, Steve); queer and/or trans clients being labelled as being *"borderline"* and *"revolting"* (Elle, p.8); and exposure to overt and covert transphobic discourses within professional spheres (H, Cleo, Sage, Elle, Jay, Steve and Kate). These experiences are grouped into three sub-themes: 'Profession as performative', 'Profession as wounding', and 'Psychology has a transphobia problem'.

a. Profession as performative

This subtheme came together through narratives from H, Cleo and Sage. For H, there was an experience of profound disappointment when she entered the profession to realise it was *"bitchy, backstabbing [and] competitive"* and *"incredibly unsafe"* (p.19:3-6). H gives a few examples of what led her to these conclusions, including experiencing some of the worst homophobic bullying from other clinical psychologists in her first role after qualifying. These incidents led H to feel that clinical psychology was a performative profession, as her initial assumptions that *"we're all in it for the same reason",* to be *"compassionate"* and *"accepting"* (p.19:4) were shattered.

For Cleo and Sage, who identify as agender and non-binary respectively, the profession is perceived as performative in the way that it weighs in on discourses around trans lives with cloaked innocence. Throughout the interview, Cleo shared their disappointment that many of the critical thinkers they looked up to in their journey as an aspiring psychologist turned out to take 'TERF' (trans exclusionary radical feminist) positions with regard to discourses around gender. The term 'TERF' refers to a specific position taken by some second-wave feminists which actively excludes the rights of trans women from

their advocacy of women's rights, and believes that gender is entirely biologically determined, rather than socially constructed (Hotine, 2021). Cleo explains their sense of scepticism at the hidden motives of TERFs within psychology, who enter transphobic discourses with a veil of curiosity.

> I think with trans identities, there's really something about how this - psychology loves to have this academic debate about it, and there are some very outspoken TERFs in psychology, and there are a lot of people who are, "just- just questioning," or, "just", you know, "being critical and reflective," and actually that's- It's actually transphobia, um, but they phrase it in a, "oh well, isn't this an interesting academic discussion?" It's like, people's identities and lives are not an academic debate, um, and there are people within your sphere, at the present moment, who are feeling like you are debating their right to exist, and whether they're just traumatised, or whether they're just, um, maybe autistic, but confused about their identity (p.19:18-p.20:2)

For Cleo, psychology as a profession is experienced as performative in the feigned innocence with which it engages in 'academic debate' about trans lives, which in fact is a debate about trans aetiology, a position which continues to centre gender-nonconformity as a pathology to be explained. Cleo recognises that there are a lot of 'TERFs' in psychology, but is not referring to those individuals who are outspoken in their transphobia. Instead, Cleo is referencing the wider prevailing attitudes in the profession, which position themselves as neutral, and hide behind *"being critical and reflective",* values that Cleo holds central in their own practice. Cleo's expressed anger at the *"interesting academic discussion"* that happens about trans aetiology in professional spheres centres around their

own experience of feeling that *"their right to exist"* is debated through these damaging discourses that are at their core transphobic.

For Sage, the allyship that is expressed by other psychologists is performative and superficial, and is directly triggering of experiences they had to endure at school, an environment that is often unsafe for queer and/or trans young people (Stonewall, 2017):

> When I'm in those spaces, like I get that false sense of safety and people saying, 'oh, yeah, I'm with you, I'm so supportive', but then in the next breath will say something that actually is quite transphobic, whether they mean to or not… I see that very much as similar sometimes in school, when people would say, like, 'oh, no, no, I have no issue with gay people'. But then in next breath be, like, 'oh, that's so gay"'
> (p.24:13-18)

Sage describes an initial *"false sense of safety"* around other psychologists who state their support for Sage's work with highly vulnerable queer and/or trans young people. However, the ease with which they will then say something transphobic, *"whether they mean to or not"*, shows the degree to which common parlance is steeped in highly gendered and transphobic language. Sage makes the comparison with hearing *"that's so gay"* at school, an expression that is not considered an insult by their peers because queer negativity is so integrated into culture that it permeates language without much thought. Though Sage's adult professional peers virtue signal their allyship, their unconscious incompetence demonstrates this allyship as performative.

b. Profession as wounding

Though Steve and Elle expressed having to manage direct queer and/or transphobia from clients, H, Cleo, Sage, Elle, Jay, Steve and Kate all expressed having experienced this

hostility from other psychologists. Both Elle and Steve are senior clinicians within their respective teams, and struggled in different ways with how to manage this targeting. For Elle, who came out as a late-blooming lesbian at a point in her career when she had already achieved seniority, the idea of having to challenge this hostility fills her with anxiety:

> I think it's made me much, much, much more, er, aware of people, erm, people's, erm, homophobic, transphobic language, erm, and I've had moments of, I've experienced still, you know, strong anxiety at times around those conversations and thinking about challenge. Erm, feeling crushed inside and just really very, very overwhelmingly sad (p.16:7-11)

Elle's particular anxiety around these incidents is perhaps in part due to finding this language newly personal, finding herself *"much, much, much more"* aware of queer- and transphobia since blooming into her lesbian identity. Her fear of challenging this prejudice is a reminder that seniority does not ameliorate the battle fatigue that queer and/or trans people experience at challenging their own oppression. The visceral description of feeling *"crushed inside"* gives voice to a wounding that Elle sustains from realising just how much this oppression occurs within her professional spheres. This embodied disappointment leads to her feeling *"very, very overwhelmingly sad"*, a truth she holds alongside the newly liberated queer euphoria she speaks of elsewhere in the interview.

For Steve, the experience of challenging prejudice has changed throughout his career:

> I have had encounters with homophobia, over the years…And looking back, I probably should've made more of a fuss, and I didn't. And I didn't. Because I didn't have the power, at the time, to do that, really (p.18:15-18)

Steve describes having had a lack of power to challenge hostility directed towards him as a junior clinician. Later in the interview, he alluded to what having the power as a consultant psychologist opened up for him when confronting *"encounters with homophobia"*:

> I'm a widower, I'm a consultant, um- Yeah. You know?...The worst thing in my life has happened, and I didn't die. You know? So- So the- The experience of it is very different these days. You know?... I am who I am. If you have a problem with it, that is your problem (p.13:7-15)

Though Steve describes the power he holds as a consultant as something that allows him to brush off others' *"problem"* with who he is as a gay man, my sense is that it has more to do with the self-assuredness that comes with having experienced *"the worst thing that can happen to anyone in the world ever"* (p.12:16-17) and surviving. Though the social rejection and homophobic stigma Steve went through at work was wounding, it pales in comparison to what Steve has endured through the bereavement of his partner. Steve goes on to describe the support that he received from his team as being instrumental in validating his grief, which had been undermined by those in his personal life: *"my office, and teammates, and colleagues were fabulous, really"* (p.11:11-12). In the first excerpt, Steve describes not having the power to challenge the profession wounding him as a gay man. In this final extract, Steve describes his colleagues as the 'safe others' he trusted to tend to the wounds of his unrecognised grief.

c. Psychology has a transphobia problem

H, Cleo, Sage, Elle, Jay, Steve and Kate collectively created this sub-theme, which captures the experiences of fear, shock, vigilance, and uncertainty that participants felt in response to increasing transphobic discourses within clinical psychology and its interface with wider society. For Kate, who has children who variously identify as gender expansive, the narratives around gender diversity she observes within the profession map onto the *"terror"* she feels at what her children face have to face in wider society:

> You know, I think…I think that there's very few people kind of in our profession, who are actively outspokenly homophobic, I think people at least have the sense to, to keep it subliminal, you know, and just not, not say the things, even if they're slightly uncomfortable, or, but the trans stuff that is going on at the moment and the conversation around that and what I hear from professionals, is just horrific, and I see my kids going out into this world and my kids are actively frightened about, about what's happening right now, to them and to their friends and to people they know through, obviously, they're in like trans youth groups and, and social circles and things and I'm just terrified about what that means for them (27:8-15)

Kate recognises that psychologists at least have *"the good sense"* to keep their homophobia *"subliminal"* these days, as there is enough consensus within the profession that to be *"outspokenly homophobic"* would be frowned upon. However, the same is not true for transphobia, which is *"just horrific"* in how freely it is used in professional spheres. Kate's terror at *"what this means"* for her children is rooted in a fear that her own profession, which is supposed to be grounded in an ethical framework, will fail her children and their peers with its *"horrific"* transphobia. Knowing that psychologists are positioned as

gatekeepers in NHS gender services, her children will undoubtably have to interact with the profession if they seek gender-affirming care in their lifetime. Moreover, Kate describes seeing her children *"going out into this world"* feeling frightened at what is happening to them and their friends through transphobia in wider society. Kate reminds us that the effects of damaging discourses within psychology are not limited to those who have access to professional spaces. Instead, clinical psychology both mirrors and shapes discourses happening in wider society, and Kate fears her children will be collateral damage in psychology's transphobia problem.

For Jay, who works in an adult gender service, the transphobia in the profession and wider society has made him wary and vigilant about even the administrative tasks of his clinical practice:

> I was doing just the thing you do, you know, if you look people up and just see what they're tweeting about, ready for the interview. And, um, and I saw it and I was like, oh, that's the job. And I clicked on it. And it was just such a string of transphobic abuse, like, um, just probably, probably, like, I don't know, 20 to 50 tweets or something, like it was like a proper stream of like, like tweets about the job I was applying for, and how awful it was and, and all this stuff. And I think there is that aspect as well, is I do feel like I have to, you know, you have to kind of cross all the t's and dot all the i's in this job for sure. And make sure that you are doing everything by the book (p.20:5-13)

Jay's first experience of transphobia within his current job happened before he had even started it. In preparing for the interview, he came across a *"stream"* of hostile tweets in response to the job advert, denouncing the position as *"awful"* as it supported trans and gender variant people. Though his values led him to still pursue the role, he realised upon

starting how vigilant he would need to be to do *"everything by the book"* in order to avoid more scrutiny than the hostile clinical context of working in gender care already entails. Later in the interview, Jay describes having to undergo media training in his role, due to the frequency with which gender specialist clinicians are negatively covered in the media: *"you know, [if] your name is posted in the Daily Mail, what do you do?"* (p.20:3). Jay's vigilance to *"cross all the t's and dot all the i's"* is in direct response to transphobia surrounding his professional context, as doing the work is personally precarious enough: "*in terms of risk…I am putting myself out there, you know, in the doing this work"* (p.20:18-19).

Steve refers to his unease around transphobia in the profession with a warning: *"We think the progress is in a continual, linear, forward motion, but it isn't, and it can go backwards, and we <u>have to</u> be vigilant"* (p.18:16-p.19:4). Steve, who refers to himself elsewhere in the interview as *"100 years old!"* (p.10:14) offers this perspective as a lesson learned from what he has lived through as an elder of a community that has faced the threat of violence and erasure. He points to the transphobia problem within psychology as a caution against apathy in the fight for human rights more broadly. For Steve, the steps that the profession has made backwards with regards to trans rights are a potential slippery slope, and warns that if we allow oppressive structures to erase trans progress, then all those whom systems of oppression seek to erase are at risk: *"Just because you're a gay white man doesn't mean it's- It's all going to go your way forever"* (p18:12-13).

5. Living and working in community

"The overlap between community where you live and work is quite interesting" (Cleo, p.23:17).

H, Cleo, Sage, Elle, Jay and Kate all spoke to the experience of living within and belonging to a community that they also interact with on a professional level. This dynamic variously effected the way that participants felt they could bring their identities into their practice. This superordinate theme is comprised of three sub-themes: 'The loss of elders', 'Overlapping lives' and 'Solidarity'.

a. The loss of elders

Cleo, Sage and Steve all spoke about their own experiences of grieving the absence of queer and/or trans psychologists as elders to look up to in their respective career paths. For Cleo, the lack of visible role models as an early career psychologist is experienced as a loss of representation:

> There's something about seeing elders, I think, that is a really important thing, and…I think there's something about representation in any community that's really important…I think there is something really powerful about seeing that other people have made it to where you would like to get to. Um. And I think the - the queer community, in general, we have generations of elders that we don't have as much of (p.7:7-p.8:3)

In the above excerpt, Cleo points to the loss of elders in the queer community in general, referring to the genocidal consequences of the early HIV/AIDS pandemic, murder and suicide on queer and trans populations (Morris et al., 2022). For Cleo, there is a sense of being untethered without queer elders to show them how to navigate the world by example. Within their professional life, Cleo speaks to feeling left to their 'gut instincts' in managing the boundary dilemmas of overlapping lives with queer clients in supervision, as their cis/het supervisor is a *"lovely person"* (p.31:13), but does not understand that

"boundaries are…an interesting thing to navigate within the queer community" (p.31:16-17) because of the greater interconnectedness and fewer *"degrees of separation"* (p.31:19) in minority communities. For Cleo, a lack of elders has led to a lack of leadership on matters germane to their lived experience as a queer and trans psychologist.

For Sage, the lack of role models as a young person growing up meant that they found themselves dissociating their queer and non-binary self as they entered the profession as an aspiring psychologist: "*I think I dissociated it because I didn't see them as congruent. I didn't see a queer person being successful, or queer psychologists, there were no models for this"* (p.11:32-p.12:1). Sage's experience of not seeing any queer successful people growing up meant they also did not see the possibility of queer people being successful, and by deduction could also not see this for themselves. For Sage, *"it's hard to be what you cannot see"* (Edelman, 2015, para. 1). As a consequence, Sage believed the only way they could be a successful psychologist was to dissociate from their lived identity in their early career. Sage described only feeling able to consolidate their professional and lived identity when they started engaging in research and clinical work around queer and/or trans mental health, finding themselves *"in a position of mild power"* (p.13:17) and consequently able to assume a position of elder for others. Sage now finds themselves with an imperative to consolidate their queer and non-binary subjectivity with their professional identity: "*I really like the opportunity to model outness and comfortableness with my young people, because I predominantly work with queer young people, and, you know, sort of support them on that journey"* (p.2:7-9).

b. Overlapping lives

Cleo, Sage, Jay and Steve all spoke to having to navigate the complex overlap of their private and community lives with clients. Cleo found themselves in a position of having to resign from their role as moderator of a queer community Facebook group in their region as they started coming across their queer and/or trans clients: "*I don't want people to feel like they can't use that group because their psychologist is also in it. Um…I don't want people to feel like I'm observing them, or holding a barrier, or reporting back, in any way"* (p.25:4-10).

In this excerpt, Cleo describes the complex ways in which queer and/or trans psychologists have to flexibly occupy insider and outsider statuses within their own communities. In this situation, Cleo had to sacrifice an aspect of their personal resources in order to make sure their clients did not have to. Well aware of the powered position that they hold as a clinical psychologist, and the degree to which power has been typically used against their community, they look to mitigate any chance of their clients feeling *"observed"* by a mental health professional. This dynamic resulted in Cleo feeling less able to participate in their own collective spaces because of the multiple relationships that they hold. Cleo's concern illustrates that to hold identities as queer and/or trans clinical psychologists is to relate with greater attention to interpersonal power imbalances, and to potentially sacrifice one's own access to safe community spaces in order to not compromise the safety of others.

Jay's experience of having a life that often overlaps with clients is described as a resource to draw on in his clinical practice:

> I think all my clients know I'm queer in this job…I do quite a lot of thinking with clients about their relationship to help at the start of working with them. And people

> have had really awful experiences…and I mean really, really terrible experiences of therapy across you know, the NHS and privately as well. Um, and I think people are often looking for queer psychologists. I will say in the first appointment quite often, um, when we're talking about it, that I am a queer person, if that's something that they've said is important to them (p.21:26-p.22:6)

Because of Jay's clients' previous harmful therapeutic experiences, Jay believes that his clients at times value his queer self more than they value his psychologist self. Being able to offer this of himself at the beginning of the therapeutic relationship serves to strengthen trust through his clients' belief that a community member would not inflict harm upon them through incompetence or transphobia. In this dynamic, Jay's queer identity ameliorates the perceived harmful power he holds as a psychologist within gender services. The way in which Jay's life overlaps with that of his clients opens up a sense of safety in his therapeutic practice. Whilst this use of self has been a helpful tool for Jay's clients, this aspect of having overlapping lives also places a pressure on Jay to navigate a complex split between his community identity and his professional identity. This will be explored in the final sub-theme, 'Solidarity'.

c. Solidarity

This sub-theme came together through narratives from H, Cleo, Sage, Elle, Jay and Kate about their felt sense of solidarity with their queer and/or trans clients. The experience of solidarity relates back to 'Living and working in community' in that participants described not feeling fully able to separate their clients' experiences of marginalisation from their own. For Jay, this played out in ways that required a thoughtful navigation of complex terrain:

> Lots of our clients will criticise the NHS and mental health services. Um, and one of the, um, things that will come up quite often is what is helpful in terms of you know, how much you participate in that? Because I can see that in some ways, you're just going to, like, further diminish hope and that, and like I said, that I think that's a dilemma I found myself in (p.32:11-14)

Jay asks *"how much do you participate in that?"* As if this is a question he has contemplated many times, and one which there is not a discrete answer to. On the one hand, Jay feels a sense of solidarity with his clients' frustration, himself feeling well attuned to the *"many, many, like limitations of that of, of, you know, psychology, mental health services"* (p.32:25). It is precisely because Jay knows that his community is systematically failed by current service provision that he spends a lot of time thinking with his clients about their relationship to help at the beginning of their work together. Concurrently, Jay has to navigate the fine line between a compassionate solidarity and further diminishing hope by splitting against his profession as an 'all bad' entity. Jay manages to negotiate a validating position without his solidarity shutting down hope for his clients: *"I have said, you know, that's not good enough. You know, what that, what that service did…But I feel like I could also get quite drawn into it, in quite an unhelpful way as well, if that makes sense"* (p.17:6-11).

Elsewhere in the interview, Jay speaks to an experience where he did not feel as able to hold a distance between his emotional experience and that of his clients:

> I just had this run of appointments, where it just felt like bearing witness to so much hard stuff, that is directly related to being queer. I had like, I really felt like less much less connected to hope than I ever had, I think. Um, and I was really like, "oh, God, I

don't know if I can like, like long term, like if this is going to be sustainable", because it does take a huge amount of energy (p.20:7-11)

Jay speaks to the personal toll of engaging in therapeutic work with his own minoritised community. Since *"the UK is quite a dangerous sphere for trans people"* (Cleo, p.19:13), the current zeitgeist means that many of Jay's clients bring similar stories of suffering in response to particular current events that affect them as a collective. If, for example, there is a transphobic murder that is highly publicised in the media, *"that comes up in every therapy session that week"* (p.22:24). The cumulative exposure to his clients' suffering and his subsequent own loss of hope in turn makes it even more difficult to bear his clients' collective suffering. This had led Jay to question his longevity in his service, feeling unsure if the *"huge amount of energy"* it took to contain the pain of his own community members felt sustainable.

Later in the interview, Jay went on to speak about the helpful narrative-based supervision that he received around these difficult experiences from his supervisor, who is also a queer clinician. Jay's clients' increased comfort through having a queer psychologist is mirrored by Jay's increased comfort through having a queer supervisor. Through narrative supervision, Jay was able to connect his experiences of hopelessness with those of connection and survival: *"it was like, especially poignant and kind of like powerful. Um, and I think, like moments like that really lift me…I guess, it's that, it's like this kind of this dance almost between hope and hopelessness"* (p.30:19-21).

Discussion

The aim of this study was to gain an in-depth understanding of the experiences of queer and/or trans clinical psychologists in the UK. It sought to explore what participants felt that their lived queer and/or trans identities opened up and closed down in their practice. The methodology included analysing eight semi-structured interviews using IPA. Five superordinate themes emerged from the data: (1) Queering practice; (2) Queer euphoria; (3) Living in threat mode; (4) 'A punch in the guts': Profession as hostile; and (5) Living and working in community. The following sections will discuss each theme and the ways in which they relate to the literature.

1. Queering practice

All participants described using their lived identities to queer dominant clinical frameworks in their practice. This included engaging with the socio-political to take liberationist stances in therapy, troubling normative understandings of what it means to be human, feeling free to challenge power and psychological pedagogy, and having increased capacity for empathy towards their clients, especially when engaging with experiences of shame.

In the sub-theme 'the psychological is political', five of eight participants spoke to their lived identities connecting them to a queered liberationist stance in their clinical practices. Aylward (2018) refers to the 'psychosocial activist' - the role that therapists can assume by acknowledging the personal alongside the socio-political context of their client in order to more fully illuminate the sources of their suffering. Stein and Plummer (1996) remind us that a queer politic is rooted in the confrontational activism embodied by grassroots organisations such as ACT UP and Queer Nation. These movements were born in

anger at the recognition of state violence and the socio-political context in which queer and trans communities experienced collective grief and suffering during the HIV/AIDS epidemic (Parker et al., 2014). Queering clinical practice can help clients connect their personal distress with social distress, externalising the problem from the person (White, 1995).

The overlapping sub-themes 'Troubling compulsory storylines' and 'Freedom to break the rules' captured participants' sense that their lived identities allowed them to destabilise hierarchies of expertise (Morris et al., 2022) and rally cry for new ways of thinking and doing, since they had already done so by coming out against cis-heteronormativity in their own lives. Stein and Plummer (1996) state that queering dominant frameworks can remind us to *"study the centre and not just the margins" (*p.185). They criticise social sciences of *"theoretical universalism"* (p.185) in which only the deviations from the mean warrant investigation and explanation. As a consequence, lived experiences that are upheld as universal go without challenge, receding into the background of normalisation. A queered therapeutic practice, then, breaks rules and opens up possibilities beyond the affirmation of minoritised communities. It allows for all of human experience to be explored without constraint. This intentional move towards a radically inclusive approach with all clients benefits everyone, not just those who are typically seen as the victims/survivors of cis-heteronormativity (Bain et al., 2016).

The sub-theme 'sitting alongside' captures participants' narratives of their queer and/or trans identities enabling them to connect more authentically with their clients' suffering. Increased empathy is well documented in positive psychology research with queer and/or trans participants. Riggle & Rotosky's (2012) large-scale qualitative study found increased compassion and empathy to be key positive attributes of queer and/or trans

experience. A separate study by Riggle et al. (2011) identified increased empathy and enhanced interpersonal connection as two of seven positive themes belonging to a trans lived experience, whilst Rosenkrantz et al. (2016) found that empathy, openness and compassionate action were named as particularly strong experiences by participants with intersectional queer and/or trans and religious or spiritual identities. The participants in this current study attributed their increased empathy to their own familiarity with suffering, especially experiences of shame and stigma, which enabled them to sit alongside their clients' experiences with an understanding of *"the hurt from within"* (Aponte & Kissil, 2016, p.3).

2. Queer euphoria

The naming of this theme was consciously borrowed from the term 'gender euphoria' – a term commonly used in the trans and gender expansive community to rectify the 'single story' that a trans experience is one marked exclusively by distress (Austin et al., 2022). As opposed to the psychiatry-generated concept of gender dysphoria, gender euphoria is a community-generated concept to describe powerfully positive experiences of inhabiting one's gender (Beischel et al., 2021). In contrast to other superordinate themes that collected narratives of exhaustion, wounding and vigilance, 'queer euphoria' brought together experiences of queer joy as a central affective concept in the lives of participants (Duran & Coloma, 2023), and the way in which that joy was brought into their clinical practice.

All participants expressed a 'joy in belonging' to their respective queer and trans communities, and a sense of pride in queer and trans culture as a whole. There is a wealth of research to show that finding community leads to resilience and promotes positive

identity formation in sexual and gender minorities (Meyer, 2014; Riggle et al., 2008; Robinson & Schmitz, 2021; Wright, Wachs, and Gamez-Guadix 2022). A study by Edwards et al. (2023) found that community connection brought about feelings of joy and support for sexual and gender minority participants, and strengthened their individual sense of authentic identity. The same study found that helping others through volunteering, activism or caregiving professions in general allowed for the development of resilience and self-esteem. Whilst this research does not speak to the experiences of queer and/or trans psychologists in particular, Edwards et al.'s (2023) findings are broadly supported by the theme of 'joy in belonging' in this study.

'Finding refuge' focused on the safety participants found in the collective as a resistance to oppressive contexts. For Kate, this oppressive context was within the profession. For Steve, it was within his personal life. Though each narrative was rooted in suffering rather than euphoria, each participant spoke both to a pain that was uniquely queer, and a relief that was found in the bonds of solidarity. The positive ripple effects that participants described once they leant into their 'safe others' echoes Ahmed's (2006) queer phenomenology, in which she advocates adopting a *"different orientation"* towards the systems of cis-heteronormativity, as this subversion "*may be the source of vitality as well as giddiness"* (p.4). By finding refuge in queer embodiment, Ahmed argues *"we might even find joy and excitement in the horror"* (p.4).

'Freedom to flourish' collected the common meaning that participants made of what was 'opened up' through the incitement of queer and trans joy. Each narrative that created this theme spoke to experiences of personal flourishing when supported in queer and trans-affirming professional environments. There is research looking at how 'inclusive' workplace

policies in general shape the wellbeing of queer and/or trans employees (Lloren & Parini, 2017; Mara et al., 2021; Hays-Thomas, 2022); but none looking at how working within the queer and/or trans sector impacts the relationship-to-self of queer and/or trans people. A significant body of literature has pointed to the positive correlation between queer and/or trans community connectedness and involvement in activism (Craney et al., 2018; Dunn & Szymanski, 2018; Harris et al., 2015, Montagno, 2021). For the participants in this study, having professional experiences that specifically empowered the aspects of their 'selves' that were 'uninvited' (Burnham & Nolte, 2020) in other professional contexts allowed them to experience queer euphoria.

3. Living in threat mode

All but two participants contributed to this superordinate theme, which comprised narrative of threat, battle and burnout whilst navigating queer and/or trans identities within clinical psychology. Whilst this psychological and physiological threat response has been well documented in everyday life for marginalised communities through research around the minority stress model (Meyer, 2003), it is notable that the experiences shared by participants in this study were specifically related to feeling unsafe within clinical psychology as a profession.

In the first sub-theme, 'covering and vigilance', H describes uncertainty about bringing her queerness to supervision, and the way in which this aspect of herself remains 'covered' as she has become accustomed to anticipating threat when interrupting heteronormative assumptions. Yoshino (2007) developed Goffman's (1963) concept of 'covering' to refer specifically to the cultural imperative experienced by minoritised groups to avoid confronting dominant norms. Whilst this process may lead to immediate self-

protection, Yoshino (2007) argues that covering ultimately undermines one's ability to experience full, authentic human prosperity.

Kate's experience of 'covering' was used for political ends, by gaining access to cis-heteronormative spaces through taking advantage of respectability politics (Higginbotham, 1992), and using her influence subversively once there. Though Kate's intentional use of 'the master's tools' (Lorde, 1984) may at first seem to continue to uphold the cis-heteronormative power relations she seeks to destabilise, she re-purposes the master's tools in the way that the master did not intend, thereby subverting the master's hegemony (Kloppenburg, 2014). Simultaneously, Lee and Hicken (2016) point to the psychological hazards of engaging in respectability politics, conceptualising the resultant vigilance as a *"death by a thousand cuts"* (p.421).

Jay's experience of being made to feel a token 'curiosity' in his previous role echoes narratives of tokenism that queer and/or trans professionals experience more widely (Baker & Lucas, 2017; Prock et al., 2019; Vitikainen, 2023). In a qualitative study of LGBTQ+ identified Canadian academics, Beagan (2022) found that participants frequently experienced their whole selves were reduced to their queerness, and their academic work dismissed as biased by their colleagues. Queer and/or trans people are often erased through cis-heteronormative discourses that do not acknowledge them, and when visible, are often treated as a curiosity to be examined (Dixon & Dougherty, 2014). In this way, they are both invisible and hyper-visible (Robinson, 2022). This has been described as 'role-encapsulation' by LaSala et al., 2008, in which queer and/or trans people find themselves constrained by the expectation of stereotypes.

This dialectic is reminiscent of a poem by Pat Parker (2000), 'For The White Person Who Wants To Know How To Be My Friend'. In two powerful lines, she captures the paradoxical 'how' of acknowledging the meaningfulness and significance of racial difference without contributing to the reduction of an individual as racially 'other':

"The first thing you do is forget that I'm black.

Second, you must never forget that I'm black" (p.73).

The sub-theme of 'battle fatigue' captured participants' experiences of exhaustion at challenging their own marginalisation within clinical psychology. Half of the participants spoke to this sub-theme in their narratives. 'Queer battle fatigue' (Wozolek et al., 2015), developed from Smith et al.'s (2009) works on 'racial battle fatigue', notes the emotional psychological and physiological tax of challenging one's own queer oppression. Elle's extract spoke to what Wozolek et al. (2016) refer to as *"the cartography of queer exhaustion"* (p.12), and the resulting choice not to challenge queer- and transphobia every time she experienced it at work. Ahmed (2014) borrows from Lorde (1988) when she speaks to the radical action of directing care towards ourselves when faced with a hostile world: *"For those who have to insist they matter to matter: selfcare is warfare"* (para. 40).

'Responsibility and burden' spoke to the cost of having the privilege to advocate for others in positions of lesser power. Five of the participants spoke to this dialectic. Allen (1990) describes the experience of being a role model, even if willingly accepted, as *"a special psychological burden"* (p.40). The responsibility placed on participants to mentor and advocate for others not only contributed to their experiences of pride, but also to those of battle fatigue. Furthermore, being positioned as queer and/or trans 'examplars' fails to acknowledge that participants are themselves minoritised individuals with increased

exposure to the environmental stressors that increase mental health vulnerability in those they are advocating for. Whilst burnout is well documented in literature focused on peer support within minoritised communities (Thomas, 2021; Worrell et al., 2022), this has not been addressed within the professional context of clinical psychology.

4. 'A punch in the guts': Profession as hostile

All but one participant experienced hostility directed towards them or other queer and/or trans people within the profession. As stated in the introduction, clinical psychology's documented history of theoretical pathologisation (Anderson & Holland, 2015; Feinstein et al., 2012; Herek, 2010; Meyer, 2003) and violent treatment (UNOHCHR, 2020) of queer and/or trans people is as old as the profession itself. This theme was formed through narratives of mistrust of peer professionals, experiences of personal wounding, and the overwhelming expression that psychology as a profession is institutionally transphobic.

In the sub-theme 'profession as performative', Cleo, Sage and H spoke to the feelings of disappointment and betrayal experienced towards their psychologist peers and mentors at the realisation that their allyship was at best performative, and at worst a veil for harmful views and practices. Whilst clinical psychology is grounded in an ethical framework of 'respect, competence, responsibility and integrity' (BPS, 2021), research by racialised clinicians demonstrates that the profession's stated values do not apply to everyone (Adetimole, et al., 2005; Odusanya et al., 2018; Paulraj, 2016; Wood & Patel, 2017).

Participants spoke to professional peers as performing a 'virtue signalling' (Bartholomew, 2015), whereby individuals demonstrate a solidarity with a social justice cause for the benefit of their own self-image. This demonstration is then coupled with a queer- or transphobic microaggression, undermining the sense of safety that was initially

created. Research by Beagan et al. (2020) and Woodford et al. (2015) implies that microaggressions are often unintended on the part of the aggressor, though the psychologically eroding effects on behalf of the aggressed include a sense of confusion, constant questioning and invalidation that the microaggression ever occurred.

Participants' narratives in the sub-themes 'profession as wounding' and 'psychology has a transphobia problem' pointed to experiences of overt queer- and transphobia from within the profession, directed towards themselves, service users, or their community as a whole. As outlined in the introduction, queer and/or trans people are over-represented in mental health services (Fish, 2020) and report poor experiences within them (Bettergarcia et al., 2021). At the time of writing, there was no other research looking at the experiences of queer and/or trans clinical psychologists within the profession. This is most concerning with regards to the findings within these sub-themes, as it demonstrates a lack of curiosity and self-reflection on behalf of the profession as to its socio-political context and its continued violence towards minoritised groups (Paulraj, 2016).

Almost all participants made reference to overt hostility or anti-trans propaganda happening on professional social media forums, to the extent that a separate closed 'LGBTQ+' Facebook group was formed to offer emotional peer support to those who felt wounded by the rhetoric. Since clinical psychology training courses often cover very little on queer and/or trans lives, for many clinicians, these mainstream forums are their only exposure to this material, and an important opportunity to interact with ideas around sexual and/or gender diversity (Psychologists for Social Change, 2021). This makes queer- and transphobic rhetoric in these spaces even more troubling and professionally consequential. In another example of how psychology both informs and mirrors discourses

outside of the profession, it is perhaps unsurprising that queer and trans communities experience discrimination, a lack of understanding and reinforced stigma when accessing mental health services (Rees et al., 2020).

Almost all participants made reference to feeling actively surprised, relieved, or anxious to have the opportunity to speak to a research question centred around their lived experiences. Most of these utterances occurred outside of the recorded interview, and were therefore not able to be included in the results, but they are somewhat represented in the verbal hesitation and tentativeness present in many of the excerpts used. This sense of surprise is perhaps a felt response to the profession not asking, not valuing, or perhaps not wanting to know the answer to the question: *"what is it like for you, here?"*.

5. Living and working in community

All but once participant spoke to this superordinate theme, which spoke to the various dynamics of both identifying with and working alongside queer and/or trans communities. In the sub-theme 'loss of elders', participants reflected on the particular ways that the absence of queer and/or trans role models left them feeling the need to dissociate their lived identities from their professional ones. Morris et al. (2022) point to cis-heteronormative institutions such as schools and higher education as the location of excluded legacies. They posit that generation after generation of queer and/or trans people have their own histories and inherited knowledges erased, leaving them *"left to fend for themselves"* as they approach adulthood (p.929). This is in part due to queer and/or trans narratives being purposely excluded from pedagogy in general (Quinn & Meiners, 2011), and the legacies of Section 28 of the Local Government Act, a homophobic Thatcherite policy which in the UK prohibited schools from teaching *"the acceptability of homosexuality*

as a pretended family relationship" (Lee, 2019, p.675), referenced by six out of the eight interviewed participants as playing a pivotal role in their early understandings of shame as related to their developing identities. Further compounding the erasure of queer and trans ancestry are the decades of criminalisation and pathologisation (Mackle, 2021), in which psychology played no small part (Drescher, 2015), and the *"epidemic of stigma"* (Herek, 1988, p.886) that fed into political inaction around HIV/AIDS. The loss of intergenerational dialogue that participants spoke to in this study is captured by Morris et al. (2022) as a *"queer heartache"* (p.928).

The sub-theme 'overlapping lives' explores how this lack access to wisdom from elders left participants navigating clinical issues with their queer and/or clients without leadership from supervisors who had experience of navigating similar complexities. As Davis (2023) points out, the lenses available to navigate and reflect on these unique challenges are largely cis-heteronormative, and do not speak to the interconnectedness that comes with belonging to a minoritised community. Furthermore, Everett et al. (2013) describe normative guidance around 'dual relationships' as leaving queer and/or trans practitioners open to judgement and accusations of unprofessionalism, leading to self-surveillance and resignation from community resources that have been implicated elsewhere as necessary to combat minority stress (Meyer, 2014). Queer and/or trans psychologists are largely left to use their own intuition on navigating the ethics of overlapping lives. Davis (2023) asserts that for those living and working within the queer and trans community, having a clinical supervisor that is knowledgeable and competent in working with gender, sexuality and relationship diversity is essential in ethically meeting the needs of one's clients and oneself.

The one participant who did feel adequately supported in this navigation was Jay, who in the final sub-theme, 'solidarity', spoke to the pivotal aspect of having a queer supervisor to help him manage his own felt despair at supporting his own community during times of cultural onslaught. Reynolds et al. (2021) suggest that solidarity, not hope, is the antithesis to hopelessness in justice-focused psychology. They suggest that building an intentional 'solidarity team' around oneself as a practitioner is essential to sustain ethical, spirited and hopeful practice. Through narrative supervision with an experienced queer elder, Jay was able to 'double-story' his felt hopelessness, allowing his supervisor to draw out more than one story to open up stories of connection and survival (White & Morgan, 2006). This allowed him to 're-member' *"the history that stands behind"* (White, 1997, p.81) the clinical psychologist he wants to be and stance of solidarity he wants to take in relation to his queer and trans community.

Limitations

This research was not without its limitations. These are largely grouped into two categories: limitations arising from the sample, and limitations arising from the methodology. First, the small sample of this study, whilst appropriate for the depth of analysis required for IPA, prevents any attempts to generalise findings. Though the sample was diverse in that it represented a variety of sexual and gender minority expressions, no other diversity characteristics were recorded. Two participants spoke about having a disability or neurodivergence, though none spoke of their positionality with regards to class, religion, racialisation, or any other social GGRRAAACCEEESSS (Burnham, 2012). As such, the narratives captured do not claim to speak to the experiences of clinicians who have had to navigate their professional lives at an intersectional nexus with any other minoritisation,

and more research is needed in this area. All but one participant lived in urban areas, which is broadly representative of queer and/trans communities in general (Office for National Statistics, 2021), though future research should consider the particular vulnerabilities of queer and/or trans people living in rural environments, who may have less access to community belonging highlighted as important to the participants in this study. Though a sample size of eight participants was chosen to satisfy the expectations of the DClinPsy thesis, it became clear through the process of analysis and write-up that a slightly smaller sample of six participants would have been more appropriate to be able to include more of the rich data that was generated through interviews. In retrospect, I believe this may have also made the emotional labour of analysis more manageable, being that I wouldn't have had quite as much to 'hold'. This is elaborated on in the critical appraisal.

The methodological decisions around language use in this study may have limited the results in a number of ways. Firstly, the research advert (Appendix 1) invited 'queer and/or trans' clinical psychologists to take part. As discussed in the introduction, the term 'queer' was purposefully chosen to be as inclusive a term as possible, speaking to anyone who self-identifies as living outside of the confines of cis-heteronormativity, and is minoritised as a result. However, as referenced in the discussion, 'queer' carries with it a political energy, is historically a pejorative term, and may not speak to everyone that this study intended to address. In every social media forum that this advert was placed, prospective participants commented with questions such as *"I identify as bisexual, can I take part?"*, or *"why did you not use the term LGBT?"*. In each of these instances, I responded with an explanation which indicated an intention to be as inclusive as possible, whilst recognising the confines of language to capture complex experiences. However, the final sample of participants may have been biased towards my chosen language, thereby

generating themes that may have been unique to their 'queer' worldviews. Furthermore, by including the opening line *"I am a queer trainee clinical psychologist"* in my research advert, I intended to signal an invitation of safety, and counter any concern that I might have voyeuristic or exploitative research intentions. However, this statement could have precluded potential participants who did not have a positive identification with my use of language, or the idea of belonging to a queer and/or trans community more generally. Another methodological limitation was the length and breadth of the interview schedule. Though having ten open-ended questions generated rich data, some of this richness was not able to be captured in the thesis due to the limited scope of the research question. This is also explored in greater depth in the critical appraisal.

Finally, the implication that there is such thing as 'a queer and/or trans experience' or a 'queer and/or trans community' warrants curiosity. The first question on the interview schedule was *"can you tell me in your own words how you identify in terms of your sexual orientation and gender identity?"*, and I was cautious to refer only to participants' own self-identification in the remainder of the interview. However, in the process of analysis, participants' personal emergent themes were collected into general emergent themes alongside their peers in the study. Though great care was taken to maintain the idiographic meaning-making of each participant, the process of grouping these themes and interpreting results meant that the particular nuances between participants may have been flattened slightly, giving way to the false representation of a homogenous queer and trans community, or a single experience within it. Though viewing queer and/or trans people as a monolithic group is to be avoided, Plotegher (2021) points to the concept of 'transversality' to describe the intersection of space between queer and/or trans people: *"the coming*

together of otherness within otherness, we [are] *all queer but we were all so amazingly different from each other"* (p.144).

Implications

The following clinical implications and areas for future research are suggested:

For training courses

- Step one (*before* any attempts to 'diversify the curriculum'): For the profession to move towards developing a critical engagement with its own active part and complicity with violence towards queer and/or trans people, through a reflective introductory curriculum specifically addressing this on DClinPsy training programs.
- Step two (*only* after step one): For queer and trans lived experiences to be thoughtfully integrated throughout the curriculum, and not confined to social GGRRAAACCEEESSS groups or teaching on diversity and 'difference'. For this to be a demonstrated requirement for all lecturers.
- For the curriculum to mainstream contributions from queer and/or trans psychologists, philosophers and researchers, and to challenge cis-heteronormativity in its reproduction of knowledge in teaching.
- For thesis project proposals on minoritised experiences to be actively encouraged and appropriately supported by supervision from queer and/or trans elders.
- For teaching staff, tutors and research supervisors to attend critical consciousness working groups to consider how they might be upholding cis-heteronormativity in their practices with trainees and colleagues.
- To set up protected space for minoritised trainees to support and mentor one another across cohort groups.

For research and clinical practice

- More research into the lived experiences of queer and trans people in general and clinicians in particular – moving beyond solely focusing on a deficit *or* a strength perspective.
- More research specifically concerning the experiences of trans and gender expansive clinicians, given the prevailing currents of transphobia within and outside of the profession.
- The creation of Trust- or department-wide queer and trans researcher and clinical supervision spaces, to allow for mentorship and modelling.
- The facilitation of intergenerational dialogue projects to strengthen marginalised communities and allow for positive identity development.
- For clinical supervisors to receive training on how to reflexively support minoritised supervisees.
- For the development of guidance on how to create affirming and queer-positive psychology team cultures to be led by queer and trans clinicians and researchers, and be appropriately renumerated, rather than taken on as additional labour within pre-existing job descriptions.

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Part 3: Critical appraisal

Critical Appraisal

This critical appraisal comprises a summary of reflections that were noted throughout the writing of the thesis. It will reflect on three themes: (1) the 'novelty of being asked', (2) 'lost stories', and (3) the ethics of researching one's own community.

1. The 'novelty of being asked'

All participants reflected either explicitly or implicitly on the novelty of being asked about their meaning-making experiences of bringing their lived identities into their work. For Steve, this brought about a surprise in his own responses: "*So, psychology and gayness - D'you know, they have been really closely linked. They have been. I'd forgotten - I hadn't noticed that. Er. Good observation"* (Steve, p.9:1-3). Steve later goes on to reflect upon this revelation more emphatically: "*Oh my god, psychology and gayness are so linked in my life! I totally never noticed that!"* (Steve, p.10:23-24).

For others, the implication that they had not previously been asked about their experiences is reflected in the verbal utterances of hesitation, such as the use of 'erm', 'umm' and 'I guess…', as if they were asked to speak to their experiences for the first time. Sage responded to my prompts with *"that's a good question"* or *"that's an interesting question"* eight times in the duration of the interview, implying they had not been asked before. Cleo expressed a direct appreciation for my research interests: *"The kind of research that you're doing, I'm so delighted to see this happen*" (Cleo, p.16:16). Elle's response to the first question on the interview schedule was *"Gosh, like therapy time, Jess"* (p.1:8), implying she felt slightly caught off guard by my curiosity into a part of the life she did not routinely talk about.

All of these responses led me to deduce that there was a novelty in being asked to speak to the experience of being a queer and/or trans clinical psychologist. The troubling conclusion I drew from this confirmed my initial assumption that this research was important to fill the gap in the profession's curiosity about its own violent legacies and current practices that marginalise its queer and/or trans members. It showed that participants were not routinely invited or supported to reflect on this aspect of their positionality during training or supervision.

Foucault (1977), often considered one of queer theory's founders, speaks to power as coming in two overlapping forms: discursive and repressive. Discursive power is derived from knowledge. Repressive power silences and punishes those at the margins who are not allowed to speak. When certain knowledge production is restricted or ignored, and other discourses are rewarded and reproduced, citizens are unable to resist repressive power through knowledge (Eliason et al., 2010). Given what has been outlined in detail in the conceptual introduction, psychology's marginalisation of queer and trans communities has been far from inadvertent. It has been documented that queer and/or trans academics find their research regulated and unsupported by their institutions (Beagan at al., 2021; Veldhuis, 2022), especially in the fields of education and psychology (Davies & Neustifter, 2021). When discourse production is limited, there is nothing to challenge the normative practices that uphold repressive power.

By asking a novel question, my sense was that participants shared their stories with me as if they had been sitting on those stories without the opportunity to be witnessed. Whilst conducting truly novel research is generally considered valuable, this scenario brought to light the ethical difficulty of what to do with data that went far beyond the scope

of the research question or the word limit of the thesis. This ethical difficulty is discussed in the following theme, 'lost stories'.

2. 'Lost stories'

Throughout the process of this research, I had to continuously remind myself of the research question: *'how do queer and/or trans clinical psychologists bring their lived identities into their practice?'*, and kept a post-it note of this question on my keyboard. This served the purpose of grounding me in the purpose of the study, but also forced me to maintain a shrewd focus on what was relevant to the question during analysis. Due to what has been outlined in theme 1, the 'novelty of being asked', participants shared rich narratives of their coming out stories, growing up with a sense of shame and otherness, experiences of loss, suffering, of joy and of the erotic. They spoke to what their lived experiences meant to them in their roles as parents, as their parents' children, as community organisers, as partners and ex-partners. Whilst the interview schedule was semi-structured, the responses that the questions elicited went far beyond the scope of the research question.

I experienced feelings of betrayal as I went through the process of analysis and cut all the narratives that did not directly pertain to the research question. Holding my participants in mind throughout each stage of the analysis and asking myself, *"would Sage feel fully seen in this analysis?"*, *"would Elle feel like I fairly represented her story?"* was both a useful way of holding myself to account throughout the write-up, whilst also engendered a sense of profound guilt that I could not do justice to all that had been shared with me. Two

themes that could not make it into the results, as they did not explicitly address the research question, are shown in Table 1 below.

Table 1

Excluded themes

Superordinate Themes	Subthemes	Dom	H	Cleo	Sage	Elle	Jay	Steve	Kate
Self as shameful	Early schemas of QT shame								
	Homosexual perversion								
Psychology as framework for survival	To understand others								
	To understand myself								

Though I am not able to present these results in full, I will give a brief overview of what was named. The themes displayed in Table 1 show that almost all participants received early messages that being queer and/or trans was shameful, disgusting, confused, or morally wrong. Cleo spoke to receiving this message from the first clinical psychologist they saw for therapy, whereas most others were told by their parents or peers at school. Sage and Jay made explicit reference to the impact of growing up under Section 28, and Jay spoke of the prevailing belief that being gay meant one would die from AIDS. Both Steve and Jay described feeling vigilant when working with young people, as they were all too familiar with tropes of 'homosexual perversion' and accusations of paedophilia or sexualising their young clients because they were gay men.

H, Cleo and Sage spoke to early motivations to seek careers in psychology in order to understand others. For Sage, this was rooted in the experience of childhood trauma and

abuse, and the belief that if they could understand others' behaviour, they could keep themselves safe by manipulating it. For Cleo and H, this was rooted in identifying from young ages that they were skilled at supporting their peers at school or university that were experiencing distress. Dominic, Sage, Elle and Steve all spoke of finding their roles as psychologists useful at different times in their lives as a framework to understand their own suffering. Dominic and Elle spoke about this with regards to the turmoil of coming out as adults, with marriages and children that were inevitably affected by the turbulence of their changing lives. Steve hoped that studying psychology would help him understand himself as a young man, and in particular, to understand why he was gay.

It is notable that one participant, Dominic, does not feature in many of the themes that became part of the final write up. Dominic's interview was the first one conducted out of the eight. I had not yet become comfortable with the interview schedule, nor the flow of structuring participants in line with the research question. Given the extremely personal and sensitive nature of what many of the participants brought to the interview, I was cautious not to interrupt or redirect anyone, out of concern that this would feel like I was distracted or unsympathetic. Instead, I found myself with a different ethical dilemma: allowing participants to speak freely on matters that could not be included in the research due to the divergence from the focus of the research question, and the limitations of the scope of the thesis.

Having come out relatively recently, Dominic shared generously his experiences of suffering in his journey to live more authentically, and the pain he had to cause his loved ones in order to actualise that authenticity in his life. Dominic was very emotional from the beginning of the interview, and I found myself slipping outside of 'researcher' mode and

into ‘therapist’ mode. On reflection, I believe this is what was called for in the moment. Mearns and McLeod (1984) note the similarity between phenomenological research interactions and psychotherapeutic relationships. Both value the primacy of experiencing, the respect for the meaning-making of others, an emphasis on the interpersonal, and a search for authenticity. However, this dynamic does raise ethical dilemmas.

Hart and Crawford-Wright (1999) point to the difference between a research interview and a therapy session as the former dynamic involving the participant helping the researcher, and the latter, the therapist as helping the client. My sense is that, for some of the participants in this study, this distinction was not as binary as Hart and Crawford-Wright (1999) put forward. Given what has been discussed in the first theme of this critical appraisal, giving participants the opportunity to speak to questions that they had not been asked before was *both* a cathartic experience for participants, and a rich location of data gathering for me. Nevertheless, this left me with the predicament of losing the majority of Dominic’s interview data as much of it involved the meaning-making of his coming out process and related *“unstifling”* (p.19:8) identity development, rather than how he brought these experiences to his clinical practice. On reflection, I believe that the questions on my interview schedule could have been more focused, in order to better contain the interview experience for participants, and reduce the ethical dilemma I found myself left with. I decided to write to each of my participants ahead of submitting this thesis, to thank them for sharing their rich stories with me, and let them know that I could only do justice to parts of them. Whilst the fullness of what was shared could not be included in the write up, their narratives were witnessed, rather than lost.

Whilst I at times found myself shifting between researcher and therapist, I also at times found my role shifting between researcher and peer. This dynamic will be explored in the final theme, 'the ethics of researching one's own community'.

3. The ethics of researching one's own community

Much has been written within feminist research methods around the ethical complications of insider/outsider dynamics in qualitative fieldwork (England, 1994; Finlay, 2002; Muhammad et al., 2015; Wilkinson & Kitzinger, 2013). Those who engage in 'insider' research – those who are members of a community they are studying – are more likely to experience accusations of self-indulgence or have their work derogatorily labelled as 'mesearch' (Davis & Khonach, 2020; Harris, 2021), especially if that community is minoritised (Velthuis, 2022). However, within-community research has been evaluated as important and illuminating, allowing researchers unique insight into their participants' experiences and easing rapport (Muhammad et al., 2015). I have addressed some of the ethical quandaries of within-community research in the methodology section of this study. Without being able to adequately explore this complex topic in full, this section of the critical appraisal will consider just three aspects: (a) fluid power, (b) signalling safety, and (c) emotional labour.

a. Fluid power

Schulz (2021) recognises that research participants have multiple and fluid positionalities and challenges the dominant portrayal of inevitably vulnerable 'subjects' that need protection from the omnipotent 'expert' researcher. Instead, Schulz argues that roles within the research dynamic can occupy power in fluid, rather than static ways, more accurately mirroring the lived realities of relationships. In interrogating my own

positionality, I am drawn to Muhammed et al.'s (2015) notes on the intersubjective: *"Identity is not a static concept, and insider-outsider boundaries are ever-shifting with tensions continually navigated"* (p.8). In the context of this study, power operated in dynamic ways. Though my own role conferred power by setting the research parameters, asking the questions that were of interest to my research aims, and conducting the analysis and write-up through my own positionality, power operated 'upwards' in that I was interviewing participants who were all more senior in my profession than me. In a profession that is steeped in hierarchy (Goodbody & Burns, 2011; Ussher, 2006), I found myself in an uncommon position as a trainee to be holding a containing space for my professional superiors. Simultaneously, there were many moments during the interviews that I felt power was horizontalized in a way that I do not believe would have happened had I not been a queer researcher conducting queer research. This will be discussed in the next two sections.

b. Signalling safety

In this current study, the research relationship between myself and participants began by me positioning myself in relation to them in the research advert (Appendix 1): *"Are you a qualified clinical psychologist in the UK? Do you identify as queer and/or trans? I am a queer Trainee Clinical Psychologist at UCL".* Leading with my own identity was a deliberate choice to signal to prospective participants from the outset that they could assume a degree of safety from someone within their community, and to dispel any suspicions that my intentions were voyeuristic or malicious. I received feedback from several participants that this early coming out on my behalf encouraged them to respond to the advert. I also signified that I was an insider by my placing of the advert in the closed LGBTQ+ Facebook group, of which I was already a member, open only to those who respond to a set of

questions to ascertain they self-identify in line with the group's description. Cleo stated during the research process that they had a familiarity with my name from also signing an open letter against transphobia in the profession, and therefore felt they could safely speak with me:

> I think you may have signed the letter, actually. There was the - the position statement – for - for the ACP [Association of Clinical Psychologists], and so we wrote a response to that, and I think I saw your name come up on it. Um. And I think that's the kind of thing that feels really recharging, and really, sort of - good, to - to have that experience, um, and to see that happen (p.21:7-13).

I was not aware prior to the interview that Cleo had already seen evidence of my activism, and I wondered how much this 'proof' of my intentions allowed them to open up to me during the interview. My own experience of this moment was one of a flattening of power and a genuine shared connection. I also left the interview feeling recharged and energised by our exchange, and yet also aware that our dialogue became more conversational after this moment. Ultimately, I reflect on this more casual dialogue as gleaning even richer and more organic insights into Cleo's experiences, though a critical consideration may be important to think about what might have been 'shut down'. Taylor (2011) has spoken to the complexities around blurring boundaries of researcher/participant shifting into friend/peer in qualitative research. Though there were definite shared experiences between Cleo and I, this may serve as a good example of where I might have flattened our differences.

Cleo, who self-identifies as an agender queer femme, is differently affected by the consequences of the open letter that we both signed. For them, their experience of being a gender non-conforming person in a profession with a 'transphobia problem' is felt on a different, more embodied level than it is for me, a cis queer woman. Furthermore, the risks they took by signing their name on the open letter were greater than those taken by me. Going beyond allyship, I strive to be an active co-conspirator (Crawley, 2021) of trans justice and dignity, seeing my own liberation as an intersectional queer feminist as inherently bound up in the liberation of all those who suffer under cis-heteropatriarchy. I myself feel belonging within a larger queer and trans community. However, the idea that there *is* such thing as a homogenous, monolithic community should be troubled, especially given the amount of inequality and prejudice that is experienced within and between members of this 'group', especially those minoritised because of their gender identities (Formby, 2017). I reflected back on this interview wondering if I had made Cleo feel more seen by shifting role from researcher to peer, or if my assumptions of sameness had flattened the important ways in which our lived experiences were different.

c. Emotional labour

Nelson (2020) speaks to the emotional impact of conducting what they term 'being/doing' research within queer and trans communities, ranging from euphoria to retraumatisation. They speak to the concept of 'emotion management' – the roles that researchers adopt to contain their participants' emotions, despite how they themselves are feeling in response to their narratives. Through the process of writing this thesis, and in particular the qualitative paper, I experienced intense feelings of joy and connection, I felt energised and 'fired up', and a profound appreciation for my own queerness. I experienced

the radical intimacy of my own community and never once felt like I did not know what to write about - perhaps what Nelson (2020) themselves experienced as 'euphoria' in their own research.

Simultaneously, the endless hours of reading minority stress research was *stressful*, the process of witnessing stories of deeply distressing queer- and transphobic violence was painful, and re-living those stories through transcription and the repetitive analysis involved in IPA was emotionally exhausting. For reasons discussed elsewhere in this critical appraisal, I was not able to include all of the stories shared with me in this research. This made the narratives of child abuse, bullying, grief and sexual violence that I witnessed even harder to process, as I had nowhere to 'put' them. Some of these stories echoed my own in ways that felt searingly painful, and travelled with me to therapy many times over the research period – perhaps what Nelson (2020) experienced as 'retraumatisation' in their research. An extremely powerful and moving sense of 'purpose' is part of what sustained me in this research process, alongside the strength of my own solidarity team (Reynolds et al., 2021). Future researchers should not be discouraged from doing work that highlights injustice and restores dignity to minoritised voices on the basis that doing this work often involves having 'our hearts broken' (Afuape, 2012). However, future researchers are strongly encouraged to consider what support in available to them in their own solidarity teams, including whether their supervisory relationships are safe and sensitive enough to be 'shouldered up' through the heartbreak (Reynolds, 2011).

In drawing this paper to a close, I am reminded of the first sub-theme in the results: 'the psychological is political'. In embarking on psychological research and practice with a liberatory purpose and a queer worldview, I am disrupting the discursive silence that allows

repressive power over queer and trans communities to continue within the profession. I am reminded of a quote by Frazier (2021) which propelled me through this work in the most uncomfortable moments: *"Discomfort produces visceral reactions that can lead to reflection, and in this reflection is the capacity for political action"* (p.1).

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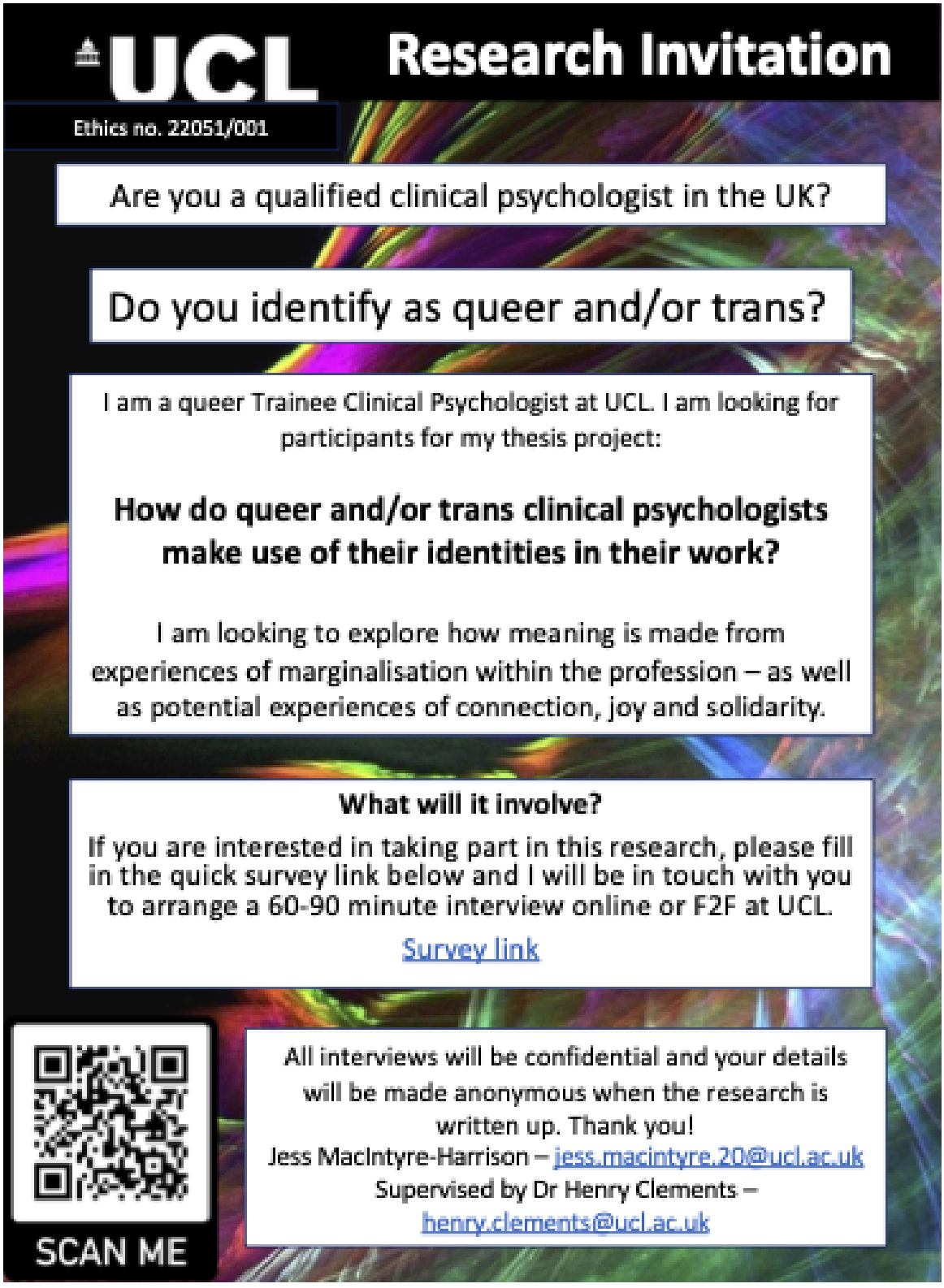
Appendices

Appendix 1: Research advert



Appendix 2 – Ethical approval letter

UCL RESEARCH ETHICS COMMITTEE
OFFICE FOR THE VICE PROVOST RESEARCH

27th May 2022

Dr Henry Clements
Faculty of Brain Sciences
UCL

Cc: Jess MacIntyre-Harrison

Dear Dr Clements

Notification of Ethics Approval
Project ID: 22051.001
Title: How do queer and/or trans clinical psychologists make use of their identities in their work.

Further to your satisfactory responses to the reviewer's comments, I am pleased to confirm that your study has been ethically approved by the UCL Research Ethics Committee until **27th May 2023.**

Ethical approval is subject to the following conditions:

Notification of Amendments to the Research
You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form' - https://www.ucl.ac.uk/research-ethics/responsibilities-after-approval

Adverse Event Reporting – Serious and Non-Serious
It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol.

The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Office of the Vice Provost Research, 2 Taviton Street
University College London
Tel: +44 (0)20 7679 8717
Email:ethics@ucl.ac.uk
http://ethics.grad.ucl.ac.uk/

Final Report

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research
- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely

Professor Michael Heinrich
Joint Chair, UCL Research Ethics Committee

Appendix 3 - Participant Information Sheet

Participant Information Sheet

UCL Research Ethics Committee Approval ID Number: 22051/001
YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET
Project Title: How do queer and/or trans clinical psychologists bring their lived experiences into their practice?

Department: Research Department of Clinical, Educational and Health Psychology

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Name of the Researcher: Jess MacIntyre-Harrison – jess.macintyre.20@ucl.ac.uk
Name of the Supervisor: Henry Clements – henry.clements@ucl.ac.uk

You are being invited to take part in a research project. Before you decide to take part in this study it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and discuss it with others if you wish. I can be contacted on the above email address (jess.macintyre.20@ucl.ac.uk) if there is anything that is not clear or if you would like more information.

Please take time to decide whether you wish to take part. Thank you for reading this.

Purpose of the study

Psychological research on LGBTQ+ communities is generally focused on mental health with a deficit perspective, drawing on the minority stress model (Brooks, 1981; Fingerhut, 2010; Meyer, 2014). Whilst the positive contribution of this research has been enormous in its efforts to highlight the psychological and physiological consequences of discrimination of minoritised communities, the framework within which this research is located has been criticised for its reliance on a biomedical model, and calls have been made to study the wellbeing and resilience of these communities with a positive psychology lens (Meyer, 2014). I am curious about considering how queer and/or trans people might reflect on what their identities might "open up" as well as "close down" for them in their roles as clinical psychologists. I am looking to explore how meaning is made from experiences of marginalisation within the profession – as well as potential experiences of connection, joy and solidarity. This study seeks to gain a fuller understanding of how queer and/or trans clinical psychologists make use of their identities and lived experiences in their work.

Can I take part?

I am looking to recruit between 8-10 participants for this study. You are eligible for inclusion if you are a qualified clinical psychologist in the UK that self-identifies as queer and/or trans. In the event that the number of people interested in participating exceeds 10, we will select participants as far as possible to reflect a diversity of identities. Therefore, if we exceed the recruitment target, it is possible that you will not be chosen to participate in the study.

Do I have to take part?

You do not have to take part and you can also withdraw without giving a reason and without any negative consequences. If you wish to withdraw, there is a cut-off point of one week post-interview to request to have your data destroyed and not used in the study. Please contact me by email at jess.macintyre.20@ucl.ac.uk to discuss this. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form.

What will happen to me if I take part?

If you take part in the project you will be interviewed by me (Jess MacIntyre-Harrison) over Zoom or face-to-face at UCL premises in central London. Interviews are expected to last between 60-90 minutes. In the interview you will be asked about your experiences of being queer and/or trans and how you experience your identity in your work.

You will be asked to choose your own pseudonym at interview. The discussion will be **audio recorded** and transcribed. Recordings and transcripts will be **identified only by your pseudonym** and they will not be used or made available for any purpose other than the research project. Your anonymity will be protected as only the pseudonym will be used to identify the transcript. Your name will not be included anywhere in the transcript. I may quote you directly in the project write up. If this is done your anonymity will be preserved.

All recordings will be held on an encrypted password-protected USB stick and will be transcribed from this encrypted memory stick directly on to a separate encrypted memory stick as soon as possible after the interview. The recording of each interview will be destroyed as soon as the interview has been transcribed. In the unlikely event that you disclose identifying or potentially identifying information in the interview, this information will so far as possible be removed at the time of transcription. As a further precaution the encrypted memory sticks will be stored in a locked box when not in use and only I will have the key to this box. The pseudo-anonymised transcripts will be kept securely and for up to 5 years post research submission as they may be used by the researcher for future projects.

Travel expenses

If you live within Transport for London zones 1-6, and you choose to meet me face-to-face for your interview, your travel expenses will be reimbursed up to the value of a TfL zone 1-6 travelcard.

Are there possible disadvantages and/or risks in taking part?

You may find aspects of this interview distressing as I'll be asking for your experiences of being a person with a minoritised identity, and possible experiences of marginalisation in your life and within your field as a clinical psychologist. You do not have to answer any questions that you are uncomfortable with. At the beginning of our interview, I will remind you that you have control over the length and content of the interview. We will make an agreement beforehand about what you would like me to do if you become distressed.

We hope that you feel you can speak freely in the interview but acknowledge for some this may mean disclosing difficult experiences in particular NHS trusts, services and/or academic institutions. You will be asked to choose a pseudonym to maintain your anonymity, and all names of identifiable services or academic institutions will be generalised. For example, "Barts NHS Trust" would be generalised to "an NHS Trust"; "UCL" would be generalised to "a university"; "Simmons House" would be generalised to "an adolescent impatient unit" etc. If you have any specific concerns about this or you would like other specific details generalised to protect your privacy, please speak to the researcher. You can request to choose a copy of the interview transcript, and can request any amendments to the transcript up to one week after it has been emailed to you.

One of the motivating factors for this research is the current (and historic) hostile environment that faces psychologists of minoritised queer/trans identities, and the desire to give voice to experiences of these practitioners. There is a small risk of specific experiences you describe in the interview being familiar to a reader and for your identity, though pseudonymised and protected as much as possible, to be guessed. However, given that the reach of this project's recruitment is national, that you are asked to choose your own pseudonym and that all affiliations will be removed or generalised, this risk is kept at a minimum.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those participating in the project, it is hoped that taking part in this research will potentially allow for experiences of catharsis, self-acknowledgement, empowerment, and will give voice to a community that has been historically pathologised and largely overlooked in research. This in turn should contribute to a fuller understanding of the experiences of queer and/or trans clinical psychologists, and may encourage other psychologists with minoritised identities to consider how they might draw on those experiences in their work.

What if something goes wrong?

If you wish to make a complaint, please contact Dr Henry Clements (the supervisor and Principal Investigator for the study) at henry.clements@ucl.ac.uk. If you feel that your complaint has not been handled to your satisfaction, you can contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk. If something happens to you during or following your participation in the project that you think might be linked to taking part, please contact the Principal Investigator.

Will my taking part in this project be kept confidential?

The interviews will be recorded and identified only by a pseudonym, and the data will be kept on an encrypted memory stick which will be stored in a locked box when not in use. The recording of each interview will be destroyed as soon as the interview has been transcribed. Any identifying or potentially identifying information will so far as possible be removed at the time of transcription.

Your personal identifiable information (name and email address) will be kept on a separate encrypted device until publication of research and for a maximum of 5 years, unless you have indicated on the consent form that you do not want to receive a copy. In this case, we will delete your information once the researcher has passed the Doctorate in Clinical Psychology course (anticipated to be September 2023).

All personally identifiable information will be kept confidential between the researcher and research supervisor, subject to the limits to confidentiality below.

Limits to confidentiality

Although everything you say will be kept confidential and anonymised so far as possible, if I have concerns that there is a risk to yourself or others, then I might have to break confidentiality and let relevant others know. I would inform you if I am going to do this, unless I believed it would increase the risk.

What will happen to the results of the research project?

The write-up of this project will be part of my thesis and published online. The project may be published in an academic journal. You will not be identifiable from the write-up of the project. If at any stage you wish to receive further information about this research project, or you have any questions or concerns please do not hesitate to contact me at jess.macintyre.20@ucl.ac.uk.

Local Data Protection Privacy Notice

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice for participants in research studies which is available here.

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

Personal data will not be sought in this research. As stated above, in the unlikely event that you disclose identifying or potentially identifying information which constitutes personal data in

your interview, this identifying or potentially identifying information will so far as possible be removed at the time of transcription.

The controller for this project will be University College London (UCL). UCL has appointed a Data Protection Officer who has oversight of UCL activities involving the processing of personal data. If you are concerned about how your personal data is being processed, or if you would like to discuss your rights in relation to personal data, please contact the UCL Data Protection Officer at data-protection@ucl.ac.uk. UCL can also be contacted by telephoning +44 (0)20 7679 2000 or by writing to: University College London, Gower Street, London WC1E 6BT.

Personal data, or personal information, means any information about an individual from which that person can be identified. It does not include data where an individual's identity has been removed (anonymous data). In this study, the lawful basis that will be used to process your personal data is 'Public task' for personal data. However, personal data will not be sought in this study and if disclosed will be removed so far as possible at the time of transcription.

Special category personal data means any personal data that reveal racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, health (the physical or mental), sex life or sexual orientation, genetic or biometric data. In this study, the lawful basis for processing any special category personal data is for scientific and historical research or statistical purposes.

As stated above, you have the right to withdraw from the study at any time and to request that all your data are immediately destroyed.

The retention periods for data have been set out above.

Complaints

If you wish to complain about our use of personal data, please send an email with the details of your complaint to the UCL Data Protection Officer so that they can look into the issue and respond to you. Their email address is data-protection@ucl.ac.uk.

You also have the right to lodge a complaint with the Information Commissioner's Office (ICO) (the UK data protection regulator). For further information on your rights and how to complain to the ICO, please refer to the ICO website: https://ico.org.uk/

Thank you for reading this information sheet and for considering taking part in this research study.

Appendix 4 – Consent Form

CONSENT FORM FOR PARICIPATION IN RESEARCH

Please complete this form after you have read the Information Sheet.

Title of Study: How do queer and/or trans clinical psychologists make use of their identities in their work?

Department: Clinical, Educational and Health Psychology

Name and Contact Details of the Researcher: Jess MacIntyre-Harrison; jess.macintyre.20@ucl.ac.uk

Name and Contact Details of the Supervisor and Principal Researcher: Dr Henry Clements; henry.clements@ucl.ac.uk

Name and Contact Details of the UCL Data Protection Officer: Alexandra Potts data-protection@ucl.ac.uk

This study has been approved by the UCL Research Ethics Committee: Project ID number: 22051/001.

Thank you for considering taking part in this research, which is my thesis for my Doctorate in Clinical Psychology. If you have any questions arising from the Information Sheet or explanation already given to you, please ask me before you decide whether to participate. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick
1.	I confirm that I have read and understood the Information Sheet for the above study.	
2.	I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction.	
3.	I would like to take part in an individual interview.	
4.	I consent to participate in the study. I understand that my personal information will be used for the purposes explained to me. This includes: 1. My email address (for correspondence only) 2. My phone number (for correspondence only) 3. My chosen pseudonym (for use in the thesis) 4. My self-described sexual orientation and gender identity (for use in the thesis) I understand that according to data protection legislation, 'public task' will be the lawful basis for processing. I understand that according to data protection legislation, 'research purposes' will be the lawful basis for processing special category data.	
5.	I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified. I understand that my data gathered in this study	

	will be stored securely and pseudonymised. It will not be possible to identify me in any publications.	
6.	I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.	
7.	I confirm that no guarantee of benefits have been made to encourage me to participate in this research.	
8.	I understand that if the researcher has concerns that there is a risk to myself or others, then confidentiality might need to be broken. I also understand that the researcher would inform me if confidentiality is going to be breached, unless she believed it would increase the risk.	
9.	I understand that the data will not be made available to any commercial organisations.	
10.	I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.	
11.	I understand that I will be not be compensated for participation in the study, but that travel expenses to an in-person interview will be refunded where that travel is within Transport for London Zones 1 to 6. This still applies if I choose to withdraw after the interview.	
12.	I understand that the interview data will be published as part of a thesis and will likely be published more widely, for example in an academic journal.	
13.	I wish to receive a copy of the interview transcript.	Y/N
14.	I understand that if I choose to receive a copy of the transcript, that amendments can only be requested up to one-week after it has been sent to me via email.	
15.	I wish to receive a copy of any publication.	Y/N
16.	I understand that if I wish to receive a copy of any publication, then my email address will be retained for this purpose only.	
17.	I agree that my pseudonymised research data may be used for future research. (No one will be able to identify you when this data is shared.)	
18.	I consent to my interview being audio recorded and understand that the recordings will be destroyed immediately following transcription.	
19.	I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and, where relevant, explained to me by the researcher; and I meet these inclusion criteria.	
20.	I am aware of who I should contact if I wish to lodge a complaint.	
21.	I understand that I can withdraw from the interview at any stage without giving a reason and without any negative consequences by contacting jess.macintyre.20@ucl.ac.uk	
22.	I understand that there is a one-week post-interview cut-off to withdraw data.	
23.	I am willing to take part in this research.	

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix 5 – Interview schedule

1. ***Can you tell me in your own words how you identify in terms of your sexual orientation and gender identity?***

2. ***What does the experience of this identity mean to you? What role does this play in your life?***

3. ***What drew you into clinical psychology?***

    1. *What ideas did you have about how being queer/trans might intersect with your profession?*

4. ***How would you describe your experience of being a queer and/or trans clinical psychologist? (LGBTQ+ specifically).***

    1. *How was this experience whilst on training? Has this changed since qualifying? If so, how?*

5. ***What does being a queer and/or trans psychologist mean for you?***

    1. *What do you get out of this?*

    2. *What would you say your queer/transness opens up in your work?*

    3. *What would you say it closes down?*

6. ***How do you draw on your experiences as a queer/trans person in your practice?***

    1. *How do you feel your clients respond to this?*

    2. *How do you feel your co-workers/supervisor/team responds to this?*

    3. *Do you feel supported in drawing on these aspects of your personhood in your work?*

7. ***How, if at all, does being a queer and/or trans clinical psychologist have an impact on your sense of wellbeing and mental health?***

    1. *Who/what makes up your support system to help you work through any difficulties you experience in this regard?*

8. ***Have there been times when you have felt that you had to keep parts of yourself back in your clinical work because you were queer and/or trans?***

    1. *In what way? Can you share more about these experiences?*

9. ***Have there been times when you have felt your lived experience of a queer and/or trans person has been particularly meaningful in your work?***

    1. *In what way? Can you share more about these experiences?*

10. ***What difference, if any, do you think your identity has on your practice compared to non-queer/trans colleagues?***

    1. *How do you relate to this difference? Is this positive/neutral/negative?*

Appendix 6 – Jay's Personal Emergent Themes (PETs)

Superordinate Theme *Sub-Theme*	*Transcript*
Queerness as central to practice	
Having a queer practice means that I am curious without making everything a curiosity.	1. And I think yeah, being a queer psychologist does just mean that, yeah, I kind of, er, like whatever people are, whatever they bring, then I kind of am open to that. I suppose it's about I don't know, being, still holding on to being curious, which is a sort of, I suppose fundamental value in the profession. Without making everything a curiosity, you know? (p.17:21-p.18:2).
Being queer has allowed me to be a lot more creative in my clinical work.	2. Um, I think it means, um, thinking outside the box, um, I think there's something really, um, for me, a quality that I really connect with, is being creative. And I think for me, that really comes from queerness. Um, and I think being a queer psychologist does allow me to be a lot more creative in the work (p.15:3-8).
My queer identity is central to my justice-seeking lens in psychology.	1. I guess, that aspect of being, um, in a minority, and then have it being, it being exposed to this kind of, I don't know if I go as far as to call it activism as such, but certainly this kind of contributing to society and trying to influence change and things like that. I think that was very much, um, connected to having a sort of queer identity (p.3:20-24). 2. I guess in a way recognising my own, the ways that I'd been oppressed, but also recognising the ways that like, many kinds of groups and individuals are oppressed, and yeah, wanting to take a bit of a stand against that (p.3:27-30). 3. I think, yeah, there is, um, there's, there's always been a theme of wanting to contribute to justice, to um, and I think to maybe have a voice as well, I think there's been some, and you know, clinical psychology is a position of power and kind of influence. And I think there was something toward working toward that place where I could strengthen my voice in, in terms of, um, yeah, what I put out there into the world around some of these things (p.4:10-15).
Being a queer psychologist means I am not shackled to a cis/het framework and don't need my clients to explain their non-normative lives to me.	4. I think kind of being, not being shackled is the word I want to use, but like, to a kind of cis het sort of framework. Um, I think, generally, whoever arrives in front of me, um, I want, I want to help them to, to find their version of their life. Um, and, you know, the people I work with have such diverse relationships, for example, you know, and how they express their sexuality. And I think being queer, like, I just, it just, I never, it never crosses my mind almost that they are, like, maybe living in a way that the majority of the population might view as different or unusual, or what, however, they might view it. Um, so I think yeah, being free of that allows possibility, I think, um, and

	allows people to, um, yeah, I think feel like their life is valid, that their experience is about, like, I think, um, and I think actually something that clients say a lot is, especially in *my service*, um, is they don't have to explain anything to me (p.16:11-21).
Being queer has directly influenced my practice and my choice of therapeutic modality.	5. I think for me, um, like, again, I, if I think about, like, my lifespan and creativity, um, I think there was always something about like, standing out, like, and, um, I don't know, like, seeing, seeing the world in quite a vibrant, exciting way that I do kind of connect to queerness and just having a different experience of the world. Um, I think part of that is in kind of like, um, like, as, as a child, I guess I was quite like gender non-conforming in many respects. Um, and I think that just opened my mind to what was possible in the world in some respects. And I think even now, with, um, like, the, the psychology work that I do, I think that's really influenced things like the methods that I, the approaches that I use, I'm really drawn to narrative psychology, for example. Um and I think that is connected to you know, the stories that have been told about me as a queer person, and who owns those stories and actually, you know, what are my stories and um, I think, yeah, so I think it's, it's led me to particular ways of working. And I think part of the reason, another reason why I feel drawn to, um, narrative approaches is that you can be quite creative with them, you can be quite expressive with them, you know, you can really kind of, um, show different parts of yourself, um, they really lend themselves to like really nice imagery and metaphors and, and things like that. Um, so yeah, I remember being introduced to narrative psychology and being like, oh, this makes a lot of sense to me, actually. And, and I do use it a lot in my work now. Um, so, so yeah, I think there's something about it has definitely shaped me as a kind of, how I want to work, the type of work I do, you know, like I literally work in a, in a queer service now. Um, so, so yeah, I think it's very much ingrained in like how I, yeah, how I work as a psychologist (p.15:15-p.16:6).
Queer supervision is a game changer	
Sometimes I lose sight of hope, but good supervision allows me to feel resourced.	6. I just had this run of appointments, where it just felt like bearing witness to so much hard stuff, that is directly related to being queer. I had like, I really felt like less much less connected to hope than I ever had, I think. Um, and I was really like, oh, God, I don't know if I can like, like long term, like if this is going to be sustainable, because it does take a huge amount of energy. Um, but I think actually, the supervision I had around that was really good and I just, I just said, um, what was going on and *my supervisor* is really wonderful, and I think, like

	now, it was kind of we did some nice narrative stuff in, in supervision, which was really helpful (p.30:7-13).
Queer supervision is empowering.	7. Um, I think my current supervisor, um, really encourages it, I think is, is queer. Um, I think he knows that is something unique that we can bring to the work, that kind of clients really appreciate it. So, yeah, it's always been really encouraged (p.25:22-25).
Having a queer supervisor was a game changer.	8. And when I was in my second year of training, um, one of my supervisors, um, in a place I actually ended up working, it-was, was queer. And that was a real game changer for me actually having a kind of queer supervisor, and, um, essentially, because I wouldn't have necessarily thought it would have, but it really did make a massive difference, just bringing together the kind of personal and professional and thinking about the work and how, yeah, how it affects you, how you affect the work, um, was really helpful (p.5:11-16).
Finding belonging in QT services	
Finding purpose and meaning in QT service	9. Um, and, yeah, I think that this is definitely where I want to be working. Um, and I feel where my, my experience and skills and things are best used. So I think just that in itself, you can't ask for much more than that, really, can you? (p.34:23-25).
Being a queer psychologist is filled with joy and affirmation in the service I work in.	10. I would describe it as incredibly joyful, I guess, um, and kind of, I, I have given you lots of examples of where, like, it's been difficult. But there's been something really powerful for me about bringing that aspect of myself into the work. And I think, um, on the whole, like, I've been really moved by how my colleagues have responded to it, actually. Um, they've been so, sort of affirming, kind of welcoming of it, I can see how much want there is to make things better. I can see how much want there is, um, for people to, um, like, learn, I guess, um, and want, yeah, want to make that things more accessible. So that's been really lovely to, to see (p.10:6-13).
I feel resourced by the solidarity and vulnerability shown by my colleagues.	11. Um, I think, I think there have been in the past, I think I'm at a point now. Um, so we recently had an away day. And, um, we, um, one of the exercises was connecting to some of our experiences and everybody went round and shared in quite a lot of detail actually, some really difficult things including myself and, um, there was people I was supervising were there, people that I am supervised by are there, and actually, it felt like a really healthy, good thing to be doing, um, and not one I've had experience before, particularly. Um, I think we were all quite like refreshed by it actually, kind of turning to and just humanising ourselves you know, and sort of, um, like, yeah, acknowledging that what, what brought us to this work? Um, what does the work mean to us and also something about like, you know, those hard parts (p.31:20-p.32:2).

Now that I work in the queer sector I don't even think about the anxiety of disclosure anymore.	12. But like, there was something about clients knowing that felt really difficult. Um, and I think I have moved a huge amount away from that now of like, um, it doesn't that, yeah, I don't even think about that anymore (p.7:19-21).
Suspicion of perversion	
Being queer means I am suspected by cis/het colleagues of having an agenda to influence and convert vulnerable young people.	13. I think the other part way that's come up in the work is, it was the same colleague, actually, but I always remember them saying, oh, there's a young person on the ward and they're using, um, they want to use they, them pronouns, and their parents that, really aren't happy about it. Um, they'd like to see psychology. And then this colleague said, um, and I was like, the psychology rep in the meeting and the, in this MDT, um, they said something like, um, oh, but they think no, I think it shouldn't be someone who's got, um, like, an LGBT agenda or something like that. Um, and I was just sat there, like, well, first of all, you're obviously talking about me, which is like, I'm the psychologist in the room. And this really kind of like, I don't know, you know, quite, I mean, I think it's quite offensive, actually. But, um, like, yeah, I guess only being seen through that, that there. And as this kind of force of, I don't know, like, I don't know, you're gonna go in and, like, I don't know, um, they didn't mean it like this, but almost like grooming, you know, like, you're gonna go in and- and I really don't think that they perceive me in that way. But like, there was that aspect, that was the flavour of it, I think was, oh you're gonna go in and influence this, this young person (p.9:16-28).
Unlike my cis/het colleagues, I could never freely use an example of my family life with a client.	14. And I can remember, um, being in a reflecting team, and one of my, colleagues, um, leading the session, and, um, they use their own family system, I guess, as an example to the family. And we're kind of talking about their experience. And I can just remember sitting there thinking, oh, God, I would never say that, I would never like say oh my partner, because I just don't know how people can react (p.6:18-23).
I feel especially cautious thinking about disclosing my queerness to young people in case I am accused of sexualising the relationship.	15. I've done a lot of work with young people in the past. I always remember thinking, oh, God, please don't ask me like, please don't ask me if I'm gay, please don't ask me if I've got a girlfriend or anything, I just don't want to like, go there (p.6:23-p.7:2). 16. I was doing like some CBT work with a young person. And, um, he said, "Are you married?" And I just said, "Oh, no, I'm not." And I was thinking, oh, God, what are the follow up questions gonna be here? And I remember talking about this with that queer supervisor I was talking about earlier. And he was saying as well that, um, he, like a young person asked him before, like, are you gay? I it was just on, he was like, on the way out of a session, are you gay? And he was, like, totally thrown by it. And like, what do I say here? And like, um, I think the question actually wasn't actually, are

	you gay? I think it was, um, “Do you like boys?” which is obviously quite a loaded, um, question to answer, you know, from, from a young person (p.7:3-12).
Psychology as perpetrator	
The transphobia in the current climate has made me feel at risk of abuse for working in QT service.	1. I think the, the other climate at the moment is the, you know, the transphobia, that's around…last week, we had media training, um, which I've never had as a psychologist before, because why would I need it? But, but, and, um, you know, you kind of get these, the, they give us these like vignettes to work through. And it's like, you know, your name is posted in the Daily Mail, what do you do sort of thing? (p.19:21-25). 2. I was doing just the thing you do, you know, if you look people up and just see what they're tweeting about, ready for the interview. And, um, and I saw it and I was like, oh, that's the job. And I clicked on it. And it was just such a string of transphobic abuse, like, um, just probably, probably, like, I don't know, 20 to 50 tweets or something, like it was like a proper stream of like, like tweets about the job I was applying for, and how awful it was and, ana all this stuff. And I think there is that aspect as well, is I do feel like I have to, you know, you have to kind of cross all the t's and dot all the i's in this job for sure. And make sure that you are doing everything by the book. 3. Um, and that there's no you know, um- but even things like we put all our names on the website, which, to me is so important that like, you know, um, our clients know who we are, before they come in, we work with loads of neurodiverse clients, it’s really important. But there is something about like, um, and I feel like I'm probably in the ladder of our service, I'm probably fairly far down in terms of risk, in terms of, um, that I am putting myself out there, you know, in the doing this work. Um, and, um, I'm sure as the service grows, which it hopefully will, that it will become even more scrutinised (p.20:6-20).
To stand by your values is to be vilified.	And I think we're probably all feeling a bit like this, when you do work there, that you stand, would stand by your values, then, you know, that other people are kind of vilifying them, then you're gonna feel that that tension, um, in, in the work (p.20:23-25).
I’m cautious about my association with a profession that has caused harm to my client.	Do you know, I think you know, what an area is that I do feel a cautious of, which I do participate in, but I do feel cautious of is lots of our clients will criticise the NHS-and mental health services. Um, and one of the, um, things that will come up quite often is what is helpful in terms of you know how much you participate in that? Because I can see that in some ways, you're just going to, like, further diminish hope and that, and like I said, that I think that's a dilemma I found myself in. I know one person I work with really likes that I'm queer and that is really important. And I think they almost like that, they don't like that I'm a psychologist, and kind of see that, as you know, the things I've

	been trained in, have been, um, set by white, upper class men kind of thing (p.32:9-18.
Hope & hopelessness of QT work	
Being queer is connected to the most joyful and most painful parts of my life.	that is connected to probably some of the most difficult times in my life, but also some of the most joyous and happy times in my life (p.1:20-22).
I feel joy and wariness about working with my community.	I feel like it's two sides of, you know, of being queer that there's, there's so much happiness and joy, but there's, there's still work to be done. There's still difficulty out there (p.10:5-6).
My mental health hangs in the balance between hope and hopelessness.	it's like this kind of this dance almost between hope and hopelessness. And I think hope is winning at the moment, which does have a really helpful effect on my mental health (p.30:20-24).
Hopeful for young people – they are going to change the world!	I was working in paediatrics with young people. Like that has been incredibly inspiring. Um, and again, really moving to see how things have changed as well. And I don't think I would have noticed that as much if I hadn't done this specific work, um, you really see, you know, how young people are, have so much more resource than I did in terms of like, you know, content to watch, you know, kind of information that can be accessed at the touch of a button, all of, all of this stuff, which I just feel so like, I don't know, obviously, there is a bit of a sense of what could have been in some respects. But, I more than that I feel just like, are these, these young people are going to change the world and they have, they've already started doing it. Um, and the world is going to be a very different place again in 10 years' time, thanks to you know, kind of all the people who have come before, but thanks to these young people as well, and, um, how engaged they are in and how much of a voice they have. So I think yeah, it's kind of made me appreciate, like when I say about hope you know, and kind of I do, you know, I witness a lot of injustice in my job, a huge amount of injustice, a huge amount of oppression. But I also have these like really lovely parts as well, where you see the, the yeah, the nice parts (p.11:8-22).
Early understanding of QT shame	
Growing up under section 28 meant that I grew up with early templates of queerness as shameful.	growing up when I did under, like section 28, um, you know, it was, I think, I think I'd left university by the time that had finished. I think that identity had been associated with a lot of shame for me. Um, I think it had been, um, really responsible for most of the kind of prejudice that I've experienced in my life (p.2:2-5).
Using queer personhood in practice	
I will sometimes share aspects of my own lived experience with clients if I think it could be helpful and humanising.	I remember was, um, where a trans masculine person, um, who's in a relationship with a CIS man had came to a session and said, I'd really like to talk about, um, holding hands in public, because this person previously presented as female, so it was, always felt, felt able to hold hands in public, but now was very masculine presenting, so felt unable to hold hands in public. And, um, and they said, oh, do you have any, like, do you know, anyone who's got any lived experience of this? Like, how do people negotiate it? And I was kind of like, well, I feel like I've got lived experience

	in this area and I shared a little bit about my own experience. and I, when I ended with that client, actually, um, they were like, oh it's been so a helpful and a big difference from other therapy I've had was, I felt like you were a real person, because you told me little bits about yourself. Um, so I think it was really important to them, actually, that I had shared those parts of, of myself in the work (p.22:28-p.23:9).
I use disclosure to signal safety with those who have experienced prejudice in mainstream services.	I think all my clients know I'm queer in this job. Um, I think that some of them will, I do quite a lot of thinking with clients about their relationship to help at the start of working with them. And people have had really awful experiences, that and I mean really, really terrible experiences of therapy across you know, the NHS and privately as well. Um, and I think people are often looking for queer psychologists. I will say in the first appointment quite often, um, when we're talking about it, that I am a queer person, if that's something that they've said is important to them (p.21:26-p.22:6).
I can role model a positive identification for others who are struggling to accept themselves in a qtphobic world.	I did some outsider witnessing, and it was the first time I had said to a client "I'm a queer person", that that was really meaningful. Um, and then I think just with, um, that, I've had quite a few endings recently that have been really lovely, actually, really lovely endings. And I think that, um, a theme that's come up from those that has felt meaningful has been people feeling like they don't locate the problem in themselves anymore. They kind of locate it somewhere else, which is something that, you know, I really believe in as a, you know, as a way of understanding problems (p.33:6-11).
My clients value me as a queer person more than a psychologist.	Do you know, I think you know, what an area is that I do feel a cautious of, which I do participate in, but I do feel cautious of is lots of our clients will criticise the NHS-and mental health services. Um, and one of the, um, things that will come up quite often is what is helpful in terms of you know how much you participate in that? Because I can see that in some ways, you're just going to, like, further diminish hope and that, and like I said, that I think that's a dilemma I found myself in. I know one person I work with really likes that I'm queer and that is really important. And I think they almost like that, they don't like that I'm a psychologist, and kind of see that, as you know, the things I've been trained in, have been, um, set by white, upper class men kind of thing (p.32:9-18.
I'm never fully seen in mainstream services	
To not see my queerness is to not see me, to only see my queerness is to not see me.	there's something about wanting that part of me to be seen, but not wanting it to be the only part of me that's, that's seen (p.9:12-14).
There's a difference between being out at work and bringing my full self to work.	Like, I was always like, out at work, for example, that was always there. But I think bringing myself into the work, yeah, probably didn't happen until like my second year of even, of training, um, and has just kind of gone from strength to strength after that (p.5:27-30).

Being out in mainstream service means being tokenised as the gay psychologist.	when I started centering this part of myself in my work, I think you do start to get seen as being like the queer psychologist by others, and like the gay, oh, the gay psychologist by others. And, um, I think that had a few effects. I think one was that you end up doing any work that is related to kind of being queer. Um, and it would be oh, yeah, of course you, you can do that. Because yeah. And it was kind of, it's framed in a way that is oh we're, we're like, being really respectful here because of course you're queer, so you would want to do this work, but it does mean that I think lots of people keep their hands off it, because they kind of think oh I don't need to do this because there's someone who's, who's picking it up. Um, and just not many, but I think some colleagues, then really only see you through that lens, like really, um, and I can give you a really good example is, um, a colleague, not a psychologist from a medical team, um, while I was at the hospital, they would all his, um, like, whenever they saw me, that would be the first thing that they would talk about. And they'd go, oh, hi, Jay, um, and it would be really weird things like, have you. Oh, hi, did you see that interview with Eddie Redmayne where he saw, he said he regretted playing that trans character? I don't think he should feel sorry for that. What do you think like? (p.8:23-p.9:8).
Miscellaneous	
I'm always aware that I might cross paths with clients in my personal life.	I'm always aware of like crossing paths of people in my personal life as well, um, which hasn't, hasn't happened yet, um, I don't think, in this job, at least. Um, but there is always that thing of, um, you know, yeah, how do you negotiate it, when you are part of the same community potentially might share the same spaces, how do you negotiate that? (p.19:4-8).
Becoming a psychologist gave my voice power.	I think, for me, progression that, um, has been really about having a voice and... as I got older, and people kind of start to celebrate you, and sort of, you know, you kind of like I said, find your people and stuff like that. I felt like I found my voice a bit more. I think there was something about progressing and kind of having this, this nourishment around me, I guess of these services that we're investing in me…that allowed me to find my voice again (p..12:24-p.13:21).
Training did not help me develop a sense of who I was as a queer psychologist.	I actually, I don't- now that I think about it, I think it was all a bit like, absent from training, even though I was having these really significant moments that I was, I think I was sharing with them. I think they were just kind of like, oh, that's nice sort of thing. I don't think they, I don't think they were adding, like, adding much to my development in that way…I was always a bit disappointed by how much was covered on training around queer lives (p.26:1-4).

Appendix 7 – Group Emergent Themes

Superordinate Theme *Sub-theme*	***Experiential statements/notes***	**Participant**	**Extract**
Queering practice But there is something about that, like queer as a verb, you know: Kate,17:9).			
The psychological is political	*Queering is a political act*	**Kate**	So I think that's the queerness of my practice, it's nothing to do really with sexuality. Or relationships. It's about queering as a kind of political act almost (p.18:13-23).
	My queer identity is central to my justice-seeking lens in psychology.	**Jay**	I think, yeah, there is, um, there's, there's always been a theme of wanting to contribute to justice, to um, and I think to maybe have a voice as well, I think there's been some, and you know, clinical psychology is a position of power and kind of influence. And I think there was something toward working toward that place where I could strengthen my voice in, in terms of, um, yeah, what I put out there into the world around some of these things (p.4:10-15).
	Psychology's role is to unstifle where injustice occurs	**Dominic**	Then psychology should be about justice, about providing justice, um, and, um, dealing with injustice and, um, working with injustice. And if you can't change it, at least making it a lot more transparent where injustice occurs. And I think like linking that back to what I was saying before is that I think that, the um, that kind of and learning about and about the importance of not, of being able to be a true self and that stifling, that there's something, there's something about that stifling that, that kind of, um, emerges out of injustice. And so the two things are linked together, people don't stifle themselves for no opinion, for no reason. Um, they do so because they're operating and living in a world, which is stifling them. And that that is, and that largely, that's an act of injustice. (P.11:14-22).

	Formulations led by compassion due to insight of suffering	**Dominic**	(link to prev quote from Dom) when people can see how shit the world is, they can stop blaming themselves for their problems (p.15:12-13).
	Psychology should attend to people's selves being stifled by their political contexts	**Dominic**	And what that then, um, contributes to, just in its alignment, I guess, with my political identity, and how I see the world is also, um, a, I was going to say, just a disappointment with the profession. And, and with the direction of the profession, and the distance it is moving away from thinking about this idea that people's true selves been stifled by their context. And their social, economic, social, political reality within which they live is a really important thing to be talking about and thinking about. And I get a bit angry now. Sorry, but like, how, just complete bollocks a lot of the direction of our profession is moving towards the manualised X, RCT for Y, that has no true relevance to people's real experience of the world (P12-13:31-5).
Troubling compulsory storylines		**Kate**	I think that's really, something that I think most people I work with wouldn't be able to put a finger on… I feel quite free to be overtly political about the assumptions that are made, the stories that the world tells us what a happy ending looks like, you know, what's okay and what's not okay, how girls ought to behave, how boys are allowed to behave, the kind of compulsory heterosexuality, that these kinds of things. (p.17:20-25).
	Unshackled from cishet frameworks	**Jay**	I think kind of being, not being shackled is the word I want to use, but like, to a kind of cis het sort of framework. Um, I think, generally, whoever arrives in front of me, um, I want, I want to help them to, to find their version of their life. Um, and, you know, the people I work with have such diverse relationships, for example, you know, and how they express their sexuality. And I think being queer, like, I just, it just, I never,

			it never crosses my mind almost that they are, like, maybe living in a way that the majority of the population might view as different or unusual, or what, however, they might view it. Um, so I think yeah, being free of that allows possibility, I think, um, and allows people to, um, yeah, I think feel like their life is valid, that their experience is about, like, I think, um, and I think actually something that clients say a lot is, especially in *my service*, um, is they don't have to explain anything to me (p.16:11-21).
	Being curious without making everything a curiosity	**Jay**	And I think yeah, being a queer psychologist does just mean that, yeah, I kind of, er, like whatever people are, whatever they bring, then I kind of am open to that. I suppose it's about I don't know, being, still holding on to being curious, which is a sort of, I suppose fundamental value in the profession. Without making everything a curiosity, you know? (p.17:21-p.18:2).
Freedom to break the rules	*Taught models don't capture queer life*	**Kate**	I don't know, this thing that you probably hear on training all the time: be warned, you know, be wary of therapeutic drift. And I sort of think, well, actually, this compulsory model, this compulsory fidelity to one particular way of thinking and working and speaking is actually not in line with my queerness. It's not in line with my worldview. It's not in line with how queer I think everyone is, you know, I think it's how queer pain is, how queer joy is, it doesn't work like that. And I think so many of the models are structured on this idea of there is a right way to be human (p.21:4-12).
	Dismantling unnecessary power dynamics	**Cleo**	INT: What's the dance between the queer and the relational? RES: Um. I think- I guess I think part of it is probably coming down to, like, hierarchy is real, but also doesn't have to be real. That's one thing. And I think, kind of, foregrounding that, sometimes in experiences. And I think one of the things I tell- I end up telling most of my clients, at some point, is to

			say, you know, “Sure, I’m here as the psychologist, and you’re here as the patient who’s been referred to see me, but ultimately we are two humans in a room, in relation to each other.” INT: Yeah. RES: “And that means that the stuff that happens between us, as two humans, is often a mirror of what happens more broadly in society.” (p.42:3-16).
			But times where I’m just like, “But I just don’t understand why this has to be a bureaucratic barrier.” Like, “That’s made up. We could just not do that.” (p.11:6-p.11:8).
Sitting alongside	*Experiences have formed clinical practice*	**Dominic**	There's something about, um, my sexual identity, it's not the same as other people's experiences, but it gives me like a hook to, like, relate to and think this kind of relate, like this is how, in yeah, how has injustice operate in my life. And where's that? And it's kind of in this place over here. And I think being able to have something that you can connect to and relate to, in that way, just makes it brings a sense of something more, live and activated, in being a psychologist where, um, justice is important to me (P.11:25-30).
	Queer experience has attuned my practice	**Elle**	it brings a softness to, a softness, an awareness of working with shame in a very, er, and, erm, aware, an ability to hold and discuss that in a different way than, than other people can… and yeah, and, er, just, yeah, openness and listening around it. Just being able to be present for those conversations. (p.24:6-13).
	A hook with which to empathise	**Steve**	And so at least my experience of difference gives me some hook with – “you know what? I know what it’s like to not fit in. I know what it’s like to not be the same. I mean, my experience isn’t your experience, but actually at least I have some experience of that” (p.27:13-20).

	Knowing 'the other side' intimately shapes my practice.	**Cleo**	It shifts my practice, or it shapes my practice, definitely. I think being aware of how service users, for example, experience services, or patients experience services, um, a bit more shapes how I interact with people as they enter services, or move through them. I assume best intentions, but I also hold a little bit of reserve there, because I know that people have had professionals working with them who have had the best intentions, but have actually caused a huge amount of harm. Um. And so, I think I- I- I feel quite a strong responsibility to my community, and I think to- To all patients, to kind of shift that balance a little bit, where possible p.13:24-p.14:3).
	QT experience as expertise	**Sage**	what it helps me do that maybe CIS HET psychologists are not able to do, is that I'm able to, like quite genuinely say, yeah, like the, like, the shit that comes from society around this stuff, or like the, you know, the way society forces us or pushes us in a very pressured way into these CIS HET boxes is painful, and like, you know, really, like, it really makes it difficult to feel like you can thrive or even live as humans sometimes (p.25:27-p.26:3).

Queer euphoria: you know, to be queer is like, wonderful (Sage, p.2:29).			
Joy in belonging	*There's a joyfulness in being who I am now.*	**Elle**	1. So, yeah and that feels, there's a kind of joyfulness in that, you know (p.15:23). 2. and it's become a kind of a special thing where, erm, we, where we can have brilliant conversations about the aspects of our identities together. And that's, that gives permission to, to celebrate, erm, and, and yeah, and thrive in that kind of diversity really and it, it, erm, so that with, as particularly within my team, erm, that I'm with that I lead and by chance, erm, well I don't know. Maybe it's not quite chance but we've ended up

			with, you know, a majority and it's just, we're not a special, we're not in sexual health or where sometimes where you do find more queer people working. We're just in bog standard adult mental health services but we're a majority gay team. Erm, how does, I don't know quite how that has happened? But that just feels like a gorgeous family of, erm, warmth and acceptance and absolute com-comfort almost reminiscent of my old straight days (p.11:3-14).
	Being a queer psychologist is filled with joy and affirmation in the service I work in.	**Jay**	I would describe it as incredibly joyful, I guess, um, and kind of, I, I have given you lots of examples of where, like, it's been difficult. But there's been something really powerful for me about bringing that aspect of myself into the work. And I think, um, on the whole, like, I've been really moved by how my colleagues have responded to it, actually. Um, they've been so, sort of affirming, kind of welcoming of it, I can see how much want there is to make things better. I can see how much want there is, um, for people to, um, like, learn, I guess, um, and want, yeah, want to make that things more accessible. So that's been really lovely to, to see (p.10:6-13).
	Finding purpose and meaning in QT service	**Jay**	Um, and, yeah, I think that this is definitely where I want to be working. Um, and I feel where my, my experience and skills and things are best used. So I think just that in itself, you can't ask for much more than that, really, can you? (p.34:23-25).
	Awareness of own team as unique critical culture and separate from profession as a whole	**Dominic**	Seeing how psychology operates in other places. I do wonder whether if I, if I worked in a different place, whether people would make assumptions based on my sexual identity, like, would it be used against me in some way*?* (P.10:1-2).
Finding refuge	*QT and neurodivergent spaces are a refuge*	**Kate**	That queer spaces and neurodivergent spaces and those relationships with people in my life, who are queer, who are neuro divergent, who are both, um, those are my places of refuge (p.31:14-16).

	Finding safety with other QT psychologists	**Steve**	Again, [the therapist] being gay, was really- Has been really instrumental in my mental health, because one of the reasons I struggled so much when my partner died was that his mother totally invalidated me as his partner. But she was a massive bigot (p.46:14-47-10).
	Resourcing in our own spaces	**Kate**	the main kind of clinical psychology Facebook group… but also sort of trying to swim against the tide of, of anti-trans propaganda, that can show up in them sometimes. And then scurrying off to the kind of little tiny, safe LGBT psychologist group and going, "oh, my God, they're doing it again". It's been really nice to find that and kind of move backwards and forwards between the two again…you can have this sense of like, a secret side conversation where we're like, "okay, who's ready? I'm going in. Does anyone want to come in with me?" p.26:24-25:6).
Freedom to flourish	*Supportive workplace changes everything*	**H**	And it was just a whole different experience there. Um very, very warm, very welcoming, and I've just grown in confidence in terms of identity just, I guess, in my personal life through a very long term relationship, but also a very, very supportive workplace (p.2:22-25).
	Queer supervision is a game changer	**Jay**	And that was a real game changer for me actually having a kind of queer supervisor, and, um, essentially, because I wouldn't have necessarily thought it would have, but it really did make a massive difference, just bringing together the kind of personal and professional and thinking about the work and how, yeah, how it affects you, how you affect the work, um, was really helpful (p.5:11-16).
	Queerer than ever	**Sage**	I like my Doctor title, rather than Mr or Miss or MX, because, you know, again, it doesn't prescribe any clue to what is going on necessarily, other than that you are different (p.3:3-5).

Living in threat mode I still don't always feel safe within the profession for a number of reasons (H, p.19:17-18).			
Covering & Vigilance	*Trojan horse*	**Kate**	I've honed my disguise over the years as a kind of straight neurotypical, professional, middle aged person, who's kind of just normal…But you know, I'm a parent, have done the decent thing, you know, and to

			almost come into a space kind of passing as straight, passing as neurotypical, and then to kind of come out once I'm in there, do you know what I mean? There's something in that, I'm kind of getting into a conversation because I can, I'm not masking anything particularly well at the moment, but I can I'm quite capable. INT: A Trojan horse? RES: Keeping a lid on it, absolutely the Trojan horse, open the doors, I'm full of queers, they'll come bursting out and burn your houses down *laughs*! (p.30:1-12).
	The need to obscure myself	**Elle**	Er, with a, with a client yesterday, erm, I decided to share about, er, a dilemma that me and my partner had. I described my partner as a partner, not a girlfriend. I described them as, they. Erm, and I think there's still, so there's still part, and I don't think I would have had any, I would never have been like, I would never have done that, you know, in a heterosexual relationship (p.20:7-11).
	I'm never fully seen in mainstream services	**Jay**	there's something about wanting that part of me to be seen, but not wanting it to be the only part of me that's, that's seen (p.9:12-14).
	I can't bring my queer self to supervision	**H**	I've definitely consciously known I've wanted to go there, and maybe hence referencing my partner, um, but never gendered her. Um, and then I've just been led by him. And I guess, I think his focus is very much sort of formal, there's never been any- I've brought emotions, I brought counter transferences, I've brought things like that when I needed to talk about them, but it's not something he willingly goes towards. It's not his area of comfort, I feel (p.16:14-19).
	Unlike my cis/het colleagues, I could never freely use an example of my family life with a client.	**Jay**	And I can remember, um, being in a reflecting team, and one of my, colleagues, um, leading the session, and, um, they use their own family system, I guess, as an example to the family. And we're kind of talking about their experience. And I can just remember sitting there thinking, oh, God, I would never say that, I would never like say oh my partner, because I just don't know how people can react (p.6:18-23).

Battle fatigue	*The loneliness of risk-taking*	**Cleo**	1. I just want to know that the organisation will have my back if TERFs come for me…I think it's a really interesting thing, that people are afraid, from within their own profession, that they're gonna get attacked. (p.45:1-20). 2. But I think one of the things that happens is that we lose solidarity, in many ways, as a result of that (p.46:6-7).
	I don't always have the energy to challenge QTphobia from colleagues	**Elle**	3. The bravery, the energy required. It just, sometimes it's easier to be like, this isn't my battle today (p.22:9-10) 4. God, I can't challenge it <u>all</u> the time (Elle, p.18:17).
Responsibility & Burden	*I feel a responsibility to protect my community from the harm that can occur in my profession.*	**Cleo**	I think probably the sense of responsibility or care towards my community also, I think is hard sometimes, where I sort of think, you know, I'm worried about what this person's experience of services will be, when they come in to the service. Um. And I think the- And then, if I find out that a person is having a hard time with the service, kind of feeling like, you know, Could I have done more? Even though I wasn't the clinician who was involved (p.34:19-25).
	Being the token LGBT person meant I had to help the organisation struggle along towards progress	**H**	They didn't have a policy or anything, because I turned to HR for some support with the, um, individual's consent and they had nothing and they literally said oh well as, as the LGBT person would you like to do the uh, would you like to write the policy? I was like, you can't just use me as the token gay for like, every policy there is…And I had to really take a lead, because I felt so passionate, that, wow, this really is archaic here. Um, to really push HR and to get everyone a bit more educated around things (p.10:1-7).
	I am dialectically burdened and privileged to advocate for my community	**Sage**	5. I felt dialectically both privileged and burdened to be in those spaces where like, you know, I was, I'm so glad I'm able to have a voice and even if my voice is shaky, because I'm so enraged by what you're saying, but like, I can advocate for it (p.13:23-26)

			6. I do feel a lot of pressure to perform for this, like for the group that I'm trying to champion and, and sort of model (p.15:23-24).

A punch in the guts: the profession as hostile I felt very alone, actually, in the, during the difficult times (H, p.22:1).			
Profession as Performative	*Profession as performative ally*	**Sage**	Yeah, it's, as I, as I think I started to allude to earlier, it is a bit like, it is a bit of a burden, because when I'm in those spaces, like I get that false sense of safety and people saying, "oh, yeah, I'm with you, I'm so supportive", but then in the next breath will say something that actually is quite transphobic, whether they mean to or not… I see that very much as similar sometimes in school, when people would say, like, "oh, no, no, I have no issue with gay people". But then in next breath be, like, "oh, that's so gay". (p.24:13-18).
	Profession is fake	**H**	I thought that clinical psychology would be the most compassionate, accepting, I mean, look at us, we're all in it for the same reason, right, what we give our clients and within the profession, I found it not just around this, but other as bitchy, backstabbing, competitive. Um, and it's totally not what I expected it to be. And as a result, it feels fake. I have this big thing about fakeness by the way. Um, so yeah, that feels incredibly unsafe (p.19:1-6).
	Psychology weighs in on real lives with cloaked innocence.	**Cleo**	I think with trans identities, there's really something about how this- Psychology loves to have this academic debate about it, and there are some very outspoken TERFs in psychology, and there are a lot of people who are, "Just- Just questioning," or, "Just, you know, being critical and reflective," and actually that's- It's actually transphobia, um, but they phrase it in a, "Oh well, isn't this an interesting academic discussion?" It's like, people's identities and lives are not an academic debate, um, and there are people within your sphere, at the present moment, who are feeling like you are debating their right to exist, and whether they're just traumatised, or whether they're just, um, maybe autistic,

			but confused about their identity (p.19:18-p.20:2).
Profession as wounding	*QTphobia is personal*	**Elle**	I think it's made me much, much, much more, er, aware of people, erm, people's, erm, homophobic, transphobic language, erm, and I've had moments of, I've experienced still, you know, strong anxiety at times around those conversations and thinking about challenge. Erm, feeling crushed inside and just really very, very overwhelmingly sad (p.16:7-11).
	I lacked the confidence to challenge homophobia at work	**Steve**	7. I'm a widower, I'm a consultant, um- Yeah. You know? I've kind of done it. The worst thing in my life has happened, and I didn't die. You know? So- So the- The experience of it is very different these days. You know?... I am who I am. If you have a problem with it, that is your problem (p.13:7-15). 8. I have had encounters with homophobia, over the years…And looking back, I probably should've made more of a fuss, and I didn't. And I didn't. Because I didn't have the power, at the time, to do that, really (p.18:15-18).
	When I first qualified I lacked the confidence to challenge oppression at work	**H**	And real, sort of some homophobic slurs being used, it was the norm. I mean, there were slurs of all sorts being, it was very, very un PC, but that was my first experience qualified, so I sort of didn't have as much confidence in myself, I think, at that stage (p.3:18-20).
Psychology has a transphobia problem	*I'm terrified of the transphobia in mental health*	**Kate**	You know, I think with partly, I think that there's very few people kind of in our profession, who are actively outspokenly homophobic, I think people at least have the sense to, to keep it subliminal, you know, and just not, not say the things, even if they're slightly uncomfortable, or, but the trans stuff that is going on at the moment and the conversation around that and what I hear from professionals, is just horrific, and I see my kids going out into this world and my kids actively frightened about, about what's happening right now, to them and to their friends and to people they know through, obviously, they're in like trans youth groups and, and social circles

			and things and just terrified about what that means for them (27:8-15).
	The transphobia in the current climate has made me feel at risk of abuse for working in QT service.	**Jay**	I was doing just the thing you do, you know, if you look people up and just see what they're tweeting about, ready for the interview. And, um, and I saw it and I was like, oh, that's the job. And I clicked on it. And it was just such a string of transphobic abuse, like, um, just probably, probably, like, I don't know, 20 to 50 tweets or something, like it was like a proper stream of like, like tweets about the job I was applying for, and how awful it was and, and all this stuff. And I think there is that aspect as well, is I do feel like I have to, you know, you have to kind of cross all the t's and dot all the i's in this job for sure. And make sure that you are doing everything by the book.
	Trans existence is dangerous	**Cleo**	I know some trans trainees, um, and they've had a rough time of things. I think mental health is not a welcoming sphere for trans people, in general, at the moment, and is actually a very dangerous sphere. Well, most of the UK is quite a dangerous sphere for trans people (p.19:9-13).
	Transphobia in profession reminds us to stay vigilant	**Steve**	And you know what? And it is totally in the- In the spotlight again, with all the trans debate, because again it shows how close to the surface bigotry is. And that we might have this veneer of respectability, we might have this veneer of acceptance, but it could go wrong, like that. And all these trusts- Look at how some trusts have de, um- De-signed from Stonewall's equality plan. All those kind of things. That actually - we think the progress is in a continual, linear, forward motion, but it isn't, and it can go backwards, and we have to be vigilant. (p.18:16-p.19:4).

Living & working in community The overlap between community where you live and work is quite interesting (Cleo,p.23:17).			
The loss of elders	*My cishet supervisor can't quite offer me the guidance that I need to navigate these*	**Cleo**	I talked about it in a supervision, um, to kind of get- Get feedback from my supervisor, and I think there was a interest in- She's- She's a lovely person, she is straight, and I think there was an- There was an interest in kind of, "Ooh," you

	decisions, as cis/het worldview won't understand queer connectedness.		know, "Boundaries," and, "How does that kind of fit?" And part of me was like, "Absolutely," but also boundaries are a thing that is an interesting thing to navigate within the queer community, and, you know - degrees of separation, um - that sort of, you know, happens. I know I've definitely seen patients who are in some way connected to my best friend, for example, either as like, an ex-hook-up, or as a date -or as, in one case, a flatmate, um- Like, a friend of a flatmate. So I think there's just the- The connections that happen there, I think, can be a bit bewildering sometimes for people to kind of see. Um. I think I'm- Yeah. I haven't gotten into the conversation, I guess, more about from a political stance and a liberationist stance, and what that means (p.31:12-p.32:9).
	As a community, we have experienced the collective grief of those who didn't survive, which has left us without elders.	**Cleo**	There's something about seeing elders, I think, that is a really important thing, and- And yeah, which I'm happy to harp on about, at some point. [Laughs]…I think there's something about representation in any community that's really important… I think there is something really powerful about seeing that other people have made it to where you would like to get to. Um. And I think the- The queer community, in general, we have generations of elders that we don't have as much of. (p.7:7-p.8:3).
	I had no QT psychologists to look up to	**Sage**	I think I dissociated it because I didn't see them as congruent. I didn't see a queer person being successful, or queer psychologists, there were no models for this (p.11:32-p.12:1).
Overlapping lives	*I feel less able to participate in my community because of overlap*	**Cleo**	I don't want people to feel like they can't use that group because their psychologist is also in it. Um…I don't want people to feel like I'm observing them, or holding a barrier, or reporting back, in any way (p.25:4-10).
	I'm always aware that I might cross paths with clients in my personal life.	**Jay**	I'm always aware of like crossing paths of people in my personal life as well, um, which hasn't, hasn't happened yet, um, I don't think, in this job, at least. Um, but there is always that thing of, um, you know, yeah, how do you negotiate it, when you are part of the same community

			potentially might share the same spaces, how do you negotiate that? (p.19:4-8).
	My clients value my queer self more than my psychologist self	**Jay**	I think all my clients know I'm queer in this job. Um, I think that some of them will, I do quite a lot of thinking with clients about their relationship to help at the start of working with them. And people have had really awful experiences, that and I mean really, really terrible experiences of therapy across you know, the NHS and privately as well. Um, and I think people are often looking for queer psychologists. I will say in the first appointment quite often, um, when we're talking about it, that I am a queer person, if that's something that they've said is important to them (p.21:26-p.22:6).
Solidarity	*I feel a responsibility to protect my community from the harm that can occur in my profession.*	**Cleo**	I think probably the sense of responsibility or care towards my community also, I think is hard sometimes, where I sort of think, you know, I'm worried about what this person's experience of services will be, when they come in to the service. Um. And I think the- And then, if I find out that a person is having a hard time with the service, kind of feeling like, you know, Could I have done more? Even though I wasn't the clinician who was involved (p.34:19-25).
	I'm cautious about my association with a profession that has caused harm to my client.	**Jay**	Lots of our clients will criticise the NHS- and mental health services. Um, and one of the, um, things that will come up quite often is what is helpful in terms of you know how much you participate in that? Because I can see that in some ways, you're just going to, like, further diminish hope and that, and like I said, that I think that's a dilemma I found myself in. I know one person I work with really likes that I'm queer and that is really important. And I think they almost like that, they don't like that I'm a psychologist, and kind of see that, as you know, the things I've been trained in, have been, um, set by white, upper class men kind of thing (p.32:11-18).
	When my community is hurting, I am hurting.	**Jay**	I just had this run of appointments, where it just felt like bearing witness to so much hard stuff, that is directly related to being queer. I had like, I really felt like less much less connected to hope than I ever had, I

			think. Um, and I was really like, oh, God, I don't know if I can like, like long term, like if this is going to be sustainable, because it does take a huge amount of energy. ***Supervision had been a helpful place to process it.*** Um, but I think actually, the supervision I had around that was really good and I just, I just said, um, what was going on and *my supervisor* is really wonderful, and I think, like now, it was kind of we did some nice narrative stuff in, in supervision, which was really helpful (p.30:7-13).