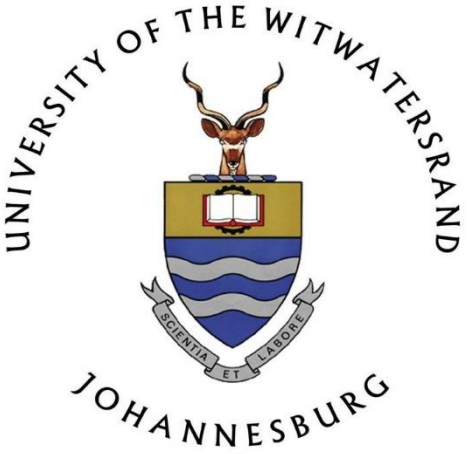

The navigation of sexual identity between novice therapists and their queer clients: Therapists' Perspectives

By:

Rebaone Kgosamang

1396263

A research project submitted in partial fulfilment of the requirements for the degree of MA by coursework and research report in the field of Clinical Psychology in the Faculty of Humanities, University of the Witwatersrand, Johannesburg.

Supervisor: Prof Carol Long

Declaration

I declare that this research report, unless specifically stated otherwise, is my own unaided work. It has not been submitted before for any other degree or examination at this, or any other university.

R. Kgosamang (signed)

Rebaone Kgosamang

1396263

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Date

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Abstract

Queer research related to psychotherapy is relatively scarce. The necessary emphasis of queer research on the HIV epidemic, social inclusion and exclusion and political and legislative issues surrounding the queer community has resulted in a relative neglect of mental health issues. Given the historical context of homophobia in psychology and psychiatry, therapists' experiences of working with queer clients are important to investigate. The current study aimed to explore how novice therapists navigate sexual identity with their queer clients in therapy. A qualitative study was conducted in which six (6) participants were interviewed using a semi-structured interview schedule. The study's sample comprised of an intern Clinical Psychologist, a newly qualified Educational Psychologist and four newly qualified Clinical Psychologists who are all in private practice. Demographically, there were two white men both of whom are cisgendered and identify as queer and four black women of whom are all cisgendered with one identifying as queer and the rest as heterosexual. A thematic analysis was conducted on the results that emerged from the interviews with the participants. The following three major themes emerged: *Disclosing sexual identity, Taking care to avoid pathologising queer clients* and *therapy shaped by therapists' own sexual identity*. The results indicated the complexity involved in navigating sexual identity in psychotherapy. Therapists experienced a process of initial unexpected openness, followed by an awareness of guardedness as well as a growing awareness of their clients' expectations of prejudice in their encounter with sexual identity in therapy. This appeared to be influenced by clients' internalised homophobia. Additionally, therapists' own sexual identity influenced how they broached sexual identity in the room, with heterosexual therapists noting a fear around misunderstand and queer therapists acknowledging a struggle with overidentification. The results implicitly revealed a gap within training programmes. Implications for practising therapists are discussed.

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Chapter 1: Introduction

Queer research related to psychotherapy is relatively scarce. The necessary emphasis of queer research on the HIV epidemic, social inclusion and exclusion and political and legislative issues has resulted in a relative neglect of mental health issues. Within the limited psychological research on queer individuals, there is a compelling call for queer affirmative mental health services (Semp, 2011). The responsibility for the actualisation of queer affirmative mental health services lies not only with the structures and bodies within the mental health sector as the general health sector, including academic, judicial, social and other sectors should equally be held accountable in working towards this end.

This proposed research aimed to play its role in reshaping queer culture in the psychology profession. Warner (2004) argues that queer research needs to stop adding letters to LGBT+ research without constructing a body of knowledge that speaks to the construction of these categories, including how they are lived daily. As such, the choice of the term *queer*, as opposed to LGBT+, represents an effort to be inclusive, flexible and appreciative of the complexity of sexual orientation. Equally, the employment of Queer Theory, as the chosen theoretical framework, is aligned with the commitment to contributing to the relatively sparse body of work in a way that appreciates, recognises and aims to uphold the nuances embedded in the queer community. It is recognised that, although related, sexual identity and sexual orientation have important distinctions (as is elaborated later). However, for the purpose of this study they are considered synonymous and thus used interchangeably.

My own identity as a novice therapist and young queer man also drove my interest in this topic. Additionally, my interest was influenced by my curiosity about how my own therapist navigates conversations about sexual identity. As such, important considerations around impartiality and constant self-reflection throughout the research process are elaborated under the reflexivity section. My positions have shaped my interest in the topic and my engagement with participants and their words. I have therefore approached this research with the value of claiming queer voices in the foreground of my mind.

Aims

The current study aimed to explore novice therapists' perspectives on how they and their queer clients navigate sexual identity in the therapeutic space. This entailed exploring how they navigate their client's sexual orientation, their client's self-disclosure and, in turn, how their clients navigate their own sexual identity. The study explored the reception of sexual orientation in the therapeutic space from the therapist's perspective, including some of the perceived influences rooted in the therapist's personal and professional identity which may have produced a certain kind of reception. Furthermore, the research explored how the therapists navigated their queer client's sexual identity in relation to their own sexual identity in the context of the therapeutic relationship.

Rationale

The rate at which emerging queer research is growing is alarming and calls for attention (Muller, 2013). In an era where the world requires mental health practitioners who are attuned and are fairly acquainted with the complexities of sexual orientation, it is worth noting that the research output on queer experience, both locally and internationally, seems to be growing at a rate that does not necessarily match the demand. In a study by van Eerden-Moorefield et al. (2018), where a content analysis was conducted on all queer-related articles in the top-ranked, general family science journals between the years 2000 and 2015, it was found that less than 3% of these articles were queer related. This study reflects the slow rate at which this field of research is growing. The research on this community generally focuses on the HIV epidemic, human rights and discrimination and stigma directed towards it (Logie et al., 2019) despite the unprecedented concern surrounding mental health issues within this community (Russel & Fish, 2016). The importance of this research area is not taken for granted, as some studies within this sector do recognize and comment on the impact of discrimination, stigma, and HIV on the mental health of queer individuals (Pereira, 2020). However, research that specifically investigates the mental health of queer individuals, let alone the psychotherapeutic process, receives the short end of the stick.

Existing psychotherapy literature seems to focus on the experiences and perceptions of queer clients in therapy (Berke & Richards, 2016; Grzanka et al., 2020; Heiden-Rootes, 2021; Israel et al., 2008; McNamara & Wilson, 2020; Quiñones et al., 2017; Rachlin, 2002; Victor, 2013).

The experiences of the therapist and how sexual identity plays out in the room is less explored. It is important to gain insight from psychotherapists' experiences with queer clients given the complex interplay of their social identities, which encapsulates their culture, perceptions and values, among other things, within the therapeutic space. Bonovitz (2005) asserts that culture, along with traditions, values, customs, perceptions and beliefs influences an individual's internal world and similarly impacts the psychotherapeutic dyad. Porter et al. (2015) also assert that who a therapist is as a person should be considered an integrative factor in all therapeutic relationships. Therefore, it is crucial to consider the various factors at play that map a therapist's mannerisms embedded in their multifaceted identity.

Furthermore, the history of psychology's treatment of homosexuality and the potential interplay it may render in both the cultural and professional identities of therapists is worth noting. Psychoanalysis, much like psychology and psychiatry, largely pathologised homosexuality (Downey & Friedman, 2008). It is granted that research exists that explores the relationship between these various schools within the mental health field and homosexuality, including its ripple effects in the field at large. However, the current study aims to uniquely explore its potential contribution within the dynamic encounter of the cultural and professional identity of the therapist and the queer client.

Therapists undertake complex negotiation of their cultural and professional identities (Tsuman-Capsi, 2012); one can imagine how stimulating and insightful the process of integrating these identities could be for novice therapists as they start in the field. Discerning one's cultural identity from one's professional identity can be challenging given the complex negotiations that need to take place between the two identities, especially for psychotherapists (Tsuman-Caspi, 2012). A professional identity is referred to as one's professional self-concept, which incorporates an individual's attributes, values, beliefs, experiences and motives (Slay & Smith, 2011). Therapists' identity formation includes the process of engaging with the actions, attitudes and values promoted by this profession while simultaneously working towards integrating these with the attributes, values, beliefs and worldviews of their larger identity system (Lile, 2017). Although the intersection of all the varying identities therapists embody is worth exploring, this research focused primarily on how the intersection of cultural and professional identities may inform how sexual identity is negotiated within the therapeutic space. It is likely that beginner therapists actively engage with this back-and-forth rendered by their cultural influences as they become

psychotherapists. Owen-Pugh and Baines (2014) argue that novice therapists lack the life experience needed to appreciate the difficulties that queer clients face, including acknowledging the damage unintentional, heteronormative assumptions can have on the therapeutic relationship and the client. This may be the case even for novice therapists who are queer but is likely to apply to heterosexual therapists in particular. In the same breath, one can argue that novice therapists could render a unique and even more effective psychotherapeutic experience for queer clients, given that they suffer from performance anxiety as they start in the field (Scovholt & Rønnestad, 2003). As such, this anxiety may see them being extra cautious with a queer client given their understanding, or lack thereof, of queer issues. It is thus important to explore therapists' perceptions on the highly stigmatized issue of sexual identity in psychotherapy.

Additionally, this study focuses on how therapists make sense of the client's negotiation of their sexual identity within the therapy space. The aspirations of this study are twofold: Firstly, to highlight the challenges and triumphs that beginner therapists experience in their encounter with issues of sexual orientation; secondly, to contribute towards the body of work that explores the unique avenue of the experiences of novice therapists and their encounter with sexual orientation.

Theoretical Framework

The current study aims to contribute to the development of queer-related research in psychotherapy. Available literature on these two constructs is sparse and warrants further exploration. The queer community is one of the most misunderstood groups in society, and it can be argued that this is partly due to the reason outlined above – lack of research. This study's adoption of Queer Theory as part of its framework is premised on the dismantling of 'normativity' as expressed and represented both implicitly and explicitly within the psychology profession. Queer theory is an academic movement that focuses on the construction of sexual, gendered identities and categorisations; more specifically, it aims to cast doubt on the widely accepted truths about these constructs and their rigidity (Callis, 2009; Owen, 2017). Queer theory seeks to challenge the dichotomous understanding of the world (Meyer et al., 2021). Categorisation can be argued to be an outgrowth of perceived dichotomies between the normal versus the non-normal. Given the history of psychology and its pathologising stance on homosexuality (Drescher, 2015), it is important to understand that

these dichotomies stem from categorising and attempting to understand something deemed to deviate from the norm, and so had to be controlled (Warner, 2004). Thus, social rules and laws sought to restrict any deviant behaviours from what was perceived and widely accepted as normal.

Butler (1990, as cited in Riggs & Treharne, 2017) argues that bodies and psyches are not produced through individuals' intent but rather by what she referred to as the matrix of intelligibility. In the context of sexuality and gender, she asserts that there is a matrix of gendered norms within which particular modes of being are rendered unintelligible and impossible (e.g., a woman who is sexually attracted to another woman). In contrast, other modes are rendered intelligible and possible (i.e., a woman being sexually attracted to a man) (Riggs & Treharne, 2017). The matrix constitutes a person by articulating differences between individuals based on what society perceives as 'natural' categories: man, woman, black, white etc. Once an individual is identified as in a particular category, assumptions on how they should be are made, making them knowable and categorizable (Warner, 2004). Any deviation from assumptions and behaviours accepted as known and categorizable is seen as abnormal.

All bodies and psyches are offered intelligibility through their relationship with a set of norms (Riggs & Treharne, 2017). These norms generally privilege white, heterosexual, young, able-bodied and middle-class individuals. It is argued that deviance from 'natural identities' makes one 'unintelligible' and warrants punishment for that individual (Riggs & Treharne, 2017). This process is seen in the discrimination directed towards individuals who do not fit the mould in terms of sexuality, gender identity, race, religion etc. Rigg and Treharne (2017) contend that prescribed norms cannot, in and of themselves, represent an actual normative body or individual. Instead, they represent a normative fantasy in which the normative standard is aspired to but can never be achieved in finality. Queer theory thus aims to demonstrate how approximation to norms will remain an approximation and always at risk of failure. As such, heteronormative standards and norms can only be aspired to as they cannot be fully achieved. Individuals can only but perform their identities to maintain the fantasy of achieving the normative (Butler, 1990 as cited in Riggs & Treharne, 2017).

Queer theory contends that for heteronormative standards and ideologies to be challenged, individuals should go beyond subscribing to one strict category and instead embrace a

multiplicity of categories (Warner, 2004). It explores privileged identities and how normalisation is used to influence organisations and enforce a unidimensional way people should interact (Meyer et al., 2021). Peters (2005) asserts that part of the queer movement's intentions with the birth of Queer Theory was to avoid reinventing the heterosexist binary of 'heterosexual' and 'homosexual'. In this binary, heterosexuality referred to the physical, emotional and sexual attraction to the opposite sex and homosexuality referred to the same attraction towards the same sex (Muller, 2013). According to Peters (2005), queer theorists argue that offering homosexuality as a challenge against heterosexuality is futile because it involves replacing one inadequate group with another seemingly inadequate one. In this example, both categories are considered flawed because they are applied as fixed identities in the social context (Peters, 2005). Queer theory calls for the suspension of the 'gay', 'lesbian', 'bisexual' classification system because it recognises these sexual and gendered identities as social, multiple and fluid (Abes, 2008; Peters, 2005).

Queer theory proposes using the term *queer* as opposed to 'gay' and 'lesbian' because gay and lesbian theories from the early gay liberation movement subscribe to the very heterosexist ideologies they seek to distance themselves from (Pickett, 2018). Pickett (2018) argues that the description of the identity of 'Lesbian', as portrayed by lesbian theory, is exclusionary because this description is derogatory. It fails to capture the complexity of sexual identity which accommodates heterosexual women who may experience emotional and sexual attraction to women but do not consider themselves queer. The term queer, on the other hand, transcends the confines of the notion of 'identity'. It does not refer to an essence, whether sexual or not in nature; it is considered purely relational and thus encapsulates all variants that deviate from what is referred to as the norm (Picket, 2018).

Queer Theory bases the proposed suspension of identity categories on the supposition that the foundations of identity are unstable. Instead, identity is understood as performative and based on fluid differences instead of a unified essence (Abes, 2008; Pickett, 2018). Warner (2004) reiterates this by positing that homosexuality and heterosexuality are as thoroughly performative as masculinity and femininity. It is difficult to properly define what it means to be homosexual and what it means to be heterosexual. In Abes' (2008) words, it is difficult to define these identities fully as sexual orientation and sexual identity are not a unified essence. For example, the acronym LGBTQIA+, while aiming to represent the various sexual

orientations it stands for, in and of itself subscribes to and thus perpetuates and reproduces the heterosexist tendencies of categorising that Queer Theory cautions against.

Acknowledging the inevitable failure of language to capture fluidity, the current research adopted the holistic term *Queer*. As argued earlier, queer research should not add letters to the LGBT+ acronym without including the body of knowledge that reveals how these categories are formed and lived out daily. Warner (2004) further cautions that queer research needs to be reflexively aware of how it constitutes the object it aims to study. He asserts that the subject-object dichotomy that positivist research studies presume eludes the constitutive nature of knowledge production (Warner, 2004). This requires the researcher to be cognisant of their role in shaping the knowledge produced. As such, constant reflection on the researcher's influence on the results, the interpretation and the write-up are required. Warner (2004) further contends that a qualitative inquiry into queer individuals' experience is important because of its ability to avoid assuming a sense of commonality between different individuals' lived experiences and desires. He argues that qualitative work stands a better chance of accounting for queer experiences in terms of the actual and lived experiences of this group of people.

Structure of the thesis

Including this introductory chapter, this thesis consists of five chapters that describe and outline the research aims and rationale for the study, the process undertaken to investigate the phenomenon under investigation and the findings that emerged.

Chapter 2 presents a literature review relevant to the current study. The literature review contextualises and situates this study within the existing literature. Firstly, general literature on the queer community is explored. Secondly, literature examining the relationship between the history of psychology and queerness is discussed. Lastly, literature published on the intersection between psychotherapy and queerness is explored.

Chapter 3 consists of the research questions followed by the method and qualitative design of the study. It further outlines how the data was collected and analysed, with a detailed elaboration on how the sample was recruited, the method used to collect the data and the chosen method of data analysis. The chapter concludes by discussing the rigour and trustworthiness of the study, followed by reflexivity and ethical considerations.

Chapter 4 presents and discusses the key findings that emerged from the data under three major themes: *Disclosure of sexual identity* describes the process through which the queer clients disclosed their sexual identity to their therapists and, the therapists' process of disclosing their sexual identity to me, the researcher, during the interviews*; Taking care to avoid pathologising* explores how therapists broached their therapies in attempt to not pathologise their queer clients' sexual identity in therapy; and lastly, *Therapy shaped by therapists own sexual identity* discusses how therapists' sexual identity influenced how they experienced and conducted their therapies with their queer clients.

Chapter 5 presents a discussion of the findings in the context of existing studies to highlight that which is consistent with the studies in this field and to identify what diverged from that which other studies have found. Implications for therapists and for training programmes are presented. The chapter concludes with considerations about the limitations of the study, directions for future research and a conclusion that summarizes the findings.

Chapter 2: Literature Review

The literature reviewed on the intersection of queerness, psychotherapy and novice therapists will be divided into three sections. Firstly, a discussion of the queer community and the politics around identity and sexual orientation is offered. Secondly, literature that explores the history between psychology and homosexuality will be presented. Thirdly, the intersection between psychotherapy and homosexuality will be explored with a particular focus on queer-affirmative practices and the appropriateness and competence of current therapist training programmes.

The Queer Community

The Queer community is a group of people who have been largely marginalized based on their sexual orientation. The 'Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual' (LGBTQIA++) acronym abbreviates a group that differs based on sexual orientation. Additionally, their sexual identity is intersected by other constructs such as gender, race and socioeconomic status (Boroughs et al., 2015; Mohr & Fassinger, 2006). Despite being problematised by queer theorists, it is important to highlight that each letter in the acronym i.e. 'L', 'G', 'B', 'T' etc. represents distinct populations, each with its unique challenges, concerns and needs (Mohr & Fassinger, 2006; Muller, 2013). Moreover, it should be understood that queer individuals' identification with a particular sexual orientation intersects with other salient aspects of their social, ethnic and cultural identities (Rusells & Fish, 2016). In the context of these important caveats, the term 'sexual orientation' refers to an enduring pattern of romantic, emotional, physical and sexual attraction towards a man, woman or both (Gates, 2011). Unfortunately, modern society subscribes to the misconception that sexual orientation predominantly refers to the sexual attraction an individual has to a particular sex. Despite the idea that sexual orientation encompasses sexual identity, sexual attraction and behaviour, which may seem to be interchangeable, scholars of sexuality have noted important distinctions between these three concepts (Egan, 2012; Geary et al., 2018).

There has been an overemphasis on the queer community's sexual behaviour and attraction, as highlighted through the extensively researched HIV epidemic, which seems to put attention on sexual aspects of queerness to the neglect of the complexity of sexual identity

(Muller & Hughes, 2016). Most of what is known about queer health is based on research conducted in highly resourced countries, especially in the United States. Existing research is heavily skewed towards queer men with a noteworthily disproportionate focus on HIV and other sexually transmitted infections (Muller & Hughes, 2016). Research studies on this community have constantly foregrounded the HIV epidemic to the relative neglect of other crucial aspects of queer individuals' health (Logie et al., 2019). This illustrates just how focused research was, and arguably still is, on the sexual attraction and behaviour of the queer community. Such research potentially becomes an additional stigmatising agent because it portrays this community in a particular light without considering the other complexities that may exist. It would be expected that there would be a neglect of other queer health issues, such as mental health and the intricacies that are embedded in the sexual orientation identities of this community.

As aforementioned, there are various subgroups within the queer community, each of which has its unique challenges, concerns and needs. An important distinction to note is the difference between 'cisgender' and 'transgender'. 'Cisgender' refers to the congruence of a person's gender with their sex assigned at birth. 'Transgender', which does not refer to a particular sexual orientation, references the difference between the sex assigned at birth and the individual's experience of their gender outside of cultural and societal expectations. Although 'transgender' is included in the queer categorisation system, it does not imply any specific sexual identity, as do its companion identities (Abreu et al., 2017). This illustrates how multifaceted sexual orientation is and how identity labels sometimes fall short in fully capturing and representing queer people's sexual identity. As helpful as they are with providing facilitation of social support and increased visibility of the community, identity labels are quite limiting. Muller and Hughes (2016) argue that these labels reflect the historical understandings of sexuality as defined by the dominant cultural group and thus fail to represent the full scope of sexual orientation. This argument revisits the earlier discussion about how the focus on queer individuals' sexual orientation neglects the other aspects of their experience and larger identity systems.

Given the theoretical framework of the current research, we understand that the idea of identities is, in and of itself, a problematic concept. Every individual may have several identities and with these identities come inclinations and desires; however, these inclinations and desires do not necessarily constitute identities. They are perceived as performative, rigid

and scripted phenomena that are not fully determined (Lance & Taneshini, 2000; Rumens, 2016). Queer theorists find it problematic that the concept of identity attempts to offer a unified essence of being, which fails to capture the fluidity of sexual orientation and sexual identities. They also argue that this concept is fundamentally based on heteronormative ideologies (Rumens, 2016). Heteronormativity has birthed misconceptions about the queer community due to misinformation and misunderstanding about the complexity of queerness.

Several widely held misconceptions about sexual orientation continue to uphold stereotypical and misinformed ideas about queerness in society. Firstly, there is a misconception that queerness is a phase. This statement is generally attributed to adolescents who express an attraction to and interest in their same-sex peers. This misconception gained currency by labelling adolescents as 'confused' and 'misguided' given that their identities are forming at this stage (Abreu et al., 2017; Butler et al., 2006). The second widely held misconception is that queer individuals are easily identifiable. This idea is often premised on an individual's gender performance. For example, men who display behaviours society generally ascribes to women are labelled queer. Sexual identity and gender identity are distinct forms of identity. It is contended that one's gender performance does not necessarily relate to or indicate a person's sexual identity (Muller & Hughes, 2016). Thirdly, it is believed that queer individuals can't keep their feelings to themselves. This misconception drives the notion that queer individuals cannot keep their sexual and gendered identities 'silent'. This belief serves to invalidate the existence of sexual minority individuals by restricting the expression of their various identities (Rumens, 2016). Fourthly, it is held that queer individuals are overly promiscuous. This assumption seeks to pathologise the expression of queer sexual desires and fantasies. Fifthly, gender-neutral facilities are believed to be a threat to safety and order. This assumption is wholly based on maintaining binary and heteronormative standards that seek to exclude sexual minority group members (Abreu et al., 2017; Butler et al., 2006). The only way existing myths and misconceptions could be effectively combatted is through knowledge dispersion and consumption.

Psychology, Queerness and Queer identities

It is widely known that psychology and homosexuality have a troubled history. The impact of the discipline on pathologising homosexuality was significant (Dresher, 2015). This pathologisation extends not only across its subdivisions and specialisations but also

across disciplines. Despite this pathologising history, psychological practices have moved away from the notion of how to 'treat' clients that identify as homosexual to a more neutral approach of how to be 'in-relation-with' with these clients in the therapeutic space (Porter et al., 2015). Contemporary psychotherapy literature insists that queer clients be afforded empathy and an interest in their sexual orientation (Owen, 2017). This stance, if fully actualised, would not only match the progress displayed by the widespread international transformation of legislation but would also render a more receptive and non-judgmental health care service delivery on a larger scale. This would allow for better health care service utilisation by these individuals and more sensitive and appropriate psychotherapeutic interventions. Unfortunately, given the history between homosexuality and psychology, homophobic and heterosexist influences inevitably penetrate not only day-to-day social encounters but also therapeutic encounters (Porter et al., 2015).

Historically, homosexuality was pathologised by psychology scholars who deemed it a personality disturbance from the first instalment of the *Diagnostic Statistical Manual* (DSM) in 1952 (Owen, 2017). One of the major influences which led to the distorted views of homosexuality is Freudianism (Friedman & Downey, 2016). As unclear and contradictory as Freud's assertions were on homosexuality, he strongly asserted that unconscious homosexuality was a sign of pathology. Homosexuality was attributed to maladaptive psychic development (Goodwin, 2014). Until the 1970s, clinical models focused on identifying the aetiology of homosexuality. Psychology and psychiatry held a pathologising view of sexual and gender diverse practices. Heteronormativity was situated as the optimum state of mental health (Tomicic et al., 2020). Drescher (2015) investigates the etiological theories which contributed to the pathologisation of homosexuality in the DSM. He categorizes them as theories of 'pathology', 'immaturity' and 'normal variation'.

Theories of pathology referred to adult homosexuality as a condition that deviates from 'normal' heterosexual development (Dresher, 2015). These theories regarded homosexuality as a disease. They posit that homosexuality is caused by an internal defect or some external pathogenic agent, either pre- or postnatally. Some examples include excessive mothering, exposure to certain hormones in the uterus and hostile or absent fathering. They premise the pathology on the atypical presentation of behaviours that deviate from the prescribed gendered norms. Owen-Pugh and Baines (2014) argue that the search for the aetiology of

homosexuality is idealistic and impractical. The intrinsic intention behind this will-to-knowledge is to objectify and normalise.

The other category Drescher (2015) presents is termed ‘immaturity’. He asserts that theories of immaturity, normally psychoanalytic in origin, are premised on the idea that expressions of homosexuality and feelings towards same-sex individuals form part of a normal trajectory towards heterosexual development (Dresher, 2015). This premise holds that homosexuality is merely a phase through which individuals pass and is later outgrown. Accordingly, individuals who exhibit homosexual behaviours in adulthood are considered stunted in their growth (Drescher, 2015). Theories of pathology are premised on Freud’s (1905, as cited in Drescher, 2020) assertion that everyone is born with bisexual tendencies. As such, expressions of homosexuality were perceived as normal. However, adult expressions of homosexuality were perceived as problematic and seen as an arrest in one’s psychosexual development (Drescher, 2020). Freud’s theory of psychosexual stages of development proposes that individuals pass through a series of developmental stages during their lifespan, each characterized by the different modes of functioning. The theory argues that any mishap that occurs at a particular phase, especially in early childhood, plays an integral part in the aetiology of psychological difficulties (Philip, 2021). Immaturity theories perceive homosexuality as a developmental arrest, or stunted growth, indicating failed progression to the next psychosexual stage of development.

Lastly, the category of ‘normal variation’ consists of theories that perceive homosexuality to occur naturally. These theories are based on the idea that queer individuals are born different. This difference is explained as an innate, natural difference that affects a small group of people, similarly to ambidexterity or left-handedness. These theories are succinctly captured by the infamous saying about being ‘born gay’ (Drescher, 2015). Despite the APA’s 1973 diagnostic revision, which led to the de-pathologisation of homosexuality, it can be argued that structural bodies within the moral and political realms such as religion, government, media, military and educational institutions continue to maintain this discriminatory stance (Drescher, 2015). Since acknowledging the progress psychology has made in normalising homosexuality, its troubled history with homosexuality still haunts it.

Owen-Pugh and Baines (2014) argued that the tendency of medicalising individuals who identify as either gay, lesbian, bisexual or transgender is an outcome of a heterosexist bias

that originates in Western society. They further argue this phenomenon is embedded in various psychotherapy theories, implying that homosexuality should and can be converted (Owen-Pugh & Baines, 2014). This suggests how deeply entrenched heterosexism – arguably homophobia - is in psychological theory, and how challenging it might be to fully emancipate mental health care professionals, including queer professionals, from their potentially heterosexist assumptions, prejudices and perceptions. Drawing on the idea of therapists' intersectionality explored earlier, Lily (2017) makes an important point about therapists' identity formation. She asserts that their identity formation process includes assimilating all the profession's actions, attitudes and values into their already-existing larger identity system. However, the larger identity systems of the therapist may prove to be in contradiction to the implicit heterosexist views held by the profession. Therefore, curiosity and creativeness may be cultivated instead of a culture of perpetuating and further reproducing heterosexist tendencies.

It has been reported that being in a highly stigmatising environment is detrimental for queer individuals. Research has indicated that some queer individuals exhibit signs of internalised homophobia as a result of being amidst an excessively hostile social environment (Williamson, 2000). Internalised homophobia is referred to as the tendency of a homosexual individual to direct negative social attitudes towards the self, which results in a devaluing of the self and subsequent poor self-regard and internal conflict (Frost & Meyer, 2009). Coolhart (2005, as cited in Moore & Jenkins, 2012) assert that, due to the excessive homophobic culture that queer individuals are exposed to throughout their lives, there is a possibility that they may suffer from the psychological effects of internalized oppression. Internalised homophobia is highly associated with internalizing mental disorders such as depression, anxiety and trauma-related disorders and affects one's quality of life and life satisfaction (Ventriglio et al., 2021). Ong et al. (2021) contend that internalised homophobia is the most proximal stressor to the queer individual compared to discrimination and experienced or perceived homophobia. It has also been noted to be inversely correlated with one's self-acceptance of sexual identity. Identity synthesis, which refers to the process of integrating a particular identity into the larger context of oneself, is argued to hinder by oppressive forces, including internalised homophobia alongside heterosexism and homophobia (Satterly, 2006).

Internalised homophobia impacts the queer individual's personal and professional well-being and can affect their professional space, both within and outside their awareness. For example, Moore and Jenkins (2012) found that all their participants, who were practising therapists, expressed that their fears about the outcome of disclosing their sexual orientation to their clients were based on their preconceived prejudices and assumptions about potential rejection and judgement.

Satterly (2006) investigated the decision-making processes behind queer male therapists' intentions to self-disclose their sexual identity to their queer and straight male clients. In this study, three major themes emerged from the results: Identity Creation, Individual Identity Management (Pre-Client Contact) and Identity Management (Client Contact). The identity creation theme unpacked participants' dual identity of being both queer and a therapist, necessitating scrutiny of ways of existing in the professional setting. The second theme, Individual Identity Management (Pre-Client Contact) explored factors associated with therapist self-disclosure outside of the therapeutic relationship, which informs the decision of managing identity before working with the client (Satterly, 2006). Thirdly, the theme of Individual Identity Management (Client Contact) documents the converse of the previous theme where factors associated with therapist self-disclosure are within the context of the therapeutic relationship. Of particular interest were sexual identity development and oppression themes, which highlighted a complex interaction between internalised homophobia and therapist self-disclosure. Some therapists recognized the reluctance of self-disclosure as informed by speculations around what their clients would think of them (Satterly, 2006).

Similar studies corroborate the above study's findings, including Moore and Jenkins (2012) (See also Carroll et al., 2011; Hearn & West-Olatunji, 2015; Manian, 2021; McPherson 2020; Thomas, 2008). The commonality across these studies is that therapists expressed difficulties disclosing their sexual orientation to their patients because of a fear of homophobia from their clients. This may signal an internalised homophobia that originates from the therapists themselves, speaking to the mapping of these therapists' potentially implicit internalized homophobia onto their clients. Many therapists have recognized that their fears around self-disclosure are largely based on internalised homophobia, prejudices and assumptions (Manian, 2021). These fears may also be influenced by the sensitivity, or lack thereof, to queer issues in therapy training programmes.

Training programmes for health care professionals do not contain sufficient queer content (Muller, 2013). This imbalance is compounded by limited research and knowledge about queer issues. Muller's (2013) findings revealed that one of South Africa's leading tertiary institutions had inadequate queer related content in its MBChB[1] curriculum. Like the broader society, healthcare professionals play a role in perpetuating the stigmatizing and negative attitude towards learning about queer individuals and related issues (Rambarran et al., 2021). Rambarran et al. (2021) found that medical students in Guyana reported not having received queer-specific medical education in their programme. Additionally, heterosexual orientation emerged as one of the other main contributors associated with negative attitudes to queer issues. Several other recent studies similarly highlight the impact of lack of queer content in training programmes (e.g. Moretti-Pires et al., 2020; Stryker et al., 2020; Yamazaki et al., 2021).

It is evident that heterosexism and inactivity in research for queer mental health issues have a firm grip on the professional sphere. Mental health professionals need to be aware of the subtle heterosexist tendencies that may simmer through in their service delivery. It is equally important for these professionals to find creative ways to combat the perpetuation of homophobia. It is argued that 'in the same way that it is important to understand the ways racism and sexism influence the lives of clients and therapists alike, it is equally important for therapists to understand the oppressive influence that heterosexism may have on the lives and functioning of queer clients and how it may negatively influence the therapy process' (McGeorge & Carlson, p1, 2009).

Psychotherapy and Queerness

Encountering queer clients in psychotherapy may prove to be a difficult experience for a novice therapist, given how sensitive this issue is both within and outside of this profession. However, it can equally and contrarily be a rewarding and insightful experience. Psychological research has reported on the detrimental effects of overt heterosexism ideologies on queer clients (Logie et al., 2018; McLaren & Castillo, 2021; McGeorge & Carlson, 2009; Sanscartier & MacDonald, 2019; Shelton & Delgado-Romero, 2013; Villarreal et al., 2021). Evidence suggests that heterosexism and homophobia can lead to the

[1] Bachelor of Medicine and Bachelor of Surgery

breakdown of the therapeutic relationship as they may have negative effects on queer clients, particularly if the therapist is oblivious to their underlying operation and effect (Porter et al., 2015). As aforementioned, these heterosexist and homophobic tendencies operate in the social world and penetrate psychotherapy (Porter et al., 2015). How they present in therapy may be somewhat disguised, and it is the therapist's responsibility to notice them and actively work towards neutralising them. Shelton and Delgado-Romero (2013) argue that subtle forms of heterosexism could potentially intrude into therapy through the form of microaggressions. They define microaggressions as forms of communication filled with prejudice and discrimination, expressed through seemingly harmless, meaningless tactics where examples include dismissive looks, snubs and gestures (Shelton & Delgado-Romero, 2013).

The study's extended interest is on how therapists perceived their subjective stances to influence the reception and ultimate navigation of sexual orientation in the therapeutic relationship. Shelton and Delgado-Romero's (2013) findings suggest that microaggressions do indeed exist in therapy as experienced and reported on by the clients they interviewed. Their study focused on gaining insight into how queer clients experienced their therapists' stance on sexual orientation and ultimately how they navigated it in therapy. It is important for therapists to explore both potential microaggressions and implicit heterosexist tendencies and instances of deep understanding. Similarly, because the therapist's sexual orientation, whatever that may be, is also a part of the therapeutic encounter, it is important to explore how this is experienced. The interaction between the therapist and the client's sexual orientation is generally neglected in the literature.

Owen-Pugh and Baines (2014) report that beginner counsellors are more likely to encounter queer clients in the early years of their clinical experience, which proves to be informative given the active engagement between their personal and professional identities at those stages of their careers. They further posit that personal identity work is called for, especially for therapists who hold negative views about sexual orientation. Training in queer-affirmative practices to foster positive, therapeutic outcomes for these clients is recommended. It is argued that the inadequate use of queer-affirmative practises and awareness may interfere with care, lead to the worsening of queer clients' symptom presentation and diminished future help-seeking (Mizock & Lundquist, 2016). Although training programmes for mental health practitioners still do not adequately equip trainees to deal with queer related issues, suitable queer-affirmative training has been identified. It has been reported that experiential

learning opportunities immensely contribute to countering negative attitudes towards queer issues and queerness more broadly (Owen-Pugh & Baines, 2014).

Hancock (2014, as cited in Hathway, 2014) captured the core of the conflict for training programmes: "when the personal beliefs of a student interfere with or impair the provision of competent services as defined by the profession to a particular group of people, it is incumbent upon educators to address this problem" (Hathaway, 2014 p. 98). Many professional psychology training programmes have committed to equipping trainees with the necessary skills to be multiculturally competent to deal with diverse populations; however, it is argued that this commitment has emphasized racial and ethnic minorities to the neglect of sexual minorities (Hope & Chappell, 2015). As any novice therapist rapidly learns, different clients present with a range of issues that include intersecting characteristics rarely evident at the early stages of treatment. The onus is thus on training programmes to equip students with foundational and transferrable skills which allow them to competently navigate clinical situations which require negotiation of identity issues such as those related to race, gender and sexuality (Hathaway, 2014). Literature reports that queer individuals have higher mental health problems rates than their counterparts but often report dissatisfaction with mental health care services due to limited practitioner knowledge regarding queer issues (Pepping, Lyon & Morris, 2018). The recent introduction of the conscience clause in Arizona, Tennessee, may prove to set back the progress made on queer-affirmative psychotherapeutic practises. Under the clause, mental health practitioners, specifically those in private practice, may refuse to offer services to any client based on the practitioners 'sincerely held principles' (Grzanka et al., 2020). While the language of the clause is ambiguous, it is concerning that this clause may be applied to sexual and gendered minority groups. Such attitudes may continue to diminish the help-seeking tendencies of queer individuals in light of such developments in the judiciary sector. This may also impact individuals' attitudes towards queer issues and individuals depending on how influential this law may become.

Owen-Pugh and Baines (2014) conducted a study on the clinical experiences of novice therapists with queer clients. The participants in their research submitted highly negative evaluations of their past training, highlighting that they felt unprepared and unskilled for their encounter with sexual orientation in therapy. The participants further reported that they found themselves relying on and drawing from their personal, lived experiences with queer individuals who became a valuable source of knowledge (Owen-Pugh & Baines, 2014). Their

findings also highlighted the need and importance for queer-affirmative attitudes and practice within the therapeutic encounter. Concerns about training and competence when working with queer clients have also been raised, as noted in rehabilitation counselling students' experience working with the two intersecting minority statuses of sexual identity and disability (Meyer, 2020). Considering the scarcity of specific sexuality training, the treatment outcome and therapeutic relationship are often influenced by therapists' ability to manage their reactions towards queer issues as they emerge in their therapies, including working creatively and therapeutically (Kelly, 2020).

Queer-affirmative psychotherapy is not an independent theoretical orientation. It is a set of additional attitudes, knowledge, and skills that can be applied in conjunction with an existing orientation (Pepping et al., 2015). This orientation necessitates that therapists develop and demonstrate: a) the capacity to be open, willing to understand and be self-aware of their attitudes, social biases, prejudices and stereotypes regarding sexual orientation; b) proactivity in accumulating knowledge about sexual orientation development, including queer psychosexual issues and disparities in mental health issues, and c) clinical skills of a professional standard to provide care and services to the queer community (Bidell & Whitman, 2014; Boroughs et al., 2015; Ferrufino, 2019; Pepping et al., 2015). There is a particular emphasis on the therapist's attitudes as it is considered to predict their engagement in affirmative practises and their clients' perceptions of the helpfulness of psychotherapy (Pepping et al., 2015).

Queer-affirmative practice is centred around three key competencies (Sue, 1991, as cited in Hope & Chappell, 2015). *Attitudes* refer to the therapist's awareness of cultural differences and how their culture influences how they view others. *Knowledge* refers to the understanding of norms, practices and values of particular ethnic and cultural groups. *Skill* refers to the active effort exhibited by therapists to enhance their multicultural knowledge and attitudes through education consultation (Hope & Chappell, 2015). For therapists to effectively address their implicit and explicit beliefs and attitudes towards individuals of different cultural backgrounds, a constant process of self-introspection is necessary. This level of self-awareness includes understanding one's values and beliefs as well as being aware of the cultural and institutional norms that privilege dominant ideologies to the detriment of minorities (Borough et al., 2015). The second core competency is knowledge: therapists should actively acquire, integrate and apply information on queer issues. This

involves familiarizing oneself with key historical events and significant points in the queer movement to gain insight into the scarcely documented content in training programmes on this community's history with discrimination and devaluation. It is an effort that works towards understanding the important aspects of this group's history, socio-political context, and the applicable empirical and clinical literature within the psychology profession (Borough et al., 2015; Hope & Chappell, 2015). The last core competency is skill which speaks to the ability to be culturally sensitive in consultation, assessment, treatment and supervision. It is argued that skill translates the first two competencies into practice (Hope & Chappell, 2015).

Pepping et al. (2015) conducted a study on the effectiveness of therapist training in queer-affirmative psychotherapy with 96 therapists with varying tenures in the field. The queer-affirmative psychotherapy training was based on the core competencies that were discussed above. Their findings indicated an increase in knowledge and skills related to working with queer people as reported by the therapists and reduced homonegative and trans-negative beliefs. Victor and Nel (2017) conducted a study on queer individuals' psychotherapy experiences in an effort to inform practice guidelines. They found that queer clients' positive experiences entailed receiving unconditional positive regard, non-judgement and acceptance, including the therapists' affirming attitudes towards their clients' sexual orientation. It is argued that through queer affirmative psychotherapy training, a therapists' openness expands to recognize the range of sexual orientation identities, which plays a role in exhibiting warmth towards the client. Additionally, the acquired knowledge competency to work with this group affords therapists a wider scope of interventions to explore given their knowledge about queer issues (Israel et al., 2007).

To minimise the impact of heteronormativity within the therapeutic context, therapists ought to actively acquire information, training, and personal insight to offer a service that is welcoming and accepting of queer clients' sexual orientations. Owen-Pugh and Baines (2014) argue that queer-affirmative basic training is not sufficient on its own. For therapists to develop the capacity to effectively work with queer clients, they would have to reflect on their personal dispositions, underpinned by their core values, political allegiances as well as varying levels of self-confidence and social anxiety (Moor, 2002 in Owen-Pugh and Baines, 2014).

It is evident that it will take more than just training programmes to develop therapists who are competent to work with queer clients. It should also be noted that much of the research cited above implicitly assumes that therapists themselves are heterosexual and/or heterosexist. The need for sensitivity to queerness in psychotherapy may entail similar issues for therapists who are themselves queer, but different issues will inevitably be involved.

CHAPTER 3: METHOD

The current study was framed by the following research questions:

- How do novice therapists and their queer clients navigate sexual identity in therapy?
- What makes it easier or more difficult to navigate this process in therapy?
- How do queer clients negotiate their sexual orientation in therapy, according to their therapists?
- How does the therapist's sexual identity impact therapeutic process and relationship?

Research Design

The current study employed a qualitative design in its approach. This approach, compared to its counterpart which is primarily based on the quantification and categorisation of phenomena and experiences through asking closed-ended questions, is characterised by its ability to focus on understanding the textured life experiences of human beings as well as their reflections on those experiences (Jackson et al., 2007). Quantitative research typically emphasizes outcomes and frequencies which generally leads to the neglect of the impact of experience whereas qualitative research is immersed in gaining an understanding of both the impact of that experience and the experience itself (Webster & Mertova, 2007). The qualitative design is an approach that relies on its participants for in-depth and rich information about how they constructed and made sense of their experiences (Ashworth, 2008; Jackson et al., 2013). This approach is best suited for this research, as the focus was on attempting to understand the experiences of novice therapists in their encounter with and navigation of sexual orientation in the therapeutic space.

Sampling

Volunteer, non-random sampling utilizing snowballing techniques were employed. To start the snowball, current interns and newly qualified Clinical, Counselling and Educational psychologists from the University of the Witwatersrand were emailed information about the study and requested to volunteer. Existing email lists were used. Potential participants were also asked to forward the invitation to any other qualifying participants they know.

Choosing a qualitative design and thus a sampling technique that is innate to this design allowed for the effective use of limited resources (Palinkas et al., 2015). Butina (2015) argues that sample sizes in qualitative inquiry tend to be small and that rules for sample sizes tend to be ambiguous in this kind of inquiry. A sample size of 6 participants was recruited for this study. Recruiting potential participants for the current study proved challenging and required several invitations to participate. Interestingly, given the minority of queer psychologists in the field, half of the current study's sample consisted of queer psychologists while the other half was made up of heterosexual psychologists. The study's sample comprised of an intern Clinical Psychologist, a newly qualified Educational Psychologist and four newly qualified Clinical Psychologists who are all in private practice. Demographically, there were two white men both of whom are cisgendered and identify as queer and four black women of whom are all cisgendered with one identifying as queer and the rest as heterosexual.

The following inclusion criteria were used: 1) Participants have some experience working with queer clients in psychotherapy; 2) Participants are 'novice' therapists (i.e. they are in their first five years of training/practice) and registered as counselling, clinical or educational psychologists with the Health Professions Council of South Africa. The study did not necessarily focus on novice therapists of a specific gender, ethnic, racial, sexual orientation or cultural background in the recruiting process. This allowed for an inclusive approach that comprised a variety of accounts of experience from a diverse group of individuals. Although the study did not intend on comparing experiences based on any of the demographic characteristics of the therapists outlined above, it was interesting to note the even divide (3:3) between the participants who identified as queer and those who identified as heterosexual. It is crucial to note that the sample's demographic characteristics was not necessarily the focus of the study; however, there was a need to recognise and highlight each of the participants' sexual identity as identified and self-disclosed by the participants themselves. This assisted with highlighting the nuanced differences and similarities in the responses offered by the participants in the interview. The sample consisted of therapists who have been trained and have worked with a diverse population. This lends it some advantage in that exposure to multicultural backgrounds may have shaped their navigation of their clients' sexual orientation in a manner that is different to a therapist who is trained and has worked in a less diverse cultural location.

Data Collection

The chosen data collection method for the current study was semi-structured interviews. The interviews consisted of open-ended questions. It is argued that semi-structured interviews are generally suited for thematic analysis as they impose topic areas on the participants' thinking. The objective was to gain a naturalistic inroad into the participants' meaning systems regarding the phenomenon under study (Joffee, 2012).

The open-ended questions were accompanied by complimenting probing questions which not only maintained the frame of the interview but also extracted more detail from the participants. Thus, as per the interview schedule appended (Appendix A), the questions were designed to frame the scope of the interview; additional, probing questions were asked during the interview to gain more insight into these therapists' experiences and to ensure that the interview is experience-centred as recommended by Squire (2013). The questions were phrased in such a way as to elicit rich responses from the participants. Particularly given the context of homophobia and how highly stigmatised queerness is within the psychology profession, questions were aimed at teasing out any noted presence of internalised homophobia from the clients and microaggressions from the therapists themselves.

Generally, the interviews lasted for approximately 30 minutes to an hour. Interviews were conducted using an online encrypted video call platform, Zoom. All interviews were audio-recorded and thereafter transcribed verbatim.

Data Analysis

Interview data were analysed following the principles of thematic analysis. A thematic analysis is a process of identifying and analysing a pattern of meanings in a dataset (Clarke & Braun, 2006). It is an approach that interrogates the affective, symbolic and cognitive dimensions of the dataset. It allows the researcher to extract and analyse both manifest and latent content (Joffee, 2012). This approach offers a tool that is unbounded by theoretical foundations (Clarke & Braun, 2014). It can be employed across a range of theoretical frameworks.

Clarke and Braun (2018) argue that thematic analysis is not a term for one approach in qualitative research. Instead, it should be considered an umbrella term for the various approaches that exist within thematic analysis. Thematic analysis draws on both themes

derived from manifest and latent content. Manifest content can often be identified easily while latent content requires interpretation (Jofee & Yardley, 2004). Thematic analysis offers a researcher the choice of deriving themes inductively (as identified from the raw data) or deductively (as drawn and influenced by theory). This research employed a dual deductive and inductive approach where participants responses foregrounded the themes that emerged while simultaneously interpreting the responses through queer theory's lens to process and produce high-quality work.

Thematic analysis has been commonly used for counselling and psychotherapy research in exploring specific groups of therapists' and clients' experiences (Clarke & Braun, 2018). This is particularly relevant to this paper's focus on interrogating the psychotherapeutic process and experiences of novice therapists with their queer clients. Additionally, given this paper's theoretical framework, thematic analysis is particularly applicable as it has been commended for its flexibility, accessibility and straightforwardness (Clarke & Braun, 2018). Clarke and Braun (2018) comment on the various analyses this approach can be employed for such as poststructuralist, queer and feminist theory-informed thematic analyses and attachment theory-informed thematic analyses. This further reiterates the suitability of this approach for this study.

The coding involved recognising an important moment in the interview process followed by encoding it before the interpretation process began. A 'good code' is said to capture the richness of the topic or phenomenon under study (Fereday, J. & Muir-Cochrane, E. 2006).

The thematic analysis followed the 6 steps of conducting a thematic analysis as stipulated by Clarke and Braun (2006). These are 1. Familiarizing oneself with the data; 2. Generating initial codes; 3. Searching for themes; 4. Reviewing potential themes; 5. Defining and naming the themes and 6. Producing the report (Clarke & Braun, 2006).

The first step entailed familiarising myself with the data which involved reading and re-reading the dataset while noting down initial impressions from it. The transcripts from the interviews conducted were read several times so as to hold and view the dataset as a whole in the mind of the researcher. Secondly, responses deemed significant and relevant to the focus of the study were encoded systematically and collated with other relevant data in the interviews to form codes. This involved highlighting any comment that appeared salient while noting whether there were similar comments across interviews to preliminarily group

similar responses. Thirdly, similar codes were collated under one general heading to form themes. The purpose of this step was not to reduce the dataset to themes as such but to organise the material into meaningful groups. Fourthly, the initially generated themes were assessed and thus ensured that each code extracted is relevant to the theme it is placed under. This step ensured the elimination of any code which did not seem to fit a particular theme. It also involved a reshuffling of certain codes between major themes. Fifthly, a process of refinement continued to solidify the themes. Finally, a reporting of the dataset in a structured and themed fashion was presented where codes of a theme were unpacked and examples given to argue for the relevance of each theme for the phenomenon under study.

Rigour and Trustworthiness

Rigour refers to the thoroughness afforded to the data collection and analysis process. This depends on the suitability of the sample to the context of the study and the researcher's commitment to the dataset. The current study employed a hybrid approach which entails deriving data-driven and theory-driven themes in order to maximise the richness of the data while maintaining its integrity (Fereday & Muir-Cochrane, 2006). Guba (1981, as cited Korstjens & Moser, 2018) identified four aspects to trustworthiness, namely: credibility, transferability, dependability and confirmability. Each of these is respectively defined as the degree to which 'truth' can be found in the findings, the degree to which the findings can be applied to other contexts, the degree to which the findings are consistent and can be repeated and, the degree to which the findings are shaped by respondents and not by researcher bias (Amankwaa, 2016; Korstjens & Moser, 2018). Each of these factors was considered throughout the data collection and analysis of the research process. Guba and Lincoln's (1981 as cited in Kortsjens & Moser, 2018) recommended strategies that ensure the accomplishment of trustworthiness were used. Specifically, persistent observation and triangulation were employed; thick description was used when presenting data, including presentation of quotes from interviews, to ensure the constructs were clearly defined to enhance transferability; an audit trail to transparently describe all steps of the research process was undertaken to ensure dependability and confirmability of the study. In terms of the process of analysis, my supervisor and I independently read the transcripts then compared interpretations to identify and explore shared and divergent interpretations.

Reflexivity

As a young, black man who identifies as queer, and who is also a novice therapist, it is crucial that I highlight my stance as the researcher of the current study and how my identity has the potential to impact the study. My interest in this specific topic to research is rooted in my curiosity about how my own therapist navigated my sexual identity and how I, in turn, negotiate it within our therapeutic relationship. Additionally, I wanted to explore some of the underlying processes which the therapist may or may not be aware of.

Palaganas et al. (2017) distinguish between two kinds of reflexivity which are relevant to this study, namely: conceptual reflexivity and process reflexivity. They characterise conceptual reflexivity as the ability of the researcher to be self-aware and recognize that they form part of the social world that they wish to study. Process reflexivity, on the other hand, is characterized by the constant introspection employed by the researcher on the role of their subjectivity throughout the research process. It involves the process of reflecting on one's values as a researcher, which also includes recognizing, examining as well as understanding the various ways in which their social identity may impact the research practice (Palaganas et. al., 2017). Drawing on these concepts and given that the topic is quite personal, I conceived of ways in which my subject positions could produce slanted expectations of the findings of the study, including the process of the whole study from the beginning to the end. My sexual orientation had the potential to contaminate the research process as I could have read and analysed the data from a perspective that does not entirely render objectivity. It may take the form of looking predominantly for the negatives and challenges of the therapists with working with queer clients to the neglect of the positives. As a result, constant introspection was employed to ensure that I conscientize myself to re-focus whenever I feel like I may be pouring too much of myself into the research, which Palaganas et al. (2017) would term process reflexivity. On the other hand, my sexual orientation could enhance the research as I engaged the research with some knowledge about and a needed sensitivity towards issues of queer individuals as a member of this community. This acknowledgement highlights the conceptual reflexivity Palaganas et. al. (2017) speak of in their paper.

Ethical Considerations

Ethics clearance from the Human Research Ethics Committee (Non-Medical) of the University of the Witwatersrand was obtained before data collection commenced. *Informed*

consent was sought for the current study by offering potential participants a detailed participant consent form (see Appendix B), which entailed gaining permission from the participants to participate in the study. This involved informing the participants of all the important aspects related to the research which may have contributed towards their decision regarding whether or not they wanted to participate in the research (Smythe & Murray, 2000). *Anonymity* could not be guaranteed given that I interviewed the participant and thus would know their identities. *Confidentiality* was assured by guaranteeing the participants that all identifying and personal information disclosed during the interview would be kept private between the researcher and the participant (Smythe & Murray, 2000). Only the researcher and supervisor read through the full interview transcripts. These transcripts were fully anonymized through the adoption of pseudonyms and the disguise of any identifying information so that participants' identities were protected in the transcripts themselves. In the resultant report, pseudonyms were used and all identifying details were disguised. Participants were told in the participant information sheet that particular care would be taken to disguise any identifying information about any clients they may discuss in the interview. Participants were told of the *right to withdraw* from the study at any time, and their right not to answer questions in the interview should they choose not to do so. Although participants were talking about a possibly uncomfortable subject matter in the interviews, the topic is not considered a sensitive topic and the study is therefore of minimal risk. Although participants could benefit from the opportunity to talk about their experiences and contribute to the production of knowledge, there were no direct benefits to participation in the study.

As part of the commitment towards developing knowledge and queer research, the findings and conclusions of the study will be made available to participants should they wish to access them upon the conclusion of the study. This will be accomplished through emailing a summary of the research report to those participants who are interested.

CHAPTER 4: RESULTS

This chapter reports on the three predominant themes that emerged in the analysis of the interviews. First, the process of **Disclosure of Sexual Identity** is examined. Second, a dominant theme of **Taking care to avoid pathologising queer clients** is explored. The third theme, **Therapy shaped by therapists' own sexual identity**, explores how straight and queer therapists differently felt, or feared, that their own sexual identity influenced the therapeutic exchange.

Disclosure of sexual identity

This theme captures the process of disclosing sexual identity which was a key thread that emerged across the interviews. First, therapists' experiences of their queer clients' process of self-disclosure are explored. Second, the therapists' disclosure of their own sexual identity to me during the interview is examined.

Client disclosure of sexual identity

There appeared to be a similar trend with regards to how queer clients disclosed their sexual identity to their therapists. Therapists described many clients who came out to them from the outset of therapy – either verbally or implicitly through their physical appearance. Amanda and Felicia, for example, worked with individuals who disclosed their sexual identity at the onset of therapy. They described this experience as follows:

> For me, it was a bit of a shock because it is not something that is expected… it's very rare to find someone who firstly says 'hi I'm gay' (Amanda - queer).

> …my experience… was interesting, I guess… It has been really graphic. That was always a shock (Felicia - straight[2]).

Both therapists describe it as a shock that their patients were up front about their sexual identity. Amanda had not expected openness, perhaps because of the stigma that comes with being queer. Felicia found not only her client's upfront disclosure to be a shock but also the

[2] This term is used to refer to individuals who identify as heterosexual

open and graphic way in which he spoke about sex. Derick and Anza also found it unexpected that their clients were initially very open about their sexual identity:

> …so in the first session, he is like 'as you can tell I am gay as fuck' (Derick – queer).

> I realized that she is queer because she told me…. in the first session (Anza - straight).

Therapists also experienced their clients as forthcoming in terms of sharing their day-today-day lived experiences as queer individuals. This was unexpected for therapists. Consequently, the therapists experienced their clients to boldly own and embody their sexual identities within the therapeutic space. When asked how they experienced their clients to negotiate their sexual identity in therapy, Amanda and Felicia commented, respectively:

> Negotiate… I don't even think it was a negotiation. I think it was just more of straight out, he knew himself from the get-go (Amanda – queer).

> It wasn't a negotiation and that was the interesting thing… He came in and he told me what he was, who he was (Felicia – straight).

While sexual identity may have been disclosed and boldly owned from the outset, therapists felt that clients did not necessarily engage with their sexual identity directly in the therapy. This process appeared to be twofold as inferred from the therapists' accounts. Firstly, this was partly due to how the therapists chose to broach and thus navigate this aspect of their clients' experience (as explored in the second theme below). Secondly, some therapists found their clients to be reluctant to explore their sexual orientation in-depth in therapy. Felicia found her clients to be 'very defensive about it'. Derick described his client as 'own[ing] it so much so that no one dare touch it or talk to it'. Despite disclosing their sexual identity from the outset, therapists experienced their clients to be guarded around their sexual identity. For example:

> What was interesting for me was his absolute denial… kind of this huge denial that his homosexual identity or desire had anything to do with any difficult feeling he had or might have and that was quite clear… Any kind of reflection around that was spat out (Derick – queer).

> The words she would use were 'I don't give a fuck about what people think about my sexuality' (Palesa - straight).

> As his defences went down, maybe like two years or like a year or so, then you started discussing his sexuality, challenging a bit more, questioning it, doubting it. Only after that did we get to a point where we thought about, actually you don't really know who you are and we can just unpack all of it and start building from scratch (Felicia – straight)

These therapists therefore found themselves having to orient themselves to their clients' initial unexpected openness and then to reorient themselves to their clients' guardedness about their sexual identity. Several participants who worked with defended clients hypothesized that their clients may have had to adopt this defensive position to protect themselves. Participants described that one of the difficult things about working with queer clients is their fear of being judged and prejudiced:

> He brought up this idea of him being bisexual and like expected me to take it up in some way that would be punitive towards him (Derick - queer)

> That is kind of like how he gave it to me - His sexual identity layered in a particular way for me to kind of receive (Derick - queer)

> They felt that they would be judged like I think they put you under a microscope to see exactly how I am going to take it [sexual orientation] (Anza - straight).

Therapists therefore became aware over time that their clients came into the therapeutic space with a particular assumption or expectation that a part of themselves related to their sexual identity would not be well received. In contrast to their initial experience of their clients' openness, they needed to reorient again to their clients' expectations of prejudice and to find ways to respond to this as therapists. While different clients (and different therapists) will no doubt follow different processes in therapy, it is striking that these therapists all experienced a process of initial unexpected openness, followed by an awareness of guardedness as well as a growing awareness of their clients' expectations of prejudice.

Therapists' disclosure of sexual identity

While there appeared to be a similar trend with regards to how queer clients disclosed their sexual identity to their therapists, this was not the case for therapists disclosing their sexual identity during the course of the interview. Each therapist disclosed their sexual identity at a

different point in the interview process. A central theme to emerge was that therapists' disclosure of their sexual identity was shaped by what it meant for them to be queer or straight.

Amanda, for example, made the point that she did not want her sexuality to be boxed. When asked in the interview about a time when she became aware of her own sexual identity when working with her queer client, she disclosed her sexual identity to me in the following way:

> So it's more about for me, I knew for me that sexuality and gender are quite fluid and I've been asked several times if I'm lesbian or not because my presentation is like I take both masculine and feminine in terms of gender expression. So people are really not sure and it's like guys whether you want to put me in a category, it's fine with me, I do me. I really I really really at this point don't care if, because I'm pointing out microaggressions amongst LGBTQ, they think that I'm part of a community. It is fine, the fact is that I am in a space where I will dabble in whatever section I feel I can dabble in and as long as the other party is consenting as well [laughs] (Amanda – queer).

Amanda's response to my question was about her own experience of others attempting to box her and her resistance to this. This in turn informed how she broached and navigated her therapy with her client. Her comment aptly captures her dilemma:

> So when he first said it [that he is gay], it was more of OK, how do I switch my mind to not express any microaggressions towards him because the minute you tell someone a specific label they already jump to the stereotypes of that label (Amanda – queer).

Amanda highlights the conflict she experienced negotiating between harmful versus non-harmful ways of engaging with her client, especially after he had disclosed his sexual identity to her. Because she was familiar with the discomfort of being boxed, she was cautious about doing the same to her client. Amanda's disclosure of her sexual identity during the interview was unexpected for her. When asked towards the end of the interview what had been unexpected or surprising for her about our discussion, she expressed that she did not expect me to ask her about her sexuality. She commented:

> The question about my own sexuality... That caught me off guard 'cause I didn't expect you to ask that and my response to it… (Amanda – queer)

Although Amanda ultimately felt that her sexual identity was not a potential hindrance in therapy, her experience of being boxed resonated both with her navigation of her clients' experiences and with the way she disclosed her sexual identity in the interview.

Palesa and Anza, both straight, disclosed their own sexual orientation in the context of their worry about their ability to understand their queer clients:

> I wondered if there'll be times when she thinks I cannot understand her or I cannot relate because she can obviously see my ring and maybe assume that I am in a heterosexual relationship (Palesa - straight).

> I'm heterosexual, I'm Christian and at the time I thought, 'you know what, this is going to be a barrier for me 'cause we don't believe in the same things' type of thing (Anza - straight).

Palesa and Anza worried that being straight would mean that their clients may worry that they would not understand and that they themselves would not fully understand what it means to be queer. Palesa described a shift in the therapy from non-understanding towards greater connection:

> Maybe the shift happened when I met the person where I realized that this is just another person, you know, just another client who needs help (Palesa – straight)

Palesa seems to suggest that once her anxiety about her inability to understand subsided, she was able to see the similarities rather than differences between her and her client.

Queer participants also disclosed their sexual identity in the context of working with their clients. The theme here, however, was not about potential misunderstanding but about understanding too well. Peter and Derick, for example, disclosed their sexual identities while describing a worry that they might overidentify with their queer patients:

> 'It is a difficult challenge to strike. Jah, I think that's been a challenge. And then another thing is kind of, an odd position to kind of - so I am queer and then to be in a therapy where your own stuff has to kind of take a back seat, as much as we can allow for things to take a back seat; so much so that, you know-' (Derick – queer).

> ‘Already I was like wondering should I say something here or not because… It's tricky. So myself I'm gay or identify as gay. And there is always a fear that by engaging with this sort of topic, your own knowledge in it is somehow unprofessional’ (Peter – queer).

Derick felt he had to actively focus on putting his own sexual identity in the “back seat” while Peter was concerned that drawing on his own experience may be unprofessional. For both Derick and Peter, this was a “challenging” and “tricky” process of negotiating the conflict between adhering to professional boundaries and acting in their personal capacity to educate on queer issues. Derick describes how this translated to his work with his client:

> But what was fascinating was the way he has continued to defend against any queer or homosexual desire and so… even at some point in the therapy – very unanalytic of me – I guess I wondered about his understanding of the word queer... it’s my stuff, right, and I kind of come and go in there like ‘Well, hey, look there is this whole different way in which to locate yourself (Derick - queer).

Peter explored how this challenge translated also to professional relationships with colleagues. He described a situation where, in supervision, a straight psychologist was misunderstanding his queer client’s fluidity in the context of sexual roles:

> One [colleague] said it's because there are males and females and he can be both male or female. Already I was like wondering should I say something here or not… there is always a fear that by engaging with this sort of topic, your own knowledge in it is somehow unprofessional (Peter – queer).

Both of these therapists described a dilemma between perceived professionalism and activism. The process of disclosure of their sexual identity, then, was linked to their dearly held process of negotiating being queer and a therapist.

By examining how therapists disclosed their sexual identity during the course of the interviews, then, it emerged that their own relationship to straightness and/or queerness was significant to their experience of themselves as therapists to their queer clients.

Taking care to avoid pathologising queer clients

Therapists appeared to face a dilemma in the interviews about how to narrate their experiences of working with their queer clients without coming across as offensive, discriminatory or stereotyping. They signalled a reluctance to generalise their queer clients’

experiences to the entire queer community and they used particular words and phrases to capture and articulate their thoughts in describing queerness without coming across as discriminatory or stereotyping. Given the extent to which homosexuality has been pathologised by psychology and psychologists historically and currently (Drescher, 2015), it is noteworthy that participants took such care to avoid pathologising their clients, and this represents resistance to the trend in the profession. All participants indicated that sensitivity to queer experience was important to them. Ironically, it will be argued, this great care may have inadvertently constructed non-heteronormative identity choices as an area of difference and caution.

Avoiding overgeneralization

Therapists used great caution when describing how they navigated their clients' sexual identity. Participants described a reluctance to spearhead discussions. For example, when asked how they navigated sexual identity with their clients, Amanda and Palesa commented:

> I would ask here and there for like clarity … only if I needed to ask those questions. I wasn't now leading the therapy by me trying to understand his story. It wasn't now that him being gay was the main reason he came to therapy (Amanda - queer)

> I think it would be awkward in the sense that bringing it up would be my agenda to want to talk about it because I feel like she's comfortable with it (Palesa - straight)

Amanda and Palesa were concerned that questions directed towards their clients would be experienced as leading or indicating their own curiosity rather than their willingness to stay with their clients. Amanda acknowledged that 'it was also about guarding my words'. Therapists were clearly cognizant of the harm certain words can have on their queer clients. They may have been aware of the expression of microaggressions as result. Therapists were reluctant to bring up issues of sexual identity for fear of imposing on their clients. This may paradoxically have led them to avoid conversations about sexual identity, implying that their clients' sexual identity was not to be engaged with because it was not part of the presenting problem in therapy. This care also extended to how participants understood their clients' relationships:

> She brings it in just as who she is in terms of her relationships, what she's going through with her relationships, what she's struggling with but not particularly related to her being queer (Palesa - straight)

> With clients that are comfortable with it, it doesn't necessarily become an engagement about sexuality but it becomes an engagement about the relationship, if that's what brings them (Anza - straight)

> It wasn't that now him being gay was the main reason he came to therapy, no, breaking up with his partner that he had been with for very long and he wasn't coping well with was the reason (Amanda – queer)

Therapists were careful not to conflate relationship issues with issues of sexual identity. In all three of these quotes, a careful distinction between the two is made. Inadvertently again, however, this care may have prevented therapists from engaging with what it means to be in a queer relationship. It appeared that therapists felt that sexual identity should not be explored if it was not presented as an area of conflict. This may also have been influenced by the way their clients' defensively presented their sexual identity in therapy. As such, they felt unjustified to seek further understanding or invite any exploration with regards to sexual identity in their therapies. For example:

> So with my client, there wasn't the thing that he was confused or he didn't know what the feelings were or didn't understand himself…. he's the one who is supposed to lead based on what he wanted to come to therapy for. His sexuality had nothing to do with that (Amanda - queer).

> I think it's already an integrated part of who she is. I have not wondered in therapy, whether it's something that I need to bring up or we need to speak more about (Palesa - straight).

Amanda and Palesa illustrate the more general trend in the interviews to resist making sexual identity an area of conflict unless expressed as such by the client. This stands in stark contrast to the tendency in the discipline of psychology to assume that queerness is problematic. Conversely, however, this led to the foreclosure of exploration. This was also evident in how some therapists aimed to attribute their clients' experiences to something else other than their sexual identity. For example, when asked about what he found difficult in his work with queer clients, Peter commented:

> I think around the ward… Uhm, the groups of climate meeting as well, but it's a little bit therapeutic so…[pause] [sigh] Can you maybe just ask the first part of the question? (Peter - queer)

Peter was reluctant to think about sexual identity as an object that complicated his working relationship and influenced his therapy. His hesitation in response to the question, which he then forgot, may indicate the anxiety aroused when asked to think about difficulty. Similarly, Anza hesitated when answering the same question, before saying:

> I don't necessarily think there is any particular thing that stands out that you don't get with any other client, but then as I said that, I thought of a client. But I do not think that this is a generalized queer thing (Anza – queer)

Anza first refuses any possibility of generalization but then thinks about a particular client. Almost as if to negate that moment, she then returns to a refusal to generalize. This highlights the level of caution surrounding the idea of being perceived as stereotyping or overgeneralising queer individuals' behaviour. It can be seen how therapists actively attempted to not problematise sexual identity in their therapies. Amanda, on the other hand, explicitly refused to attribute her client's tendencies to what she described as 'stereotypically queer behaviours'. She described working with her client to make him understand that there is an alternative explanation to his sexually risky behaviours given the context within which she was working with her client. She commented:

> So it was more about navigating… yes you feel like you're entering into the stereotype of being a gay man in Johannesburg but when you look at the pattern, you yourself haven't healed from the relationship with your ex and now you are acting out because you haven't dealt with this emotionally (Amanda – queer).

Amanda is suggesting that her client should not link their sexual behaviour to the ethos of being queer in Johannesburg, but rather to personal factors. In other words, she privileges personal factors over issues of identity. While there may have been other therapeutic factors at play, it can be argued that her approach was also influenced by the potential need to actively distance herself from being complicit in perpetuating narratives that seek to stereotype queer individuals.

Use of politically correct language

The therapists appeared to be conscious of the language they used to refer to and describe their clients, attempting to offer statements free of any sense of stereotype or discrimination.

Some therapists acknowledged the difficulty in finding appropriate, non-stereotypical words to describe their clients. In describing how they realized that their clients are queer, Peter and Anza alluded to some difficulty in being non-stereotypical. They commented:

> I'm trying to think of how to explain this without it being stereotyped but there is no other way to do it really because, it's kinda the way, when everyone around you thinks a certain way, you can't help but conceptualize it that way (Peter – queer)

> Some clients, and I guess to be very stereotypical, looked either lesbian or gay in the stereotypical kind of way… So that was my stereotype. (Anza – straight)

Both Anza and Peter describe the dilemma of talking about their clients without stereotyping. They signalled that they wished to avoid stereotyping. Anza's words 'so that was *my* stereotype' highlights the awareness that comes with struggling to describe her client without being stereotypical and also showcases how she assumes the responsibility of being stereotypical as opposed to simply describing her queer clients' presentations as the expression of their sexual identity. It is significant that Peter and Anza each assumed responsibility to regard their clients as exempt from participating in any stereotypical behaviours or mannerisms. It is evident that therapists' care to not pathologise their clients' sexual identity was prominent. Other therapists were less direct in avoiding stereotypes. In answering a question that invited them to reflect on a time they realized their client is queer, Palesa and Felicia commented:

> I actually realized the first time I met her - just in terms of her demeanour, how she embodies her sexuality… I could tell from just looking at her (Palesa - straight)

> He was also just aesthetically very dramatic and very expressive from the colours of his nails, to the shawls he wore, to the headscarf and the hairstyles (Felicia - straight)

The careful selection of words is apparent. Therapists wanted to convey a point without coming across as offensive. Interestingly, this means that queerness is not explicitly named but rather alluded to. Felicia, for example, opted to use descriptions such as 'aesthetically dramatic' and 'very expressive' in an attempt to avoid naming her client. This is significant given her answer when asked how she experienced her client to negotiate his queerness in therapy:

> It wasn't a negotiation and that was the interesting thing… He came in and he told me what he was, who he was.

Felicia's client owned their sexual identity and, judging from Felicia's answer, explicitly came out to her. This lends us to revisit the argument posed earlier about the tension between being non-stereotypical at the cost of neglecting the client's core sense of identity. Therapists may experience this tension where they attempt to work towards creating a non-judgemental and non-stereotypical environment but then find that there is limited room for their client's sexual identity. Palesa is also tentative about exploring how she knew about her clients' sexual identity:

> I was so-so, with the first one, with the female patient, I actually didn't know until I got there but the other one, the male patient, I kind of got a hint before we met

Palesa goes on to explain that her client's voice on the phone led her to speculate about their sexual identity. Amanda spoke about how she became hyperconscious of the language she used in sessions with her queer client to avoid offending her client:

> it was also guarding my words sometimes… in English there are very politically correct terms I could pick out at the top of my head but when switching to vernac and Zulu, there isn't much friendly terms

Trying to find a language for talking about queerness without pejorative associations was thus challenging for therapists. On the one hand, this led to awkward and overly cautious ways of describing their patients. On the other hand, however, the care all therapists took to avoid pejorative associations indicates a sensitivity to the prejudice queer people face. This was clearly a difficult dilemma for therapists to navigate and one that could not be navigated smoothly.

Therapy shaped by therapists' own sexual identity

The previous two sections explored themes present in the interviews of both straight and queer therapists. In the section above exploring how therapists disclosed their own sexual identity, nuances unique to straight versus queer therapists emerged. This section continues to explore these differences between queer and straight therapists. Therapists' own sexual

identity informed both how they answered questions in the interview and how they navigated sexual identity with their clients. Therapists also spoke in interviews about the dilemmas they experienced as therapists concerning their own sexual identity. The therapists who identified as heterosexual shared a fear that their sexual identity would act as a barrier between them and their queer clients. Those who identified as queer described a tension between their queer identity and their professional identity. Because of these unique differences, this section explores the experiences of queer and straight therapists separately.

Straight Therapists

In reflecting and articulating their initial anxieties about working with queer clients, heterosexual therapists expressed concern that their sexual identity would interfere with therapy. For example, when asked to reflect on the time they became aware of their own sexual identity in therapy with their queer clients, Palesa and Anza commented:

> I wondered if there'll be times when she thinks I cannot understand her or I cannot relate because she can obviously see my ring and maybe assume that I am in a heterosexual relationship (Palesa – straight)

> I think the thing about the countertransference that usually comes, it did more so earlier on in my M1, was more about - well that was before I was married - it was more about will I understand… (Anza – straight)

Both Anza and Palesa express a fear of not understanding – either that the client will not feel understood or that the therapist will be limited in her understanding. This was an ongoing thought which was reflected upon and revisited throughout the interview for both participants. Amanda did not experience this worry consciously but wondered whether it may have been there nonetheless. Upon reflection on a time she became aware of her own sexual identity while working with her queer client she commented:

> I wouldn't really identify a particular time when I was working with the client… So I don't think in the therapy- I don't think my personal biases and prejudices were actually at the forefront - maybe unconsciously, but definitely not consciously (Amanda – straight)

Amanda acknowledges that her heterosexual orientation predisposes her to othering her queer client. While she does not perceive it to be an interference, she acknowledges how her implicit prejudices and biases may have been at work despite her not being aware of them.

Anza reflects on how she worried that another queer individual would better understand a queer client:

> ‘I think at some point I was like ‘perhaps you know, ‘cause my biggest boundary for me was perhaps another queer person would understand them better. And maybe they would.

This concern, that her understanding would be limited by her sexual orientation, was expressed by other straight therapists. In addition to Palesa’s fear of not understanding her queer client, she wondered about her competence and adequacy. In answering the question about what she found difficult about working with queer clients, she reflected that:

> So it did come to my mind that I've never really worked with someone identifying as queer before. Am I adequate? Is it any different from anybody else coming to therapy with a particular presentation? So those kind of questions did come to my mind and suddenly I thought to look up an article and read up.

Straight therapists were therefore aware of the limits of their own understanding and anxious about their ability to understand. This worry also places therapists in a dilemmatic position: by acknowledging difference, they acknowledge their limits but at the same time place their clients in the position of ‘other’.

Queer Therapists

The queer therapists expressed, implicitly and explicitly, their difficulties with regards to withholding their ideological positions and removing themselves – as it relates to their sexual identity – from the therapeutic engagement with their clients. This tension was conveyed in different forms. Peter, as explored above, describes a situation where his straight colleagues were discussing a transgender client in a manner that he felt was ignorant:

> They were like ‘What is that?’ and then the one said it's because there are males and females and he can be both male or female. Already I was like wondering should I say something here or not because… It's tricky. So myself I'm gay or identify as gay. And there is always a fear that by engaging with this sort of topic, your own knowledge in it is somehow unprofessional (Peter – queer)

As a queer man himself, Peter was uncomfortable that his client’s lived experience, one which he shares and resonates with, was being portrayed negatively and misunderstood. He

felt conflicted about whether to interject or not. Other queer therapists also expressed uncertainty about how to engage with queerness with their colleagues and/or clients. There appears to be a tension between negotiating that which they believe in and stand for, as informed by their sexual identity, with what their profession prescribes and expects of them. Amanda describes a similar dilemma where she decided to err on the side of protecting her queer client by confronting her colleagues about how they referred to her client:

> as much as he did tell me he is gay, people often referred to him as my 'gay' client. So it's one of those things which I wasn't comfortable with, so I was like 'no, refer to him by his name, he is not just gay' (Amanda – Queer)

Amanda resonates with her client and rejects her colleagues' stereotyping because of her own experience of being queer. She reflected on her own queerness:

> So people are really not sure and it's like guys whether you want to put me in a category, it's fine with me, I do me. I really I really really at this point don't care… the fact is that I am in a space where I will dabble in whatever section I feel I can dabble in and as long as the other party is consenting as well [laughs]. If someone wants to describe that as bisexual or pansexual or whatever then go ahead, what I know is that I will dabble in my… whatever… [laughs].

Amanda's refusal to box her client is mirrored in her refusal to be boxed herself. She elaborated at another point in the interview::

> It's very rare to find someone who firstly says 'hi I'm gay'. It is not one of those things that I have been exposed to even though I do consider myself to be someone who feels that sexuality and gender is on a continuum. There isn't for me… I don't believe in categories. People can be in categories if they choose to because it also comes with identity (Amanda – queer)

Again, Amanda's experience of her own sexual identity helps her to resonate with others. Derick appeared to share the same sentiments about categories in describing sexual identity. In reflecting on a time in therapy where he and his client were exploring the politics of categories, Derick commented:

> I guess I wondered about his understanding of the word queer, and thought about it beyond bisexual, homosexual - and it was fascinating how – and it's my stuff, right, that's why it's unanalytic and I kind of come and go in there like 'Well, hey, look there is this whole different way in which to locate yourself; it gives you more space and wiggle room (Derick – queer)

Derick expresses a felt tension between his professional identity and his queer identity. He wanted to engage with his client about queerness but worried that it would be untherapeutic or unprofessional to do so. His words ‘it’s my stuff, right, that’s why its unanalytic’ suggest that he believed that his queer identity does not align with his professional identity or with the expectations of the profession.

It is important to highlight the words ‘it’s my stuff’ from Derick’s quote. This was central to both Derick and Peter’s negotiation of their queer identity and their professional identity. For example, in narrating the time they became particularly aware of their sexual identity, Derick and Peter commented:

> The other time that it had clearly been in the room was when a heterosexual patient, and I had started to be like ‘I think there might be some psychosexual stuff happening here – I can feel it in the countertransference. Is that mine? Am I attracted to the patient? Let me delineate this stuff out – take it to supervision, take it to therapy.’ (Derick – queer)

> Yet, for me, who can see the bigger picture, and maybe it's my own queerness here; my own sexual identity that I might be identifying with, or even maybe adding on and it's not warranted (Peter – queer)

Both therapists were cautious about how their sexual identity may be impacting the therapy and conveyed this wrestle between their queer and their professional identities.

Both the queer and heterosexual therapists appear to share this tendency of assuming the responsibility of what transpires between them and their queer clients in therapy. By the same token, it is crucial to highlight the distinction between the heterosexual therapists and the queer therapists as they appeared each to also struggle with the tendency to distance or other their queer clients versus overidentifying with them, respectively.

Chapter 5: Discussion

The current study aimed to explore novice therapists' perspectives regarding how they and their queer clients navigate sexual identity in the therapeutic space. This entailed exploring how they navigate their client's sexual orientation, their client's self-disclosure and, in turn, how their clients navigate their own sexual orientation. This extended to the reception of sexual orientation in therapy from the therapist's perspective, including some of the perceived influences rooted in the therapist's personal and professional identity which may have produced a certain kind of response. Furthermore, the research explored how therapists navigated their queer client's sexual orientation in relation to their own sexual orientation in the context of the therapeutic relationship. This chapter explores the implications of the findings, possible limitations of the study and possible directions for future research.

All therapists in the current study described a process of initial openness from their queer clients, which was unexpected to therapists, followed by an awareness of their clients' guardedness about their sexual orientation as well as a growing awareness of their clients' expectations of prejudice. Additionally, therapists' own sexual identity appeared to shape the navigation of sexual identity which brought about unique challenges and triumphs in the context of their respective therapeutic relationships. Most of the clients seem to have begun therapy without restraint. Contrary to therapists' expectations, they explicitly presented their sexual identity to the therapy either by verbally claiming it or by physically embodying and expressing it. However, as therapy progressed, therapists experienced some reluctance to engage with their clients' sexual identity, partly due to the clients' guardedness and partly due to therapists' reluctance to pathologise their clients. This saw therapists having to reorient themselves to working with this guardedness in therapy. It later emerged that the clients' guardedness appeared to be influenced by an expectation to be discriminated against, judged and prejudiced by their therapist. Similarly, therapists' own reluctance to engage the sexual identity in therapy was attributed to the fear of perpetuating prejudice and stereotypical narratives of queer individuals. In light of these findings, each of the three themes presented in chapter 4 above will be discussed in turn.

Disclosure of sexual identity

Queer individuals' subjective experience largely entails navigating a world that is rejecting and discriminatory towards them. Goodwin (2014) has found that queer patients enter the therapeutic space with the expectation of being prejudiced and discriminated against. Part of this understandable ambivalence may be attributed to the fear of being re-traumatized by being subjected to homophobia in therapy. Keating et al. (2021) found that queer clients enter therapy with a fear of being harassed by their therapist and worry about whether they will receive non-discriminatory treatment. Therapists' initial experiences of their clients as being unexpectedly open diverge from the literature which predicts that clients will likely be cautious about disclosing to their therapists (Godfrey et al., 2006; Shiperd et al., 2010). One possible explanation for this different finding is that clients may, in expectation of prejudice, have presented themselves in a particularly confident manner to head off possible prejudice. An alternative is that clients in this context expected to find acceptance in psychotherapy. If this latter interpretation is the case, as seems to be possible for at least some of the clients discussed in this study, then it may be helpful for therapists to be aware that they are presented with an opportunity to demonstrate their acceptance of their clients early in the therapy. Therapists in this study may have taken note of this opportunity to offer their clients a different experience to what literature anticipates tends to unfold.

Nonetheless, the results of the current study showcase the underlying influence of homophobia within the context of therapy. While the results offer a very different picture to Goodwin's (2014) findings, which highlight the pervasiveness of homophobia in queer individuals' lives, both therapists and clients were very aware of the potential for homophobia in clients' lives and in therapy. This underscores how entrenched and concretely integrated homophobia is in the lived experiences and self-concepts of queer individuals. Literature extensively speaks on the long-term effects queer individuals suffer due to being victimised and discriminated against in their social spaces. One of the most prominent long-term effects that emerged in the current study is internalised homophobia as drawn from therapists' descriptions of their clients' presentation in therapy. The results were consistent with the findings of Goodwin's (2014) study which suggested that internalised homophobia and hypervigilance are two of the many long-term effects of rejection, discrimination and prejudice noted in psychotherapy with queer clients. Therapists in the current study noted a kind of hypervigilance and defensiveness as well, alongside the expressed internalised

homophobia, around conversations that were elicited around sexual identity in the therapy (as is elaborated on later in this section).

The presence of homophobia in therapy has been noted; both as expressed by queer clients (Mair, 2003) and by therapists (Bowers et al., 2005). Consistent with Mair (2003) and Bowers et al. (2005), respectively, clients in the current study expressed their internalised homophobia through their description and presentation of their sexual identity in therapy, while therapists were acutely aware of their capacity to be covertly homophobic in therapy.

Mair (2003) also observed a similar unexpectedness towards the presence of internalised homophobia, both as it emerged in his study but also in the context of therapy. As with the current study, he reflects on his appreciation for the profound awareness internalised homophobia has afforded him on how impactful negative messages can be on a queer individual's psyche and development.

Therapists did not necessarily term their clients' expectations of judgment or discrimination as an expression of internalised homophobia. Cerbone (2020) contends that the expression of internalised homophobia is difficult to recognize even for queer clients themselves. It is possible that clients may not have been aware that they were expressing their internalised homophobia. It is important to draw attention to how disguised this phenomenon's expression tends to be and how difficult it may be for therapists to easily understand its presence. In addition to this, therapists may have been overwhelmed by their internal processes and anxiety about trying to ensure that they engage non-defensively and non-harmfully with their clients to avoid subtly negative communications. This attitude was strongly held by therapists in this study, quite contrary to research that anticipates therapy to be a homophobic environment. Young or new therapists, in particular, may be motivated to change social discourses. This trend was also observed in de Los Reyes and Collict's (2020) study where participants recognised that to reduce discrimination and prejudice against queer clients, trainees and therapists need to understand their roles as agents for social change. Far from simply reproducing the prejudice of the profession, therapists may seek to challenge traditional ways of engaging with, and attitudes held towards, queer individuals both socially and within therapy. Queer theory's unsettling of normativity, the findings of this study suggest, may potentially be enacted by therapists in the therapeutic relationship by interrogating themselves and their positionality towards queerness. This stance of

interrogating one's positionality and biases is encouraged and is useful in working with queer clients (Godfrey et al., 2006).

Therapists were aware that there are harmful ways of engaging with queer clients which may be detrimental to their clients and the therapeutic relationship. There is a growing body of research that supports the existence and effects of microaggressions in therapy (see, for example, Banks, 2021; Hund & Thomas, 2015; Johnson, 2014; Shelton & Delgado-Romero, 2013; Spatrisano, 2019; West, 2018). The results seem to indicate an underlying dual process at play between novice therapists and their queer clients: clients express their internalised homophobia, consciously or unconsciously, in various forms while therapists hold in mind how they are interacting with this while assessing how they may be expressing microaggressions. Skovholt and Ronnestad (2003) argue that novice therapists' performance anxiety reduces the quality of their work due to their preoccupation about reducing their anxiety. While part of this may be true, novice therapists' anxiety may potentially work in their favour. The anxiety of therapists in this study about working with their queer clients, given their inexperience, fostered a sense of hypervigilance in their engagement with their queer clients. This may have reduced harmful, unconscious communications, including the exposure to microaggressions in their therapies with their queer clients. Conversely, however, therapists reported being unsure how to approach their clients, and while their process offers an intuitively helpful guide, it also highlights how little therapists had to think about, or be guided on, working with queer clients prior to their therapeutic engagements.

This has important implications for therapists (both novice and experienced in the field) and for training programmes. Queer individuals may enter therapy in anticipation of rejection and prejudice, and therapists ought to anticipate this themselves in order to normalise this experience for their queer clients. Training programmes may aid training therapists by strongly encouraging constant self-interrogation to confront biases therapists may hold. Godfrey et al.'s (2006) findings suggest that efforts invested by therapists to evaluate, clarify and potentially shift their biases is effective in offering high-quality, non-harmful mental health services to queer individuals.

Taking care to avoid pathologising queer clients

The care taken by therapists to avoid pathologising their clients is likely to have both positive and negative effects. Bowers et al. (2005) also note that therapists' perspectives on sexual identity and subsequent approaches to therapy impact the client and constitute helpful and

unhelpful responses to the phenomenon under study. Noteworthily, therapists in the current study were hyperconscious, as noted earlier, of their engagement with their queer clients which may have been helpful in certain respects and unhelpful in others. Their hyperconsciousness saw them carefully assessing how they broached sexual identity conversations in therapy. This sensitivity indicates care and caution against perpetuating and repeating queer individuals' traumatic experiences of being victimised. As indicated earlier, re-traumatisation through exposure to homophobia can exist within the context of therapy (Bowers et al., 2005 & 2010; Goodwin, 2014; Willging et al., 2006). Goodwin's study (2014) contends that queer clients can be at risk of being re-traumatized when they encounter homophobia in therapy. Kelly's (2020) findings suggest that the treatment outcome and therapeutic relationship are often influenced by therapists' ability to manage their reactions towards queer issues as they emerge in their therapies, including how they creatively work with such issues and queer clients in the room. From this perspective, therapists' reactions in this study can be seen to be helpful, particularly in curbing the re-traumatization of their clients.

Inadvertently, however, therapists' hypervigilance saw them displaying a certain reluctance to engage with their clients' sexual identity. Their care to avoid pathologising their clients' sexual identity saw them evading conversations around it. Again, a dual process was at play where the clients defensively held onto their sexual identity by 'own[ing] it so much so that no one dare touch it or talk to it' (Derick's words), while therapists avoided centralising therapy around sexual identity lest clients perceived this as problematising their sexuality. A sense of hypervigilance seemed, then, to be shared. Israel et al. (2007) suggest that therapists' attitude towards their clients' sexual identity contributes towards queer clients' positive experiences in psychotherapy. This has important implications for therapists who work with queer clients. Recognising one's stance towards queerness, including how one engages with queerness in psychotherapy, impacts the therapeutic outcome and overall experience for the clients. It is recognised that queer clients do face prejudice and discrimination in psychotherapeutic contexts; however, limited literature explores the implications of therapists who actively pay attention to how they respond to their queer clients' sexual identity.

Clients are said to notice the manner in which their therapists engage with sexual identity (Goodwin, 2014). The displayed sensitivity towards conversations around sexual identity may have counterproductively left the clients feeling that conversations around their sexual

identity were not welcome, thus potentially reinforcing the idea that their sexual identity is unimportant and leading to the foreclosure of further exploration. Participants in Quinones et al. (2017) reported it to be helpful when their therapists engaged with their sexual identity in an open-minded fashion. This also included the acknowledgement of sexual identity as relevant in therapy, whether or not it formed part of the presenting problem. This is also corroborated by a study conducted by Israel, Gorcheva et al. (2008). This highlights a dilemma described by therapists in the current study which may also be faced by other therapists when working with sexual identity or queer clients in the therapeutic context. Their stance to evade core sexual identity conversations, as informed by clients' presentation of sexual identity in therapy as well, may be misinterpreted.

Therapists may experience this tension where they attempt to work towards creating a non-judgemental and non-stereotypical environment by avoiding certain conversations but find that there is limited room for conversations about their client's sexual identity. It is recognised that this is also generally guided by queer clients' hypervigilance regarding further traumatization as queer clients report perceiving homophobic messages being conveyed in therapy through avoidance of conversations around sexual identity among other microaggressions, regional values and cultures values to name a few (Goodwin, 2014). Owen-Pugh and Baines' (2014) findings also recognise the difficulty therapists experience in navigating sexual identity, especially with the background of internalised homophobia. Therapists can anticipate encountering similar challenges when working with sexual identity. It is noteworthy that the refusal to pathologise queer clients celebrates the tenets of queer theory and echoes its refusal to categorize. However, it does not acknowledge what queer theory also tells us: that being queer is a site of prejudice and difficulty, and that this is felt in a lived way and should not be ignored. Training programmes that encourage therapists to explore these complexities would help therapists to navigate the fine line between sensitivity and avoidance.

Therapy shaped by therapists' own sexual identity

Both queer and straight therapists worried that their sexual orientation could potentially negatively impact therapy, but the contours of this worry were differently shaped according to sexual orientation.

Queer therapists negotiated a tension between using their identification with their own experiences as queer to help their clients and fearing that their personal experience would be inappropriate to share with clients, or would lead them to be untherapeutic because of their identification with queer experiences. This fear was linked to perceived disapproval from the profession. The results indicate a different challenge for straight therapists (as elaborated later). Queer therapists seemed to struggle most with their dual identities as therapists and queer individuals. Identification with their clients, which inspired a willingness to help, was also difficult for therapists as they feared they may overidentify with their clients. Queer therapists may identify with their clients based on shared lived experiences of navigating a world that is prejudiced and discriminatory. Feminist psychotherapists argue for and support identification in that it works to dismantle the power dynamics between therapist and client and, in some cases, works to promote important behavioural changes to the benefit of the client (Mahalik et al., 2000). Similarly, queer therapists may appropriately self-disclose for the client's therapeutic gain. Conversely, overidentification may indeed be countertherapeutic. The scarce literature on this topic suggests that overidentification with clients is also considered a microaggression (Tomicic et al., 2020). As such, queer therapists need to navigate a tightrope between therapeutic identification and non-therapeutic overidentification. It is, however, interesting that queer therapists largely perceived identifying with their queer clients as potentially unethical. This may be related to these therapists own internal struggle with internalised homophobia as well as the broader homophobia of the profession.

Straight therapists feared misunderstanding their clients or being misunderstood by their clients due to not knowing what it means to be queer. Bernstein's (2000) study suggests that when therapist-client sexual identity differs, it creates an initial sense of 'otherness'. This was consistent with the findings of this study which suggests that straight therapists are likely to feel a distance between themselves and their queer clients which may evoke feelings of anxiety and worry around issues of competence. It is equally contended that this sense of otherness can be bridged through the working alliance (Bernstein, 2000). This too was showcased in the study as one of the therapists reflected on a moment of greater connection between her and her client when she began working with her client in therapy.

It is important to note the categorization of therapists into distinct sexual identities given the current study's theoretical framework. Queer theory, as argued earlier, suspends the tendency to refer to sexual identity as a unified essence, more importantly, to regard sexual identity as

categorizable. Additionally, queer theorists caution against the comparison between heterosexual and homosexual individuals. This study may be challenged as it further perpetuates the tendency to categorize which reinforces the false argument about identity being a unified essence. However, rich similarities within the separate groups were found, and the lived experience of therapists was interlinked with their categorization of their own sexual identity. Therefore, an argument can be posed that the purpose of categorizing therapists was not to compare each group's performance but rather to highlight the unique experiences, challenges and triumphs experienced by therapists of differing sexual identities.

Limitations

Although a small sample size is generally suitable for a qualitative study, allowing depth rather than breadth, the generalizability of this study's findings are inevitably limited by the small sample size employed. This was further compounded in this study by the difficulties encountered in recruiting participants. It is possible that so few participants volunteered because of the topic itself: therapists may not feel comfortable or confident in talking about their work with queer clients. A small sample size may therefore be a limitation of this field of study as well as of this specific study itself.

The sample itself was relatively diverse in terms of sexual identity, racial identity and gender. However, the majority (five out of six) were clinical psychologists while one was an educational psychologist. The findings of the study may therefore be more applicable to clinical psychology practitioners. It was interesting that the sample was evenly divided with 3 therapists identifying as queer and the other 3 as straight, since it is expected that the majority of the population of therapists are likely to be straight. This overrepresentation of queer therapists (relative to the population of therapists) may indicate their particular investment in the topic area. While the inclusion of both straight and queer therapists is arguably a strength of the study since it allowed deeper investigation into the relationship between their sexual identity and their therapeutic work with queer patients, it does mean that the sample size for each group is particularly small.

Additionally, the study solely recruited novice therapists. Experienced therapists may have offered a different perspective and it may be difficult in this study to separate the relative contributions of the challenges of working with queer clients versus the challenges of inexperience.

The South African context within which the study took place also shapes the findings. Despite having a progressive constitution that recognizes queer rights (for example the right to marry), South Africa is characterized by strong homophobia both interpersonally and structurally, to the extent that queer people are sometimes subject to severe violence. Furthermore, South Africa is a diverse society where race and queerness strongly intersect. Although this study included therapists of different racial groups, who in turn had treated patients of different racial groups, the intersection of race and sexual identity was not a focus of the study and was seldom spontaneously explored by participants in interviews. This study cannot, therefore, shed light on the intersection of race and queerness or of other intersecting identities.

Directions for future research

Some possible directions for future research arise from the limitations outlined above. It would be helpful to undertake both qualitative and quantitative studies with a larger sample size in order to contribute to both the depth and generalizability of knowledge in the field. It would also be helpful to include questions exploring why participants volunteer for such research, and why they may have felt reluctant to volunteer. Future research could focus specifically on straight versus queer therapists to deepen the understanding offered in this study regarding how therapists' own sexual identity shapes the therapeutic encounter. The perspectives of experienced therapists would also contribute to existing literature. Further, given the extent to which context influences the experience of queerness, it would be helpful to investigate the influence of the South African context as well as of other contexts, and it would be helpful to explore the intersection of identities to a greater extent.

A central theme in existing literature, which has helped contextualize the findings of this study, concerns the limited training in working with queer clients in therapy that is generally offered to therapists. Future research could interrogate the issue of training to a greater extent, in order to offer recommendations for improvement.

When making sense of the findings, it has also been noted that existing literature tends to focus on prejudice and discrimination in psychotherapy. While this is an important focus and one that must be addressed, it was striking in this study that therapists were very motivated to avoid prejudice and discrimination. Further research that focuses not only on the deficit of

psychotherapy but also on the strengths and possibilities psychotherapy may offer for creative insights into how best to worth therapeutically with queer clients.

Finally, it is noted that the relative lack of research directed at understanding therapeutic engagement with queer clients suggests that the potential for, and importance of, growth in the field.

Conclusion

This study investigated how novice therapists navigate sexual identity with their queer clients in therapy. Research that explores therapists' experiences of working with queer clients is limited. As such, the study intended to explore the challenges and triumphs novice therapists experience with working with queer clients; how they experience their queer clients to negotiate their sexual identity in psychotherapy; and how they experience their own sexual identity to impact the therapeutic relationship and process. This study showed how therapists experienced a process of initial unexpected openness, followed by an awareness of guardedness as well as a growing awareness of their clients' expectations of prejudice in their encounter with sexual identity in therapy. This influenced how they conducted their therapies, including how they broached conversations around sexual identity with their clients. Additionally, therapists' own sexual identities were seen to influence the quality of engagement with their clients' sexual identity including how their therapies unfolded. The results have showcased how complex and nuanced navigating sexual identity in the context of therapy is for novice therapists. Furthermore, the results revealed a gap in training programmes that needs to be addressed in order for novice therapists to feel equipped enough to work with queer clients in therapy.

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Appendix A:

Interview Schedule

For the purposes of this interview, and research at large, the term *queer* will refer to an individual who identifies as being sexually, emotionally and physically attracted to the same sex i.e. a *'homosexual'*

1. Tell me a story about you and your queer client's encounter with queerness in therapy?

Subsequent probing questions:

2. Tell me a story about when you realized that your client was queer?

3. Tell me about how you navigated queerness in therapy with your client? Can you give me an example of a time when it became particularly present in the room?

4. Tell me how you experienced your client to negotiate their queerness in therapy?

5. Tell me about what was difficult with working with your queer client(s)?

6. Tell me about what was rewarding with working with your queer client(s)?

7. How did the therapy shift or change, if it did, when they told you they are queer?

8. Tell me about a time when you became very aware of your own sexual identity when you were with a queer client?

9. Is there anything that we have not spoken about that you would like to add?

10. Is there anything that you talked about today that you were surprised you ended up talking about?

11. What was it like talking about your story today?

APPENDIX B:
PARTICIPANTS' INFORMATION SHEET

Department of Psychology
School of Human & Community Development
FACULTY OF HUMANITIES
University of the Witwatersrand
Private Bag 3, WITS, 2050
Tel: (011) 717 4500
Fax: (011) 717 4559

Dear Sir / Madam

My name is Rebaone Kgosamang and I am a Master's student in Clinical Psychology at the University of the Witwatersrand in Johannesburg. As part of my studies, I am undertaking a research project that is titled: 'The navigation of sexual identity between novice therapists and their queer clients: Therapists' perspectives. The project aims to investigate how novice therapists navigate sexual orientation with their queer clients in the therapeutic relationship as well as how they understand their clients to negotiate their own sexual identity too.

As part of this project, I would like to invite you to take part in an interview. The interview will involve answering several questions and will take around 45-60 minutes at my office situated at The Emthonjeni Centre on the Braamfontein Wits University Campus or, alternatively, at a place of your convenience. An online interview will be offered should a physical interview not be possible. With your permission, I would also like to record the interview using a digital device. Please find additional form on which you grant your permission for this.

You will not receive any direct benefits from participating in this research, and there are no disadvantages or penalties for not participating. You may withdraw at any time or not answer any question if you do not want to. The interview will be completely confidential as your name, institutional affiliation or any identifying information will be excluded from the study, and the information you give to me will be held securely and not disclosed to anyone. My supervisor will only have access to disguised transcripts with no identifying information. I will be using a pseudonym to represent your participation in my final research report and in all transcripts sent to my supervisor. Furthermore, since you will be talking about your clients in the interviews, particular care will be taken to disguise all identifying details so their anonymity is guaranteed. Additionally, I would like to request permission for anonymized data to be used for future studies. If you experience any distress or discomfort at any point in this process, you may choose to stop the interview or resume another time.

If you have any questions during or afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the university library website. If you wish to receive a summary of this report, I will be happy to send it to you. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrec-medical.researchoffice@wits.ac.za

Yours sincerely,
Mr. Rebaone Kgosamang (Researcher)

Researcher's details:
Email: 1396263@students.wits.ac.za
Cell: 072 466 7351

Supervisor: Professor Carol Long
Email:Carol.Long@wits.ac.za
Tel: 011 717 4510

Appendix C: Consent Form

Psychology

School of Human & Community Development

University of the Witwatersrand

Private Bag 3, Wits, 2050

Tel: 011 717 4503 Fax: 011 717 4559

TITLE OF PROJECT: The navigation of sexual identity between novice therapists and their queer clients: Therapists' perspective

NAME OF RESEARCHER: Mr. Rebaone Kgosamang

I, _____ consent to being interviewed by Rebaone Kgosamang, for his study entitled: 'The navigation of sexual identity between novice therapists and their queer clients: Therapists perspectives. I understand that:

- Participation in this study is voluntary.
- I may refrain from answering any questions.
- I may withdraw my participation and/or my responses from the study at any time.
- There are no risks or benefits associated with this study.
- Should a physical interview not be possible, an online interview will be conducted on an encrypted video call platform such as Zoom or MS Teams
- All information provided will remain confidential, although I may be quoted in the research report.
- No identifying information will be used in the transcripts or the research report.
- Although direct quotes from my interview may be used in the research report, I will be referred to by a pseudonym (example, Participant A).
- None of my identifiable information will be included in the research report.
- I am aware that the results of the study will be reported in the form of a research report for the partial completion of a Master's degree in Psychology.
- Anonymized data may be made available to future researchers unless I indicate that I would prefer for this not to be the case.

Consent for interview:

Signed: _____ Date:_____

Appendix D: Audio/Video Recording Permission Form

Psychology

School of Human & Community Development

University of the Witwatersrand

Private Bag 3, Wits, 2050

Tel: 011 717 4503 Fax: 011 717 4559

TITLE OF PROJECT: The navigation of sexual identity between novice therapists and their queer clients: Therapists' perspectives

NAME OF RESEARCHER: Mr. Rebaone Kgosamang

I, _____, consent to being interviewed by Rebaone Kgosamang and for the interview to be recorded, for his study entitled: 'The navigation of sexual identity between novice therapists and their queer clients: Therapists' perspectives.

This research has been explained to me and I understand what participation in this research will involve. I understand that:

- My confidentiality will be ensured. My name and personal details will be kept private.
- The recordings will be stored in a password protected file on the researcher's computer.
- Only the researcher will have access to these recordings.
- After transcription, the recording will be disposed of.
- Should a physical interview not be possible, an online interview will be offered on an encrypted video call platform such as Zoom or MS Teams.

Consent for recording:

Signed: _____ Date:_____

Home Tools 1 Clearance Certi… ×

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE:	**PROTOCOL NUMBER: MCLIN/20/01**
PROJECT TITLE:	The navigation of sexual identity between novice therapists and their queer clients: Therapists' Perspectives
INVESTIGATOR	Kgosamang Rebaone (1396263)
SCHOOL/DEPARTMENT OF INVESTIGATOR	SHCD/Psychology
DATE CONSIDERED	18 May 2020
DECISION OF THE COMMITTEE	Approved unconditionally
RISK LEVEL	Minimal Risk
EXPIRY DATE	31 December 2022

ISSUE DATE OF CERTIFICATE 21 May 2020 **CHAIRPERSON** _____
(Dr Esther Price)

cc: Prof. Carol Long (Supervisor)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am are authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

KGosamang
Signature

Date 29 / 06 / 2020

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES