TRAINING WHILE QUEER: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS
OF THE EXPERIENCES OF QUEER THERAPISTS-IN-TRAINING

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Abstract
In recent decades, mental health training programs have increased efforts to recruit diverse applicants as well as integrate LGBTQ+ affirmative approaches into their curricula (Hope & Chappell 2015; Hsueh, Werntz, Hobaica, Owens, Lumley, & Washburn, 2021). However, little is known regarding the challenges queer therapists-in-training encounter when working with LGBTQ+ clients and the extent to which training programs provide adequate supports for their queer students in this capacity. The present study examines how queer identified therapists-in-training experience working with LGBTQ+ clients, who share their minority identity status, as well as how they experience challenges and supports in their training programs. Eight participants were recruited through purposive sampling from local Clinical Psychology and Social Work programs in the Northeastern U.S. Participants were interviewed about their experiences through a semi-structured interview format. Interpretative Phenomenological Analysis (IPA), a qualitative approach appropriate to exploratory studies, was employed as a method of analysis to better understand the lived experiences of LGBTQ+ identified therapists-in-training (Smith, Flowers, & Larkin, 2009). Across participants, emergent themes manifested in three domains: experiences related to working with LGBTQ+-identified clients, experiences of the training environment, and the intersection of queer identity with professional identity. Themes in the domain of experiences related to working with LGBTQ+ clients included deep personal meaning and investment, use of lived experience, and awareness of difference; themes in the domain of training environment experiences included the peripheral nature of LGBTQ+ training and absence of support, experiences of heterosexism in the training environment, and self-initiated efforts to improve training environments; finally, themes related to the intersection
of queer and professional identity included the ambiguity of visibility and disclosure, and a sense of internal struggle in navigating identity-specific training challenges. These findings present several implications for understanding the unique challenges and needs of LGBTQ+ therapists-in-training as well as tentative suggestions for improving training programs for LGBTQ+ trainees. Further research of the lived experiences of specific sub-identity groupings within the broad and diverse category of queer mental health trainees is recommended to better understand within community differences and specific needs of queer mental health trainees of various backgrounds and intersecting identities.
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TRAINING WHILE QUEER

TABLE OF CONTENTS

ABSTRACT ........................................................................................................................... ii

ACKNOWLEDGEMENTS ................................................................................................... iv

LIST OF TABLES ................................................................................................................. vii

LIST OF FIGURES ............................................................................................................... viii

INTRODUCTION ................................................................................................................. 1

   Definition of Terms ....................................................................................................... 3

REVIEW OF LITERATURE ................................................................................................ 4

   Queer Clients ............................................................................................................... 4

   Heterocentric Bias and Affirmative Practices .................................................................. 6

   The Therapist is Queer ................................................................................................. 9

   Challenges in Queer Therapist-Client Relationships .................................................... 11

   Therapists-in-Training ................................................................................................. 15

   The Present Study ....................................................................................................... 18

METHODS ............................................................................................................................ 19

   Participants .................................................................................................................. 19

   Procedures .................................................................................................................. 19

   Data Analysis ............................................................................................................. 21

   Reflexivity .................................................................................................................. 22

RESULTS ........................................................................................................................... 23
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Table 1: Participant Demographics</td>
<td>136</td>
</tr>
<tr>
<td>2. Table 2: Cross-Participant Themes</td>
<td>137</td>
</tr>
</tbody>
</table>
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figures</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fig. 1: Emergent Themes</td>
<td>138</td>
</tr>
<tr>
<td>Fig. 2: Model of Theme Relationships</td>
<td>139</td>
</tr>
</tbody>
</table>
Introduction

Queer trainees entering the mental health professions gain access to a field with a long and fraught relationship with LGBTQ+ communities. This landscape has shifted significantly in the last 50 years, with the American Psychiatric Association’s removal of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders in 1973, to the advent of LGBTQ+ affirmative therapies, and greater acknowledgement of the contributions of queer identified therapists, theorists and researchers (Bidell, 2016; Drescher, 2010). Broadly, the mental health disciplines have demonstrated an expanding interest in making therapy inclusive of and reducing harm to LGBTQ+ people and communities (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015; Dentato, 2017; Godfrey, Haddock, Fisher & Lund, 2006). In line with this shift, mental health training programs have increased efforts to recruit diverse applicants as well as integrate LGBTQ+ affirmative approaches into their curricula (Hope & Chappell, 2015; Hsueh, Werntz, Hobaica, Owens, Lumley, & Washburn, 2021).

Despite the growing diversity of trainees entering the mental health fields, it is unclear whether training programs have expanded their training to account for the needs of LGBTQ+ trainees (Hsueh et al., 2021; Moon, 2011). The literature on the experiences of queer-identified trainees with regards to working with LGBTQ+ clients and their training needs is notably scarce. This is concerning given that there is reason to suggest that queer trainees may have qualitatively distinct experiences working with LGBTQ+ clients as opposed to their heterosexual, cisgender counterparts; for example, there is evidence that queer-identified career therapists working with LGBTQ+ clients experience unique challenges and culturally specific phenomena, due to sharing a marginalized identity with these populations (Glassgold & Iasenza, 2000; Porter, Hulbert-
These differences appear to be especially well-documented in the areas of therapist self-disclosure, overlapping client-therapist experiences related to queer identity, and a sense of shared identity in queer therapist-client relationships (Iguarta & Des Rosiers, 2004; Kronner & Northcut, 2015). Little is known, however, about how queer therapists-in-training experience sharing a marginalized identity with their clients when working with LGBTQ+ populations. Thus, it is unclear how the experience of training intersects with sharing a marginalized identity for queer trainees and what their specific training needs around working with LGBTQ+ populations may be.

Furthermore, there is evidence to suggest that counter to the growing advocacy for in-depth training around LGBTQ+ affirmative practices, the implementation of these goals in training programs have been inconsistent. In studies focusing on self-perceived LGBTQ+ competencies, mental health trainees frequently report lacking key skills to work competently with LGBTQ+ clients (Bidell, 2014; Graham, Carney, & Kluck, 2012). Similarly, in a qualitative study by Rutherford, McIntyre, Daley & Ross (2012) queer-identified mental health providers, with expertise in LGBTQ+ mental health, described a scarcity of opportunities to develop LGBTQ+ competencies in their training experiences. Instead, participants reported gaining expertise in LGBTQ+ concerns through seeking out independent training opportunities (Rutherford et al., 2012).

The impact of this training climate on queer trainees and their professional development has remained largely unexamined. Notably, Moon (2011) found that queer identified counseling trainees experienced narratives around LGBTQ+ identities in their training programs as inaccurate and pathologizing. These findings suggest a need for further exploration of current
training practices from the perspectives of queer trainees. Given the paucity of research on the needs of queer trainees, the present study seeks to better understand the experiences of queer mental health trainees by addressing the following research questions: How do queer-identified mental health trainees experience their work with LGBTQ+ clients? How do queer-identified mental health trainees experience navigating their training contexts? To what extent do they experience these training contexts as meeting their needs in working with LGBTQ+ clients?

Definition of Terms

For the purposes of this study, ‘queer’ is used in its contemporary meaning as an umbrella term that encompasses the spectrum of sexual minority and gender diverse identifications, including but not limited to: lesbian, gay, bisexual, pansexual, fluid, questioning, transgender, non-binary and gender non-conforming identities; the specific identities of participants are noted in participant demographics (Table 1). Similarly, LGBTQ+ (lesbian, gay, bisexual, transgender, questioning/queer and others) is used throughout as a shorthand to refer to the diversity of sexual minority and gender diverse identities.

The terms ‘heterosexism,’ and ‘heterocentrism’ are used to broadly in the present context to refer to bias against LGBTQ+ identities, people and communities which exists at structural, cultural, and interpersonal levels (Pachankis & Goldfried, 2004). In the context of this study, these terms are used with minor distinction: ‘heterosexism’ is generally used to refer to pathologizing or negative views of LGBTQ+ identities, whether implicit or explicit, while ‘heterocentrism’ is used to describe the passive or implicit centering of cisgender/heterosexual identities as the taken-for-granted norm (Pachankis & Goldfried, 2004). Where applicable, distinct experiences of discrimination/stigma, such as ‘cissexism’ or ‘transphobia,’ the pathologization of trans and gender diverse identities, or ‘biphobia,' the pathologization of
Finally, the terms, ‘queer therapists-in-training,’ ‘queer mental health trainees’ and ‘queer trainees’ are used interchangeably to refer to LGBTQ+ graduate students currently enrolled in mental health training programs. In the context of the results and discussion sections, these terms are used to specifically refer to the participants of this study; these terms are alternated throughout these sections for the purposes of flow and clarity.

**Review of Literature**

**Queer Clients**

Much attention has recently been devoted to meeting the needs of underserved LGBTQ+ individuals seeking therapy (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008; Pachankis & Goldfried, 2004). Part of this emphasis has emerged from the growing necessity for mental health providers to meet the needs of individuals within LGBTQ+ communities; this is particularly relevant given the strong evidence that LGBTQ+ individuals are disproportionately impacted by mental health disparities (Mongelli, Perrone, Balducci, Sacchetti, Ferrari, Mattei, & Galeazzi, 2019). It has been established that LGBTQ+ individuals more frequently seek out therapy, endorse higher rates of suicidality and depressive symptoms, and report greater psychological distress than their heterosexual, cisgender peers (Cochran, 2001; Lewis, Derlega, Griffin, & Krowinski, 2003).

These mental health disparities have been attributed to the manner in which stigma and discrimination become internalized by queer individuals. The minority stress model, proposed by Meyer (2003), theorizes that queer individuals face multiple, unique stressors by virtue of having a minority identity and that these stressors contribute to poorer mental health outcomes. Hatzenbuehler (2009) asserts that these emotional and social stressors, such as experiences of
discrimination and erasure, eventually work their way “under the skin” through repeated exposure (p. 2). Notably, these stressors may be experienced both directly, from family and peers, and indirectly, via dominant cultural narratives (Meyer & Frost, 2013). There is evidence to suggest that the expectation of ill-treatment and hypervigilance associated with repeated experiences of discrimination contribute to this pathogenic stress for LGBTQ+ people, particularly in unsupportive environments (Meyer & Frost, 2013; Mongelli et al., 2019).

Similarly, internalized heterosexism has been theorized to play a primary role in disrupting social and emotional functioning (Syzmanski & Chung, 2002). Internalized heterosexism refers to the phenomenon where cultural messages that pathologize homosexuality or center heterosexuality as normal are absorbed and turned against the self (Pachankis & Goldfried, 2004). These internalized messages and the recognition that one is 'different' both increase the likelihood that queer individuals will struggle with feelings of alienation and difficulties with self-acceptance (Meyer, 2003). Models of minority stress that focus on gender diversity have proposed internalized transphobia as a contributor to mental health disparities among transgender, non-binary and gender non-conforming individuals (Hendricks & Testa, 2012). Similar in concept to internalized heterosexism, internalized transphobia describes the phenomenon where dominant narratives that pathologize trans identities are internalized by transgender individuals (Rood, Reisner, Puckett, Surace, Berman, & Pantalone, 2017).

It is important to note that within-group disparities have also been found across LGBTQ+ identities. Transgender individuals have been found to be at increased risk for depression and suicidality compared to cisgender queer individuals, associated with experiencing higher rates of discrimination, violence and greater pathologization in mainstream narratives (Su, Irwin, Fisher, Ramos, Kelley, Mendoza, & Coleman, 2016). Similarly, bisexual individuals have been found to
endorse greater mental health concerns than their gay and lesbian peers (Persson & Pfaus, 2015). This discrepancy has been attributed to the relative absence of community and social support for bisexual-identified populations (La Roi, Meyer, & Frost, 2019).

While LGBTQ+ individuals may seek out therapy for many of the same concerns as their heterosexual, cisgender counterparts, they may also face issues specific to having a sexual/gender minority status in a largely heteronormative culture. Pachankis and Goldfried (2004) identify identity formation, romantic relationships, family structure as well as workplace and legal protections as areas where LGBTQ+ clients may have specific and distinct concerns. A significant difference for many queer clients is the developmental experience of coming into a concealable, stigmatized identity (Goffman, 2009; Lane, 2020). Part of coming out first to oneself and then others is navigating the meaning of holding this identity in various settings, including one's family of origin, among one's peers and in the workplace. Given the heteronormative emphasis of mainstream culture and the potential 'concealability' of queer identity, the recognition that one is not heterosexual/cisgender is often “discover[ed in] isolation” and must be integrated with other pre-existing identities (Pachankis & Goldfried, 2004, p. 232). Notably, this process varies from person to person, with social support and ability to access positive queer representation contributing to more positive mental health, self-image and quality of life outcomes (Meyer, 2003).

**Heterocentric Bias and Affirmative Practices**

As a historically underserved population, queer clients seeking treatment are often met with an absence of appropriate training on the part of clinicians (Cochran, Sullivan, & Mays, 2003; Semp & Read, 2015). Literature pertaining to the specific experiences of LGBTQ+ clients in therapy suggest that it is not beneficial for therapists to gloss over the ways in which queer
TRAINING WHILE QUEER

clients differ from heterosexual clientele, as in a one-size-fits-all approach, nor is it beneficial to focus exclusively on queer identity in ways that may alienate clients or ignore other salient identities. Burckell & Goldfried (2006), in surveying the preferences of queer clients in potential therapists, found that clients seeking services for problems related to sexual orientation were more likely to see lesbian, gay and bisexual-specific knowledge as an indispensable trait and value therapists with personal experience with lesbian, gay and bisexual issues. While not found to be essential to pursue a therapeutic relationship, having a therapist who specifically identifies as LGBTQ+ was also favored, indicating that openly queer clinicians may create increased comfort for underserved queer clients in seeking out therapy (Burckell & Goldfried, 2006).

The preference for therapist-client matching among queer clients may be due in part to the perception that therapists who are queer (or have close relationships with queer people) will have a better understanding of client's concerns and refrain from pathologizing a client's sexuality or gender identity. These concerns are not unwarranted as heteronormative biases in therapy present a significant challenge for therapists interested in meeting the needs of queer clients (Israel, Gorcheva, Burnes, & Walther, 2008). While deliberate discrimination in the context of therapy is no doubt damaging to queer clients, researchers have also focused on the role that unexamined biases or heteronormative assumptions by well-meaning therapists may have in creating distance in the therapeutic relationship (Hodges, 2011).

TRAINING WHILE QUEER

Competency with LGBTQ+ clients also involves remaining informed about the range of specific concerns that may impact LGBTQ+ people and determining how and when to integrate this information with one's first-hand knowledge of the client (O'Shaughnessy & Speir, 2018). Striking this balance, what Sue (1998) refers to as “dynamic sizing,” is a key skill highlighted in the literature on LGBTQ+ competency (p. 446).

Therapists who adopt an affirmative approach appear to have more favorable treatment outcomes with queer clients and reduce the risk of repeating oppressive dynamics within the context of therapy (Burckell & Goldfried, 2006; Stracuzzi, Mohr, & Fuertes, 2011). LGBTQ+ affirmative practices center around acknowledging LGBTQ+ identities as valid, healthy variations of gender and sexuality, and seek to consider the role of heterocentric bias in theory and practice (Moradi & Budge, 2018). Coping with stigma and discrimination, developing strategies for resilience, and building social support networks are highlighted as common foci of affirmative approaches (O'Shaughnessy & Speir, 2018). For transgender, non-binary and gender nonconforming clients, affirmative therapy may involve assistance in accessing gender-affirming services and support in navigating a dominant culture hostile to gender diversity (Singh & dickey, 2016).

Recent decades have witnessed an increased interest in relational models of psychotherapy, which take into account both the client and the therapist as active and mutually-influenced participants in the therapeutic relationship (Frey, 2013; Maroda, 2009). This shift has placed a focus on the identities that the therapist brings with them into the room. Relational approaches to therapy consider the therapist as a whole person involved in constructing a relationship with a client; for LGBTQ+ therapists, queerness is an inseparable part of that personhood (Kassoff, 2004; Porter, Hulbert-Williams, & Chadwick, 2015).
Much of the current literature focused on LGBTQ+ clients, however, operates under the implicit presumption that the therapist is heterosexual and cisgender. Gabriel and Monaco (2000) refer to this “socially …institutionally sanctioned” default as “the heterosexual assumption,” whereby clients, colleagues and supervisors assume, unless otherwise informed, that the therapist is part of the heterosexual majority (pp. 166). In the literature on working with queer clients, this assumption positions the therapist on the outside looking in and locates queerness as 'other.' Acknowledging queer client-therapists dyads prompts new inquiries about the issues faced by queer clients. What if the therapist is plunged into the same social milieu and struggles with the same challenges as the client? How does the landscape of working with LGBTQ+ clients shift when experiences of queer therapists are centered? The following section will attempt to address these questions and summarize the extant literature on queer therapists working with queer clients.

The Therapist is Queer

Therapist identity becomes salient in novel ways when operating under the presumption that the therapist is also queer. In many ways, the experience of queer therapists in working with queer clients appears qualitatively different from that of heterosexual therapists, presenting both distinct advantages and challenges. Unlike heterosexual, cisgender therapists, queer therapists enter the therapy relationship with their own subjective experiences and first-hand knowledge of “growing up and making a life in a heteronormative culture” (Hodges, 2011, p. 30). In this sense, queer therapists are the site of different forms of expertise, both their organic and subjective knowledge of moving through the world as queer people as well as their clinical training.
A significant trend across the literature is the affinity many queer therapists hold for working with queer clients (Pearlman, 1996; Porter et al. 2015). This affinity may be due in part to the ways in which personal experience can enable queer therapists to identify with their queer clients' experiences. Pearlman (1996), reflecting on her own experiences as a lesbian therapist working with lesbian clients, points out how drawing on her own experiences inform her interventions:

“My identification with these women means I can deeply understand and am quickly able to clarify feelings and the undertow of possible meanings to events and interactions. I am also able to validate and normalize their perceptions [and] the appropriateness of their reactions and responses to homophobia.” (p. 78)

Pearlman is also careful to exercise caution in her identification, naming the importance of being able to set aside her own emotional experiences to attend to that of her clients’, with an ear to important differences between them. Part of exercising this skill for queer therapists may rest in knowing when to draw from common personal experiences and when to attend to the uniqueness of a client's particular challenges.

Given their shared minority identity status, queer therapists may also have the unique ability to function as models for LGBTQ+ clients, filling in an important gap for clients who have encountered few positive queer representations in their lives. Glassgold (1995) elucidates how social stigma and structural erasure of queer identities can invade and displace client's ownership of their own experiences; this internalization limits possibilities for identity and self-expression that be imagined and held in mind, let alone pursued. Thus, an out queer therapist can serve to model what is possible for clients, particularly those struggling with shame or internalized homophobia around their sexuality.
TRAINING WHILE QUEER

Sharing culture and community with clients can also inform and expand the language, roles and topics available therapists to session. For example, Huxley, Clarke, and Halliwell (2014) identify appearance as an important cultural medium for lesbian and bisexual women to express and signify their relationship with gender, sexuality and the larger queer community. While some of these commonalities may be culturally bounded, therapists can explore and connect over the ways in which clients express their identities through mediums such as appearance to further therapy. Similarly, in-community language (i.e. butch, femme) and other cultural knowledge, can be used by queer therapists as a way of connecting with queer clients and signifying their membership within the same subculture.

While the majority of the literature on queer therapists has focused on the experiences of cisgender lesbians and gay men, the limited body of literature on bisexual and transgender therapists is informative of the diversity of queer therapist experiences. Petford (2006), in a phenomenological study of bisexual therapists, found that participants often experienced erasure of their bisexual identity in the context of their work and training experiences. Shipman and Martin (2019), reflecting on their own experiences as transmen, comment on the distinct experiences of transgender therapists. The recommendations provided for trans therapists and trainees illuminate the unique perspectives of trans therapists regarding gender, the necessity of exploring internalized transphobia, and distinct concerns related to self-disclosure and safety (Shipman & Martin, 2019).

Challenges in Queer Therapist-Client Relationships

Focusing on the experiences of queer clinicians also brings to light several pragmatic challenges around negotiating therapist and client identities. While working closely with clients that share similar experiences of discrimination is often found to be rewarding for queer
TRAINING WHILE QUEER

therapists, it may also carry with it the risk of the client's struggles 'hitting too close to home.'

Clients experiencing family rejection, difficulty coming out, shame or absence of social support may touch on the therapist's own historical wounds of growing up queer (Iguarta & Des Rosiers, 2004). Iguarta and Des Rosiers (2004) exploring the benefits and pitfalls of identification in lesbian dyads, remark that therapists who identify with their clients as lesbians may also feel a form of “survivor's guilt,” when clients experience discrimination or challenges they have not encountered (p. 137).

Queer therapists' emotional experience of working with queer clients also may be influenced by whether therapists are out in their personal and professional communities, their comfort with disclosing their orientation, and their own process of coming to terms with internalized heterosexism (Glassgold & Iasenza, 2000). Both queer clients and therapists come of adulthood in a mainstream culture that centers upon heterosexuality, and thus they may have internalized negative social messages about LGBTQ+ identities or about what manifestations of queer identity are socially acceptable. For example, bisexuality may be associated with stereotypes, such as hypersexuality or being solely 'a phase,' assumptions found to be common in both mainstream and gay communities, even in therapy with lesbian and gay therapists (Dworkin, 2001).

For queer therapists working with queer clients, areas of difference may still arise in terms of sexual identity, such the previous example of a gay therapist working with a bisexual client, or other intersecting facets of identity such as race, class and gender. Pearlman (1996) reminds that is important not to attempt “to universalize or essentialize” the experience of being queer, but to instead navigate various dynamics of sameness and difference (p. 309). Queer individuals with multiple minority or stigmatized identities are a key example of how these
dynamics might emerge. For example, Bridges, Selvidge and Matthews (2003) emphasize that lesbian women of color face challenges that white lesbian narratives do not take into account, such as feeling pressured “to either identify with their race or their sexual orientation to fit into a culture” (p. 115).

Community size may also present a challenge for therapists and clients who co-exist in small, overlapping queer communities. Kessler and Waelher (2005) observe that lesbian therapists may be more likely to encounter their clients in social settings due to the “tight-knit” nature of the community or feel pressure to isolate from the community to avoid double relationships with clients (p. 68). As this challenge is rarely addressed in training, queer therapists may need additional support and resources in maintaining therapeutic boundaries and discussing the possibility of social overlap with clients.

Self-disclosure of sexual orientation is particularly foregrounded in literature focused on lesbian, gay and bisexual therapists. This topic touches on two historical taboos in therapy: therapist self-disclosure and therapist sexuality (Gibson, 2012; Kronner & Northcut, 2015). While self-disclosure of therapist sexuality has been viewed by some models as a disruption of the therapist's neutral stance, literature on queer dyads has often framed self-disclosure as a viable intervention, enabling queer therapists to model self-acceptance and counter the heterosexual assumption. Countering the traditional stance that therapist self-disclosures impose on the client, Cole & Drescher (2006) assert that disclosures can serve to remove a barrier that would not be present for heterosexual clients. In a society that centers and normalizes only cisheterosexuality, compartmentalizing queer therapist sexual identity potentially isolates queer clients further and may contribute to client perceptions of psychotherapy as a heteronormative institution. Here, Cole and Drescher include the important caveat that self-disclosure be done
intentionally and in the service of the client's therapeutic growth, noting that different clients may have different needs (2006).

Queer therapists have also contributed to relational approaches to psychotherapy, many of which have spoken to the power of self-disclosure in facilitating therapeutic connections and “undo[ing] aloneness” (Fosha, 2009, p. 4). In this vein, Coolhart (2005), a self-identified lesbian therapist, describes her own experience of coming out to clients as a joining process, providing comfort and relief to clients who fear their experiences may be misunderstood or judged. Kronner and Northcut (2015), in a qualitative study of gay male therapy dyads, found that therapist disclosures of shared experiences as gay males often served to create safety and deepen the therapeutic relationship; notably, disclosures that ‘missed' clients often pertained to the therapist and clients differing experiences around embodying a gay male identity, such as cultural factors.

However, it is also important to hold onto the awareness that queer therapists are not removed from the social and structural context that stigmatizes and decenters queer identity. Shame and stigma around identity for queer therapists may also play a role in the decision to disclose or refrain. Gabriel & Monaco (2000), articulating the dilemmas faced by queer therapists when confronted with self-disclosure, emphasize “[f]or many lesbian and gay therapists, self-disclosure of their sexual orientation remains associated with their own particular and personal history of shame around sexual orientation (pp. 165).” Disclosure is a position of vulnerability for the queer therapists, the intensity of which may vary based on their own personal circumstances. For therapists who identify as queer but have not (or do not wish to) come out to their professional community, the decision of whether to disclose to clients may be a fraught process (Gabriel & Monaco, 2000; Shipman & Martin, 2009). It is important to note that
queer therapists must weigh not only their clients' needs, but also the emotional impact and particular risks that coming out in therapy can have for their own wellbeing.

**Therapists-in-Training**

Therapists-in-training face unique challenges in navigating sameness and difference in therapeutic relationships. Kannan and Levitt (2017) found that therapists in training are particularly vulnerable to self-criticism and anxious about implementing unfamiliar interventions, although this insecurity appears to diminish with greater experience. It is not unexpected that therapists in training may be more vulnerable to anxiety in negotiating social and cultural identities, both clients' and their own, in session. The literature emphasizes trainee difficulties in working across cultural, race and sexual orientation differences with clients (Sue, Rivera, Capodilupo, Lin, & Torino, 2010). However, therapists-in-training may also need additional support negotiating boundaries or potential ruptures with clients from similar backgrounds or with whom they identify strongly (Goode-Cross & Grim, 2016).

For queer trainees working with LGBTQ+ clients, the heterosexual assumption also appears to extend to their training. The majority of training resources geared toward working with LGBTQ+ populations appear to assume an audience of heterosexual/cisgender trainees and while general training centers heterosexuality as the norm. In Moon's (2011) qualitative study focused on the training experiences of queer-identified therapists, queer trainees reported feeling alienated by the heteronormative assumptions of their training and the absence of attention to non-(cis)heterosexual experiences outside of specific diversity courses. Moon’s findings raise the question: How do queer therapists in training move through a discipline, and a training philosophy, that has only recently begun to address the needs of queer clients and its own history
of heterosexism? Much like queer clients, queer trainees are also tasked with navigating an environment that was not initially built with their needs in mind.

While limited in scope, similar findings have also emerged in the small body of literature regarding the experiences of queer identified trainees. For example, a small-scale qualitative study by Chinell (2010), found that lesbian and gay social work trainees experienced heterosexism in classroom scenarios that challenged their perceptions of Social Work as a field. The impact of these experiences is important to consider given the association of exposure to repeated incidents of heterosexism with and poorer mental health outcomes for LGBTQ+ individuals (Meyer, 2003). Notably, a recent survey of the mental health of clinical psychology doctoral students, found that LGBTQ+ identified participants endorsed significantly higher rates of depression, suicidal ideation and substance use (Hobaica, Szkody, Owens, Boland, Washburn & Bell, 2021). In addition to the elevated rates of anxiety, depression and stress reported by mental health graduate students in general, it is possible that queer-identified trainees also face unique stressors related to heterosexism in training contexts which adversely impact their wellbeing (Rummell, 2015).

Additionally, queer trainees in their formative work with LGBTQ+ clients may face many of the same challenges as their more advanced counterparts in the field. Gaps in the literature on trainee experiences leave open to speculation how these challenges may be more complicated for queer therapists-in-training. For example, trainees tend to be younger and may be in the process of reconciling their own identities as sexual minorities. They may have also more recently passed through milestones their clients are struggling with, such as coming out to family, or undergoing these processes at the time of therapy. Additionally, little is known about the emotional impact of disclosing sexual identity in therapy for the training therapist nor the
TRAINING WHILE QUEER

impact of remaining quiet on the subject. Further research is needed on how trainees negotiate the intentional clinical decision to disclose or whether they feel safe disclosing, regardless of clinical impact (Moon, 2011).

Porter, Hulbert-Williams and Chadwick (2015) in their phenomenological study of established and training gay male therapists, acknowledge the power of self-disclosure to create connection and safety with LGBTQ+ clients. However, their findings also characterize the queer therapist as experiencing multiple internal conflicts regarding self-disclosure (Porter et al., 2015). As the therapist's queer identity is concealable and may be considered off-limits by some models, trainees may be left with a number of unarticulated clinical, emotional and personal challenges as well as unresolved identifications with clients that share their minority status. Queer therapists-in-training may also experience homophobia from clients, both directly and indirectly, complicating the therapist's ability to maintain rapport (Porter et al., 2015).

Depending on trainees' prior experiences in the workplace and their own process of coming to terms with their minority identity status, queer trainees may face dual identity development tasks, navigating the process of coming out in professional settings and integrating queer and professional identities (Russell & Greenhouse, 1997). Discussing these issues in depth in supervision and coursework also relies on the assumption that the training therapist is 'out' to supervisors and peers, which may not be the case. Russell and Greenhouse (1997) acknowledge that the heterosexual assumption may persist not only in therapeutic but also supervisory relationships. Therapists-in-training, who share queer identifications with their clients, may feel uncomfortable discussing LGBTQ+ identities with supervisors, particularly those who express homophobic attitudes or a lack of familiarity with LGBTQ+ issues (Burkard, Knox, Hess, & Schultz, 2009). Developing a better understanding of these experiences and bringing light to the
challenges that queer trainees face may allow training programs to better support queer therapists in early stages of professional development.

**The Present Study**

The present study seeks to understand the experiences of queer-identified therapists in training in their clinical work with queer clients. It is hoped that shifting the focus onto queer therapists in their early professional development will provide insight into the unique challenges trainees experience and how they seek to navigate them. This line of inquiry raises several questions: how do queer therapists in training develop rapport with their queer clients? Does their approach or choice of interventions differ from working with heterosexual, cisgender clients? What is the clinical and personal impact of disclosing or choosing to not to disclose information pertaining to the therapist's sexuality for therapists-in-training? How do trainees negotiate these decisions? Given the documented gaps in training, do queer therapists-in-training draw from their own experiences in relating to queer clients?

Additionally, few studies have examined how the diversity of queer communities may impact the way the therapeutic relationship is experienced by therapist and client. Kassoff (2004) notes the importance of not painting the LGBTQ+ communities as a monolith, noting the fluidity and multiplicity of attractions and relationships with gender the term ‘queer’ encompasses. It is predicted that differences specific to the makeup of the client-therapist relationship, such as gender, race, SES, sexual orientation or even differing perceptions of LGBTQ+ identities, may complicate the therapeutic relationship.
Methods

Participants

Recruitment procedures consisted of distributing recruitment information, through email listservs, to Clinical Psychology and Counseling Psychology doctoral programs as well as masters-level Social Work and Counseling programs within the Northeastern U.S. Purposive sampling and snowballing were used to select queer-identified participants, currently enrolled in mental health training programs, who had worked with at least one LGBTQ+ client. Participants included eight queer-identified therapists-in-training recruited from four training programs; six participants were recruited from Clinical Psychology doctoral programs and two from masters-level Social Work programs. Participants included 2 white gay male participants, 1 white bisexual female participant, 1 white bisexual/pansexual female participant, 1 Latina bisexual/pansexual female participant, 1 Afro-Latina queer female participant, 1 bisexual Asian female participant and 1 white lesbian participant. All participants identified as cisgender. This significant limitation is discussed further in Limitations. More detailed participant demographics are provided in Tables (Table 1).

Procedures

The present study seeks to understand the experiences of queer therapists-in-training through a qualitative, phenomenological methodology. The primary researcher conducted semi-structured interviews in person and via video conferencing, on a secure platform (see Appendix A for interview protocol). The interview schedule was developed by the primary researcher and consisted of open-ended questions about the experiences of queer therapists-in-training based on the present study’s primary areas of inquiry. Prior to use, the interview protocol was piloted with two queer therapists-in-training and revised according to feedback.
Informed consent was obtained from participants prior to the interviews. Participants were informed about the purpose of the study and the benefits and risks of participation. Additionally, participants were informed about confidentiality procedures, including the right to withdraw their participation at any point during data collection, and provided with the opportunity to select their own pseudonyms.

Participants were encouraged to respond at length to interview questions regarding their experiences working with LGBTQ+ clients and related experiences within their training contexts. Participants were also encouraged to provide examples of clinical and training scenarios and include relevant experiences outside of the interview schedule. Interviews were audio recorded, with participants’ consent, and later transcribed verbatim for analysis. Due to the potentially sensitive subject matter of the interviews, participants were de-briefed after the interviews and provided with a referral list of local therapy resources and LGBT community resources should they need to seek out further support.

Interpretative Phenomenological Analysis (IPA) was employed as method of qualitative analysis due to its emphasis on lived experience and utility in understanding relatively unknown phenomena, consistent with the exploratory nature of the research question (Smith, Flowers, & Larkin 2009). IPA is a phenomenological approach to understanding how individuals ‘make sense’ of and derive meaning from their lived experience, in this case, the experience of queer therapists-in-training working with clients who share their minority status (Smith, Flowers & Larkin, 2009). IPA seeks to capture both the core, shared features of a given phenomenon across participants while also acknowledging key participant differences at the idiographic level (Pietkiewicz & Smith, 2014).
TRAINING WHILE QUEER

The present study sought to gain rich, detailed accounts of how queer therapists-in-training perceive their work with queer-identified clients and make sense of experiences in their training contexts. Interviews were conducted with the aim of understanding the perspectives and experiences of queer therapists-in-training on their own terms, with the intention of bracketing previous assumptions and avoiding leading questions (Smith, Flowers & Larkin, 2009).

Data Analysis

Interpretative Phenomenological Analysis (IPA) provides a methodology for analysis, including multiple in-depth readings of transcripts, annotation, cataloging findings into themes, drawing connections and contrasts between transcripts, and establishing a narrative that draws together themes and interpretations of participants first-hand accounts into a coherent framework (Smith, Flowers & Larkin, 2009). IPA is distinct from other qualitative methods its emphasis on the experiential and psychological aspects of a phenomenon, seeking to convey what a given experience ‘is like,’ rather than provide an explanatory model (Smith, Flowers & Larkin, 2009).

In line with this methodology, the transcripts obtained from interviews with therapists-in-training were annotated and coded for emergent patterns as follows. First, transcripts were analyzed individually for patterns within interviews and relevant themes were noted. Next, transcripts were analyzed for connections and differences between participant accounts. Commonalities between transcripts were cataloged into larger themes. Finally, interpretations were made based on themes and notable differences found throughout the transcripts, with attention to broader, practical, and conceptual implications for queer therapists in training working with queer clients. Examples of the analysis at these various stages are presented in Appendices (Appendix B).
Reflexivity

The primary researcher recognizes her potential bias as a white, queer-identified trainee, currently enrolled in a Clinical Psychology doctoral program (Psy.D. degree). All interviews with participants, transcription of interviews, and subsequent analyses were conducted by the primary researcher. The analysis took place over the course of a month, during which transcripts were read and re-read, consistent with Smith, Flowers & Larkin’s (2009) recommendation of immersing oneself in the data. This process also required an ongoing self-reflective component, whereby the primary researcher engaged in the ‘double hermeneutic’ characteristic of IPA (i.e. making sense of how participants make sense of their experiences).

In line with Creswell’s (2000) recommendations for assessing quality in IPA research, the following steps were undertaken to minimize researcher bias, improve validity, and engage in researcher reflexivity throughout the process of interview development, data collection and analysis. Prior to interviews, the primary researcher engaged in journaling to note assumptions and initial impressions. This was done with the intention of bracketing these preconceptions during the interviews to differentiate the primary researcher’s lived experiences from the phenomena described by participants (Alase, 2017).

Additionally, interviews were intentionally piloted with queer trainees who differed from the primary researcher along various identity dimensions and their feedback regarding the interview and schedule was incorporated prior to conducting participant interviews. Given the primary researcher’s status as current graduate student, recruitment excluded participants with ongoing personal and/or professional ties to the primary researcher.
Results

Emergent themes fell into three domains: Experiences with LGBTQ+ clients, Intersection of Queer Identity and Professional Identity, and Experiences of the Training Environment (depicted in Figure 1). Each domain with relevant themes and variations is discussed below. Emergent themes that were endorsed by over half of the participants, at least four of the eight total, were included in the final analysis. For variations on each emergent theme, those endorsed by at least three participants were included in order to preserve a sense of the diversity present in the sample, which included several sub-groups of LGBTQ+-identified trainees.

All participants endorsed the themes of Deep Personal Meaning and Investment, Use of Lived Experience, Awareness of Difference, Peripheral Nature of LGBTQ+ Training and Absence of Support, and Self-Initiated Efforts to Improve the Training Environment. Three themes were endorsed by majority of participants but were not universal: Ambiguity of Visibility and Disclosure, endorsed by 7 of the 8 participants, Sense of Internal Struggle, endorsed by 7 of the 8 participants, and Experiences of Heterosexism, endorsed by 6 of the 8 participants. A table of the themes endorsed by each participant is provided in the Appendix (Table 2).

Experiences with LGBTQ+ Clients

Queer trainees entering the mental health field carry with them their own previous experiences of living and navigating the world as LGBTQ+ individuals. This intersection of lived experience and clinical work appears to lend itself to specific experiential features for queer therapists-in-training who work with LGBTQ+ populations. The following section discusses themes which emerged from trainees’ accounts of working with LGBTQ+ clients.

Trainees’ experiences with LGBTQ+ clients emerged as three major themes: Deep Personal Meaning and Investment, Use of Lived Experience, and Awareness of Difference. The
TRAINING WHILE QUEER

themes in this section center on the ways in which trainees make sense of their work with LGBTQ+ clients across various modalities, including group, couples and individual psychotherapy, and across a range of age groups and intersecting identities. The focus of this section includes how trainees experience and derive meaning from their experiences with LGBTQ+ populations; additionally, this section discusses the ways in which trainees use their lived experiences with LGBTQ+ clients and navigate areas of similarity and difference between themselves and their clients.

Deep Personal Meaning and Investment

Across interviews, participants described deriving a deep sense of meaning from their work with LGBTQ+ clients. A central source of meaning, described by all participants in some variation, was the desire to construct therapy as a place that is different from the world, namely one that provides safety, acceptance, and space for exploration (without shame or fear of consequences) for clients who may not currently have access to these in their daily lives. Throughout interviews, participants expressed the importance of establishing therapy as an explicitly affirming space, not governed by heterosexism, and a desire to create sufficient safety for clients to express themselves on their own terms. Adelaide, a bisexual doctoral student in her late twenties, illustrates this theme while talking through her experience of working with a transgender client in the process of transitioning:

“"It's just you need to be there for her, help her find those coping skills, just affirm her even when other people in her life don't. Just being with someone through that journey of-- oh, I remember, I was there the first time she decided to paint her nails. That was the first thing she did. Oh, and she went shopping for women's clothes the first time when she was in treatment with me and started the process of changing her name at the university. So all of that stood out to me as so meaningful, just being with someone through those first experiences."
Here, the role of therapist is constructed as creating an affirming space and ‘being with’ clients in their experience of self-exploration. As demonstrated above, participants often described experiencing vicarious joy or feeling moved by witnessing self-exploration, first milestones, or growing self-acceptance on the part of a client.

For more vulnerable clients, therapy was often framed as sort of refuge from heterosexism in the world, where a sense of community could be found and where resilience skills could be imparted and practiced; this space appeared to serve as a bridge while working on building these supports in the outside world. This theme arose particularly in the context of working with younger clients and those facing family rejection, an absence of safety or security in daily life, absence of community or acceptance, or an inability to be out as queer in contexts outside of therapy. Lisa, a lesbian returning student and mid-career social worker, described her approach to working with LGBTQ+ youth as follows:

“I think that identification piece with the LGBTQ youth population is really huge. I think that showing them, not only that you can be successful, but that there are resources out there. And that you know what they are, and that you know how to direct them to it, is really huge. And then beyond that, as far as my youth go-- and I think I probably empower them to do a lot of their own advocacy, as well.

One of the kids that I work with-- they didn't have a [Gay Straight Alliance]. All right. Let's go set up a meeting with your guidance counselor. Let's get you guys set up with a Safe Space Package and have a conversation about how you want to start a GSA... Here's your ticket to a safe space in school. When you're ready, I'll help you put it together." And six months later, we put a GSA together in the school. And by the time the spring came around, they had a field trip. So obviously, it was needed. Teaching the kids to advocate for themselves is huge in dealing with bureaucracy and systems. Because they're going to be in various systems their whole lives, and dealing with their peers, as well.”
For younger clients or those earlier in their identity development, trainees often found themselves acting in a role model fashion, which was felt to be particularly meaningful when this inspired clients’ hope for the future or provided an affirming alternative to heterosexist messaging. As illustrated in Lisa’s description, trainees could adopt a mentor or advocate role in working with younger clients, transferring strategies for navigating heterosexism and creating affirming spaces outside of therapy.

Due to the nature of their shared experiences, participants often described a sense of personal significance in various aspects of their work with LGBTQ+ clients. Broadly, participants conveyed a sense of intimacy, connection, and fulfillment in working with queer clients. While participants described varying degrees of connectedness and compatibility in their work with LGBTQ+ clients, they often referred to poignant moments in which they felt deeply connected or in synch with clients; such moments appeared to be the result of shared, typically formative, experiences related to living in a heteronormative context. Elliot, a gay doctoral student in his early thirties, illustrated this theme while describing his work with a younger gay client:

“He was this young guy who came in and was just really depressed and a little kind of passive suicidal ideation after kind of having his first romantic experience with another man. Not just sexual but kind of where he actually kind of, as he said, caught feelings and was, in a way, really-- just his heart was broken by this guy.

And to be able to-- and so I'm aware, with this client, I never expressed that I was a gay man. However, I'm certain that the client knew. And even as I say that, I'm like, "Am I?" But I feel like there was a way with this client where talking about Grindr or talking about PrEP with a certain kind of really attempting to have no stigma, ease, fluency, kind of communicating without telling you kind of something about me. We're speaking a shared language. And there's a communication happening in that that--  ".
TRAINING WHILE QUEER

Here, Elliot’s attempts to de-stigmatize discussion of gay dating and sexuality suggest a desire to navigate these experiences from a place of openness and affirmation, creating a space significant for its insulation from heterosexism. As seen above, trainees generally expressed finding meaning in helping clients work through specific identity related concerns and significant milestones, such as first romantic relationships, exploring dating, coming out, transitioning, and grappling with internalized heterosexism.

Due to these similarities in lived experience, trainees reported that they could often communicate with LGBTQ+ clients in a shorthand, generating an experience of comfort and unspoken understanding. Additionally, these moments of connection seem to be marked by therapist and client relating to one another as fellow queer people (indicated by the usage of ‘shared language’ in Elliot’s description) in addition to the therapist-client relationship, allowing for an additional layer of intimacy.

This process of providing an affirming environment where clients could come more fully into themselves tended to be described as mutually empowering or evoking a sense of solidarity by participants. Molly, a bisexual social work student in her late twenties, conveyed this sentiment in discussing her work with LGBTQ+ youth:

“I think that my experiences directly relate to my desire to be a permission giver, a smasher of shame…and I'm really, really proud that my experiences have navigated me towards a practice that focuses on strength and empowerment and breaking down stigma and oppression.”

As per Molly’s description above, trainees framed creating affirming spaces as their way of taking part in dismantling the impact of heterosexism. Additionally, participants appeared to derive a sense of meaning from using their own experiences to assist another queer person, in a
sense being the person they may have needed during a difficult period. In their descriptions of these challenges, participants often alluded to a sense of identification with their clients, seeing themselves or those they care for in their clients’ circumstances and stories. Bianca, a queer doctoral student in her mid-twenties, recounted her experience of identification with LGBTQ+ clients not far from her own age:

“When I was with the college counseling center last year, I would say it was a pretty adequate chunk of my supervision because it's these transitioning adults going through a lot of things and at that point I wasn't much older than them myself. So I was seeing a lot of myself in a lot of my clients. And it's like okay---to a point, I was like all right, how do I help this person navigate the situation better than I navigated it myself when I was going through the same thing?”

This excerpt captures both the meaning derived from identifying strongly with client experiences as well as the challenge of providing clients with a supportive space to navigate what one has only recently worked through themselves.

While participants expressed a desire to positively impact their clients’ lives, several trainees alluded to moments in which working with LGBTQ+ clients was mutually impactful, finding themselves changed or deeply moved by an interaction. For example, Leah, a bisexual doctoral student in her late twenties, who also identifies as non-monogamous, described her experience working with a non-monogamous lesbian couple as follows:

“I didn’t realize that they felt so connected to me, and that made me wonder, maybe there are other ways to disclose how you feel, at least. And they said, "You're like our third secret girlfriend." And that made me-- I was like maybe, maybe they know. It could have just been like her way of phrasing it, but I felt seen and validated when they said like, "You're like our third secret girlfriend. You just know what's happening in our lives. You're always there for us."
Throughout interviews, participants framed experiences of recognition, connection and validation as often healing in response to damage inflicted by heterosexism, both internalized and in the world. Given the role of shared experiences and minority identity status, it appears that therapy with LGBTQ+ clients may also serve as a site of mirroring and recognition for queer trainees. This sense of shared minority identity appears to be underscored by an awareness on the part of the therapist that therapist and client are referring to the heteronormative world as outsiders.

Participants’ meaning-making was often linked to a strong personal investment in working with LGBTQ+ populations prior to entering their training programs, with participants reporting engagement in advocacy programs, prior careers and/or volunteer work to this end. Participants generally described a desire to work with LGBTQ+ communities as a therapist prior to beginning their training programs and expressed an interest in pursuing LGBTQ+ mental health as one of their areas of specialization. Bianca referenced her prior experiences working with LGBTQ+ communities while discussing her interest in working with LGBTQ+ clients:

“*When I was in undergrad I used to do volunteering with LGBT teenagers who are homeless. So it's something that really is dear to me. It's a population that I really care about and I feel like it's very underserved.*”

Similarly, Scott, a gay trainee in his early twenties, described his desire to work with LGBTQ+ clients from the outset of his training program:

“I knew going into the program that I wanted to be working with queer clients...As a gay man, I see myself working in the future very closely with the LGBT population. I really want to be able to give back as much as possible to my brothers and sisters and non-binary family and I think taking every single opportunity I have”
As evidenced above, working with LGBTQ+ clients was generally construed as a meaningful way for participants to give back to their communities or engage with a continued sense of responsibility in advocating for LGBTQ+ populations in their role as clinicians.

Of the eight participants, four also made note of the pitfalls of strong emotional investment and situations where meaning based in connection or creating a refuge did not hold. For example, Scott described both his initial excitement and the adjustment of expectations that occurred during his first case with an LGBTQ client:

“So he was my first LGBT case and I was so excited. I was like, "Oh, my God. I'm finally getting a gay person or any type LGBT person. I can't wait. It's going to be amazing." I actually realized very quickly that I actually really don't like them as a client. I'm working on it, but it was just-- our first session was really bad....”

While shared experience appears provide a strong basis for meaning-making and rapport in trainees’ experiences with LGBTQ+ clients, the above suggests that this sense of connection and deep meaning is not inherent to shared minority identity nor universal across cases; Scott’s example highlights how ruptures and disconnection can challenge this desire, prompting a re-evaluation of assumptions in working with LGBTQ+ clients and considering their therapeutic needs.

**Use of Lived Experience**

In describing their experiences of working with LGBTQ+ clients, all participants recognized the contribution of their lived experiences as queer identified individuals to their clinical understanding of and ability to intervene with queer clients. Participants described utilizing lived experience, in conjunction with clinical training, to empathize with LGBTQ+
clients, understand their clients’ concerns, and inform their clinical interventions. Across interviews, participants noted referencing their first-hand knowledge of navigating the world as a queer person in various cases, particularly where clients’ presenting concerns intersected with or centered on LGBTQ+ identity concerns. Molly described her experience of working with queer clients in contrast to heterosexual, cisgender clients:

“I think there's a different comfort level that I experience. I feel more in my comfort zone working with queer folks versus-- You know what's interesting? Yes. It's not so much language, but it's a lens...I'm able to talk about things in certain ways that I think could be helpful to clients, that I think other folks who aren't aware or don't have that lived experience couldn't.”

As this excerpt demonstrates, participants often described their lived experiences as an intuitive lens through which they could interpret or more deeply understand the subtext of their clients’ communications, access a felt sense of their clients’ lived realities, and decode certain interactions with LGBTQ+ clients in the clinical setting.

Participants described using their own lived experiences as an internal reference point in empathizing with a given client’s experience. This was often framed as bringing to mind past experiences or versions of themselves to engage in perspective-taking; in this way, participants were able to reflect on what was helpful to them in working through common developmental experiences. For example, Scott, described how his own experience of coming out informed his approach with a client in similar circumstances and offered a sense of perspective in working through this process:

“I was only really in his position like two years ago-- my own experiences of having to come out, parallel what he wants to do which is to come out to his mom and then to his dad...it's certainly something that I keep, I would say, more in my consciousness to pull out if it was to come up... one
of the things I try to get from him especially is for him to future project in particular because he feels so distraught and so dismayed about the future and his future prospects of dating or just having a relationship with anyone. And I'm trying to get him to realize his future...And that's something that I found really helpful for myself was when I was getting ready to come out and going through that process.”

This approach was typically employed when therapists had an internal sense of ‘having been there’ or experienced some version of a phenomenon described by a client. As evidenced above, engaging in this self-comparison appeared to be a strategy for getting in touch with the emotional realities and implications of these experiences.

For trainees experiencing similar identity-related challenges to their clients in the present, this was often conveyed as adding a heightened sense of empathy or an insider’s perspective to their work. Bianca described the impact of her own experiences in empathizing with her clients:

“I definitely do try to draw a little bit from my experiences. I don't talk about my sexuality or anything with my family, so I understand what it's like from that perspective to kind of hide that part of you. And I feel like, unfortunately that's a way that I am able to empathize with some people and connect to them. I don't necessarily like share like, okay, I'm also a queer person of color, but I know from within I can understand what they're going through.”

Bianca’s description demonstrates how shared experiences can evoke associations to personal experiences and emotionally resonant ways of knowing that inform queer trainees’ work “from within.”

Across interviews, participants described lived experiences, such as navigating heterosexism and stigma, coming out, identity exploration, finding community and support, and dating and sexuality, as relevant in understanding clients’ needs and guiding their questions and interventions; this was also conveyed as having a frame of reference for LGBTQ+ experiences,
external to the clinical setting, in which to properly contextualize their clients’ concerns, without unnecessarily pathologizing them. Molly detailed one such occasion where her first-hand experiences as a bisexual woman enabled her to grasp the identity-specific complexities of a bisexual client’s experience:

“In group today [there was] a client talking about an experience very similar to my own. They also identify as bisexual, and they were saying how they, up until recently, had only been sexually intimate with cis men. And they felt like, at their age, if they’re going to be affirmed bisexual, they need to have sexually intimate experiences with other folks, with women. And a few years ago, that was a very-- I felt very similarly, except with men, not with women... I feel like I’m able to dive into very specific experiences that are generally specific to the LGBTQ+ community or communities that I otherwise wouldn’t.”

As seen here, when client and therapist identities overlapped, this knowledge often served as a map in navigating the terrain of their clients’ experiences, guiding areas for further exploration and filling in unspoken meaning. Generally, lived experience was felt as removing obstacles in connecting with and understanding clients, making explanation and education about LGBTQ+ identities on the part of the client less necessary; this is exemplified by Molly’s sense of being able to “dive” into experiences related to bisexual identity and related stigma around proving legitimacy. Participants indicated the utility of having a context for queer identity and culture outside of the clinical setting (a context generally not offered by their training) in being able to connect clients with appropriate resources and normalize their experiences.

Participants also expressed a sensitivity to the impact of heterosexism and concerns related to safety, minority stress, and internalized stigma for LGBTQ+ individuals; this sensitivity was often expressed as knowing what it is to live with a marginalized identity and navigate the world from that space. Daniela articulated how this awareness shapes her approach
to working with LGBTQ+ clients and addressing the impact of heterosexism within the context of therapy:

“It definitely does make me more passionate about making sure that they're getting the treatment that they need because it's really difficult to be vulnerable about your identity. I would say half of the patients that I work with, they do experience some sort of discomfort or have experienced discrimination harassment.

And I always want to make sure that I process that with them. And even if it's briefly or just even suggest that they could always go back to that if that's something that they wanted to explore... and I give them the space to explore it if they choose to do so, which I wish I had growing up too.”

As demonstrated by Daniela’s account, participants voiced an awareness of the impact of stigma and discrimination in their clients’ lives and how it intersected with their presenting concerns. This often included contemplating how social factors impacted clients’ wellbeing when describing how they conceptualized cases. Accordingly, the importance of affirmative models of LGBTQ+ identities, community, representation, and countering internalized heterosexism were also emphasized in working with LGBTQ+ clients. Here, the connection between Use of Lived Experience and Deep Personal Meaning is also made evident, with Daniela demonstrating how trainees can derive a sense of meaning from using their own experiences of heterosexism to offer support to clients that they may not have had access to themselves.

Use of lived experience also manifested in participants’ use of shared cultural understandings, particularly first-hand knowledge of specific LGBTQ+ identities and subcultures, to connect with clients and contextualize their experiences. This lived experience
often translated into a familiarity with specific narratives within LGBTQ+ communities, common LGBTQ+ experiences, and adversity related to being socialized and living in a heteronormative dominant culture. Elliot described the centrality of his lived experiences in having a cultural context when working with gay men:

“I mean, I know that we'll get there, but I haven't had any training about queer communities. My life experience is the only-- if I were to kind of take away my life experience, I've had no training. That's speaking in broad, broad, broad...

But I really can't think of anything else. Everything I know about the dynamics of gay men, gay communities, gay sex, culture around coming out, culture around men dating men, sex and intimacy among men and gay men, that's all from personal experience.”

As referenced above, lived experiences and pre-existing knowledge of LGBTQ+ communities were felt to be especially valuable in clinical work with LGBTQ+ clients, given the absence of an in-depth focus on LGBTQ+ identities in their training programs. This application of lived experience was generally perceived by participants as having something valuable to offer in terms of insider knowledge in the clinical setting as well as a vital point of connection with LGBTQ+ clients. Similarly, Adelaide captures this aspect of Use of Lived Experience in her description of working with queer women:

“I definitely feel I have-- when I'm working with queer clients, specifically women, I feel I have this knowledge that's very useful. Whereas with straight people, I don't even think about it. I guess I just unconsciously assume that everyone knows what this is about. But with the queer clients, I have this special knowledge and it makes me feel good.

But yeah, it mainly applies to women though. Because when it comes to gay men, I feel I-- if they say something like, "Oh, queer dating in [this state] is
difficult," or something. I'm like, "Yeah. I get it." But a lot of the issues that are specific to gay men, I don't feel I have that special inner circle knowledge of. I feel I'm just learning. Whereas with the straight people, I have knowledge and it doesn't feel I have anything special there. But with the queer woman, I have this knowledge and I also feel like an insider. It feels nice."

Importantly, Adelaide’s description highlights the variation in exposure to queer communities and lived experiences to draw from amongst queer trainees. Participants made note that their ability to hypothesize or extrapolate from first-hand experiences navigating queer spaces tended to be contextually bound. For example, as in Adelaide’s account, gay, lesbian, and bisexual/pansexual participants identified distinct identity-specific experiences and typically felt more comfortable extrapolating from lived experience to the degree that they felt clients held similar identities and experiences.

While participants described most often using lived experience as an internal reference, they also noted more infrequent moments of sharing or alluding to their lived experience and knowledge of LGBTQ+ communities with clients. Almost all participants touched on the unique interventions available to them as queer trainees in terms of being able to normalize, empathize, and provide information and resources based on lived experience and knowledge of LGBTQ+ communities obtained largely outside of training. Trainees typically used their lived experience indirectly in their interventions, to provide context and psychoeducation and affirm from personal experience, without directly disclosing their identity or personal details of their experiences. Scott provides one such example:
“I haven't necessarily said explicitly I'm gay but I have kind of touched upon—"Oh, the experiences of gay men," or the experience of having to come out. And so I use a lot more we language...without necessarily just outing myself directly.”

As seen above, it was common for participants describe translating their own knowledge and experiences into general normalizing statements about queer experiences in order to validate clients. This was also done to deliberately introduce relevant LGBTQ+ topics, where appropriate, to demonstrate therapy as an affirmative space. As Leah notes:

“I think I will bring up topics that I wouldn't necessarily bring up with clients who are presenting as straight and gender conforming, whatever you want to call it, like cis gendered straight clients. To try and model, I'll bring up sex more, I think. I'm always kind of pulling like, "Where can I bring you in a topic that will show them that I'm really willing to talk about anything? And I try to do that with other clients as well because maybe they have a sexual concern that they don't feel comfortable bringing up, for example. But I notice myself being much more intentional about it with queer clients.”

Per participants’ accounts, these interventions were often carried out with the intention of creating safety, establishing credibility of the therapist as competent in LGBTQ+ issues, addressing shame or internalized stigma, or in an attempt to break down the assumption that therapy is a heteronormative space. Acutely aware of the mental health impact of heterosexism due to personal experience, participants frequently discussed the importance of using their power as therapists to create explicitly affirmative spaces.

Finally, participants recognized themselves as more explicitly embodying/enacting aspects of their queer identity in terms of nonverbal self-expression and language usage or
codeswitching with particular clients. Elliot demonstrates how this use-of-self emerged in the context of two cases with gay male clients:

“There's another client who is probably 10 years younger than me, and the second one is probably like 6 or 7 years younger than I am. And it's similar. I have not yet disclosed kind of that I'm a gay man or that I identify as a gay man but notice myself making an effort to kind of almost animate myself as one to kind of communicate something about our alliance or a shared experience”

Participants reflected that this often served as a way of underscoring shared experience or connection with clients, given the salience of mirroring and representation of similar others in LGBTQ+ communities and the relative absence of this in heteronormative spaces.

On occasion, participants described instances of explicitly disclosing their own similar or shared experiences. Autobiographical disclosure, in which trainees directly shared personal experiences, was described as occurring more rarely and typically done in the context of countering a client’s sense of being alone in the world or pathologically different. For example, Daniela shared a moment where she used her own process of self-exploration and community knowledge to normalize the experience of a transgender adolescent client:

“At the time when I was working with this youth, I was still exploring some parts of myself. And used that as a way to send a message...that if this person ever wanted to explore, that there was always space for this them to explore that. Because a part of it too was the shame that I thought that they were experiencing. I even brought up like, "I'm wondering if you're experiencing shame right now. Is that an emotion that's coming up for you?" Because I know that that's something that I struggled with-- and I also know a lot of people struggle with in this community”

This type of disclosure appeared to be more likely when safety concerns arose related to internalized stigma or when clients had little access to affirmative environments outside of therapy. Lisa illustrated this in her description of intervening with an adolescent expressing
suicidality related to family rejection; this example was presented as a deviation from Lisa’s more reserved approach to autobiographical disclosure in lower risk scenarios:

“And she told me she was going to jump off the top of the parking garage. I had to talk her off... So I kind of processed it with her. And she basically was like, "My dad told me I’m worthless, and that I’m a lesbian. And people who live my lifestyle are never going to amount to anything. And I’m never going to be successful. And nobody’s ever going to love me." And she just went through the whole story.

And I looked at her and I said, "Man. My dad told me the same. Do you think I’m not successful? Do you think I feel loved as an adult? Do you think that I am a happy person? So well, you can jump off the top of the parking deck, or you can come back to program tomorrow, and we can keep working on it." And she was like, "Oh. I’m coming back to program."...sometimes, that self-identification piece, specifically in the LGBTQ population is huge. As soon as you have a kid that goes-- they feel like nobody understands. And you’ve got to let them know, ‘Yeah. I clearly understand.’"

This example highlights how the direct disclosure of shared experience could be used as a ‘high impact’ intervention in countering heterosexism, particularly when the need to establish trust is urgent to clients’ safety. Here, the shift in Lisa’s approach is described as becoming less neutral and more direct in proportion to the clients’ perceived needs; participants similarly reported that they found themselves taking a more active or less neutral role in addressing heterosexism when it arose within clinical settings, given their awareness of its detrimental mental health impact.

As evident in Lisa’s example, participants noted disclosing shared personal experiences in response to clients sharing unique identity-specific concerns, which were not likely to validated elsewhere. These interventions were experienced as impactful from the perspective of the therapist, particularly when they involved modeling self-acceptance, hope for the future, or offered clients positive representations of LGBTQ+ identities. Overall, participants perceived
these interventions as a way of expressing connection and solidarity with clients, while keeping the focus on the clients’ needs.

Awareness of Difference

Across participants, use of lived experience in the clinical setting was often accompanied by a complementary awareness of difference among LGBTQ+ individuals. This theme emerged in participants’ descriptions of attending to salient differences between themselves and their clients as well as attending to the diversity within LGBTQ+ communities. Participants commented on the limits of extrapolating from lived experience on a number of different dimensions; this ranged from acknowledging the impact of cultural differences, attending to clients’ multiple intersecting identities and how they shape their experience of being LGBTQ+, the diversity of sexual and gender minority identities under the umbrella of ‘LGBTQ+’, and individual differences in experiences of stigma, visibility, safety, support, and identity development and expression.

Typically, participants used examples of cases with significant therapist-client differences to illustrate moments when a client’s concerns fell outside of, or even felt alien to, the scope of their own lived experiences as LGBTQ+ people. Scott, a white gay trainee, described encountering cultural differences in his work with a younger gay client as follows:

‘And this client is second generation [Central American] and his presenting problem is that someone had... outed him to his mother who has very, very traditional Catholic values. And so for him, one of the things that really struck me was that he said, "When my mother was ended up in the hospital due to the lack of sleep and the amount of stress that she was experiencing from knowing that her son was gay--" he was saying to himself, "Okay. I'm just going to marry a woman and I'm going to have children with her just to appease my
mother and I won't even consider the possibility of dating a man at all. Because I can't handle that responsibility of hurting my mother anymore…

I think for me that individualistic side comes out much more strongly in how I want him to respond versus trying to meet him where he's at which is still trying to be this balancing act between the mom and between his own desires which are completely in conflict with each other.”

Here, Scott demonstrates his awareness of the difference between his cultural understanding around coming out (as an act of independence to be prioritized before family) and his client’s values; simultaneously, he also acknowledges an awareness of the difference between how he, Scott, might “want [the client] to respond” from his own cultural bias and his goal as a therapist to “meet” the client on his own terms. While shared experiences were often referenced as a basis of connecting with clients, this appeared to be balanced out by the sensibility that therapists should not attempt to equate their experiences with those of their clients or assume a monolithic LGBTQ+ experience.

As seen in Scott’s account, differences in culture and privilege between therapist and client, despite a shared LGBTQ+ identity, emerged as areas of focus across several interviews. Participants described specific challenges and additional considerations in working with LGBTQ+ clients with multiple marginalized identities. Clinical scenarios involving clients in the process of navigating religious and cultural conflicts, with regards to their LGBTQ+ identities, were typically included in discussing challenges that emerged around difference or areas where participants felt their lived experiences were less applicable (when the therapist was outside of the salient culture or faith).
Participants who identified as having multiple marginalized identities, particularly the three female participants of color, emphasized the importance of conceptualizing and addressing how culture, spirituality, race, ethnicity, and ability intersect with LGBTQ+ identity; these factors were also named as important considerations that could impact safety, support, and identity development. Bianca identified her process of attending to cultural dimensions with LGBTQ+ clients in assessing challenges to support and safety:

“[It’s challenging] working with clients who are uncomfortable coming out and really trying to explore their sexualities and genders…. just navigating that and having to think in terms of spirituality and race and ethnicity and whether or not they would be accepted in their community or by their family… it’s just a lot of empathizing, reading for myself on different cultures and how different cultures may or may not accept non straight people, and encouraging safety first and foremost.”

In this narrative, Bianca exhibits an awareness of LGBTQ+ clients’ intersecting identities and how these, especially minority and stigmatized identities, can shape or compound LGBTQ+ clients’ experiences. Similarly, Daniela acknowledged of the ‘added layer’ of religious stigma in her lived experience of heterosexism as a Latina woman:

“As a Latina woman, I know that there is a lot of stigma in our community to identify as lesbian or gay or bi or pans because if you come from a religious background, there is that added layer of-- well, if you identify in these ways, you're going to go to hell. If you identify in these ways, that's a sin. So there's a lot that I have to take into account when I'm working with these patients.”

Daniela also illustrates how these participants described using their own lived experiences to better understand the needs and perspectives of clients navigating multiple marginalized identities. For these participants, their awareness of intersecting marginalized
identities and related stigma was framed as personal; participants with multiple marginalized identities described using their understanding of how their own identities intersect in order to inform their considerations with clients contending with multiple forms of stigma.

Participants also accounted for individual differences in diversity of client presentations and needs related to support systems, safety, age, identity development, diagnoses and presenting concerns. Different perspectives, desires, and values related to identity expression as well as understandings of what it means to identify as LGBTQ+ were described in the context of several therapist-client relationships, often used by participants as examples of moments when their assumptions were challenged. Again, Daniela provides one such example:

"And in other cases... they're like, 'Yeah. I'm lesbian.' And then I'd ask 'Is that something that you feel-- are you open about your identity, and is that something that you feel like safe in and that you don't want to discuss or want to discuss further while you're here?' And then they're like, 'No. It's not a big deal.'

So I'm getting exposure to the wide range of patients, in this case adolescents, who either are really just like accepting and in their identity and feel like they have a safe community, a safe family, a safe place to express themselves and then other patients who don't have that yet, who are struggling with coming out, and who are fighting with exploring and knowing what to do with their identity and then how that may play into the other issues that are coming up for them."

While participants tended to focus on cases in which LGBTQ+ identity concerns were foregrounded, this excerpt indicates an awareness that the salience of LGBTQ+ identity and how central it was to the focus of therapy varied from case to case. As demonstrated above, the presence of clients who identified as LGBTQ+ but whose presenting concerns were only peripherally related to this identity (or who did not wish to focus on identity-related concerns)
was often offered as a caveat by participants when making broader generalizations about their experiences with LGBTQ+ clients.

Throughout interviews, participants described the challenges of navigating sameness and difference between themselves and their clients across various cases. All participants reported actively attending to differences between themselves and their clients and working to monitor their assumptions about a given client’s experience in some variation. This process was typically characterized as a negotiation between the therapists’ lived experience and understanding of LGBTQ+ communities and an openness to difference. Elliot captured this dynamic in discussing his experiences of working across difference with queer women:

“For example, a queer female client was talking about the stereotype about lesbians and the U-Haul on the second date, which I'm aware of that stereotype. I've watched The L Word, and we've talked about The L Word and everything that that show both kind of did and foreclosed for that community in terms of kind of questioning and also perpetuating stereotypes, whatever.

But it was just this kind of curious moment where it's like, "Yeah. I want to know more about how you think about that stereotype and how it is for you to almost be kind of anxious about enacting or aligning with or perpetuating that stereotype right now. And I want to know how you think about it kind of broadly within your communities. And I want to be able to talk about it in a way where it doesn’t—" I know that I'm not experiencing that firsthand. Yeah. How to kind of talk with somebody about our differences?”

Elliot’s example touches both on his awareness that his knowledge of the cultural contexts of queer women is not “firsthand,” in contrast to his experiences of working with gay men, as well as how this awareness can carry with it an uncertainty about how to best address and understand these differences. In line with this excerpt, participants generally described experiencing this as a balancing act or dialectic between what is known or assumed by the therapist about a client based on their shared minority identity (or the therapists’ familiarity with
TRAINING WHILE QUEER

LGBTQ+ concerns) and what is beyond the therapist’s experience or awareness, with an emphasis on remaining receptive to the latter. Daniela described her efforts to counterbalance assumptions based on shared LGBTQ+ identity with curiosity in the context of a case:

“And then it really hit me. I'm like, ‘Whoa, I'm going in with preconceived assumptions and notions about what this person's experience is like based on my own experiences and what I know.’

So it was a good learning experience to remind myself-- whenever I meet any person, regardless of how they identify, just to really ask them what their experience is like identifying in particular ways...and to be very mindful of making these assumptions and just going in and having them teach me.”

Daniela’s account indicates how awareness of difference and fluency in navigating it can develop with experience, as exposure to new cases challenges trainees’ assumptions around queer identity. This shift is evident in participants’ accounts of learning that their initial assumptions of similarity did not hold in their early cases with LGBTQ+ clients. In response to these experiences, participants often described an ongoing process of self-correcting assumptions, visible in here in Daniela's reminder to herself.

Exploring biases and engaging in self-reflection were also commonly named as crucial components of attending to difference. For example, Adelaide discussed monitoring her personal reactions in her work with LGBTQ+ clients working through identity conflicts around faith:

*I think religion's a tough one. Because I really need to check myself in order to empathize with why people would stay in their faith when it's so not affirming. Or I have to really bite my tongue...to just stop and listen and try to understand their reasons for staying instead of just being blinded by my own biases, which is all I can see are reasons to leave.

It's tough, because I grew up in a very non-affirming religion and I left and it was the best thing I ever did. It's hard for me not to think, "Look, you should do this too. It'll be the best thing you ever do." So just remembering that*
everyone's journey is different and they may have valid reasons to stay even if they don't apply to me.”

Here Adelaide describes a process of internal self-management, acknowledging and separating out her own experiences with religion and queer identity; this process is described as an effortful renegotiation (‘I really have to bite my tongue’) toward openness to difference, in the service of attending to the client’s experience at hand. Similarly, participants discussed their attempts to become more aware of personal biases and contain strong personal reactions based on their own experiences, particularly when they felt did not apply to their clients’ experiences or needs.

A variation of this theme was participants’ felt sense of the paradoxical nature of the LGBTQ+ umbrella. Of the eight participants, four alluded to the complexities of engaging with both the similarities and differences among lesbian, gay, bisexual, transgender and queer identities housed under the LGBTQ+ acronym. Elliot captures this sense of struggling to reconcile the dimensions of common experience and real difference within LGBTQ+ communities:

“I mean, I think it's interesting how just LGBTQ, under one umbrella, we all share something. There is something common to our experiences. But then when it gets down to it, are the experiences of a white gay man the same as a trans person or a lesbian woman?...

I both do feel this sense of it's a community and we have something that we share but there are certain kind of identifications within that community I feel like they almost couldn't be more different. Working with, for example, women who are attracted to women, I feel aware of, sometimes, how little I feel like I know about that experience because it's so far from my own as a man who has had kind of attraction or relationships with other men. Sometimes, just the work feels a little bit, at least in the beginning, more cautious and less intuitive. And I think that this goes across - I don't know - not just sexuality but many identifications.”
Elliot’s account suggests that working across gender differences was particularly impactful in recognizing the limits of applying lived experience. As shown above, when describing cases, participants tended to position clients’ experiences and concerns relative to their own, as either more or less experience-near their own lived contexts as queer people. Generally, participants voiced more comfort and ease with clients who they perceived as having more similar experiences to them, particularly at the outset of treatment. Conversely, this work becomes “more cautious and less intuitive” as clients’ presenting concerns and identities become less familiar or relatable.

Notably, as the study contained only cisgender-identified participants, trainees discussed their experiences working with transgender and gender-nonconforming clients as an area of navigating differences in privilege, power and experiences of stigma. This was also an area in which participants discussed concerns about perpetuating transnegativity or cissexism in the clinical setting and described seeking out training to provide trans-affirmative care. As Adelaide described:

“I would say one that was super memorable was my first time working with a transgender client. Probably memorable because of how nervous I was that I would say something wrong. For example, early in our treatment, one of my supervisors had to tell me, "Don't say gender reassignment surgery," because I think-- I can't remember if I accidentally said that in session or in supervision, but I said it and I had to learn that it's called gender affirmation.

So just things like that that you don't even know you're messing up on until you mess up on. I was just very afraid of those. But, ultimately, I think looking back, if I could tell my past self something, I would say, "You're already doing better than most of the people that she meets. So relax a little and just focus on the relationship," is what I would tell myself if I could go back and be with my past self.”
This except demonstrates trainee’s concerns about perpetuating cissexism and doing harm within the context of the therapy relationship; here Adelaide voices an awareness that a sexual minority identity does not necessarily translate into an awareness of trans experiences or transaffirmative care, despite these identities often being housed under the same umbrella.

Adelaide’s advice to her “past self” is also telling of a reduction of anxiety around working across difference over time, as training therapists established more points of connection with a given client and more competency in working with different populations; participants further in their training seemed to describe a less conflicted approach to navigating therapist-client differences. For example, Lisa, a returning student who has established a career in social work, articulated a clear stance on negotiating difference, particularly when working with the families of LGBTQ+ youth:

“That ongoing education so that you can relate to people who have different cultural backgrounds from you is so important. Those common grounds and your ability to understand their belief structure or their cultural structure. It’s huge and impactful...You have to translate cultures. How do you help somebody that you're not comfortable with?”

Here learning to “translate cultures” competently is framed as necessity for connecting across difference and understanding the challenges that multiply marginalized families encounter regarding LGBTQ+ identity. Trainees frequently expressed desire for more training in these areas and support in balancing lived experience with competent approaches to navigating differences. Leah expressed this sentiment as follows:

“And I think that's something-- I don't feel like that makes a world of sense. I think I'd like to learn how to support queer clients better in a way that-- in
such a way that there is a boundary between my own identity and theirs, and my experience and theirs. But it doesn't necessarily need to be shared. It could be, if that's therapeutic. And that I am being sensitive to their identity development and what stage they're in. And I don't feel like that's really been a part of my training here.”

This excerpt illustrates an unmet desire to learn about approaching difference from the perspective of shared queer identity between therapist and client, indicated by Leah’s phrasing of “a boundary between my own identity and theirs.” Across interviews, as demonstrated above, this desire was often accompanied by a sense of importance in understanding clients’ needs, respecting differences and a desire to provide affirming, equitable care.

**Intersection of Queer Identity and Professional Identity**

In describing their experiences, queer therapists-in-training outlined the intersections between their experiences with LGBTQ+ clients and their experiences of the training environment. Participants often found themselves navigating the spaces between training and clinical work as well as the personal and the professional spheres. Here, it appears that several identity-based challenges arose for queer trainees, centering around the intersection of queer identity and professional identity.

This intersection manifested throughout interviews in two, overlapping themes: Ambiguity of Visibility and Disclosure and Sense of Internal Struggle. As such, this section focuses on the internal cognitive and affective experiences of trainees in navigating competing clinical realities and training expectations. Additionally, this section discusses perceived mismatches between training environments and queer trainees’ needs, particularly as they pertain to working with LGBTQ+ clients.
Ambiguity of Visibility and Disclosure

Throughout interviews, participants framed their experiences as queer trainees in terms of visibility and disclosure within clinical, professional, and training contexts. Of the eight participants, seven discussed the impact of being perceived (or not perceived) as queer on their experiences with LGBTQ+ clients. Generally, visibility and disclosure of queer identity within the therapy relationship was experienced as a site of ambiguity and uncertainty for participants. This theme of ambiguity also emerged as trainees described their internal decision-making processes around disclosure of queer identity in the therapy room and in their training contexts.

The ambiguous nature of visibility and disclosure was present in participants’ descriptions of indirectly communicating their positionality as queer people in their work with LGBTQ+ clients. As discussed in Use of Lived Experience, participants often engaged with their own experiences as queer people while working with LGBTQ+ clients and experienced their queer ‘parts of self’ as more present in the room; as a result of these shared experiences, participants often described feeling that their queer identity was at the forefront, despite remaining unnamed, when engaging with LGBTQ+ clients. Revisiting Elliot’s description of his work with a younger gay client, this ambiguity generated by this context becomes apparent:

“And so I’m aware, with this client, I never expressed that I was a gay man. However, I’m certain that the client knew. And even as I say that, I’m like, "Am I?" But I feel like there was a way with this client where talking about Grindr or talking about PrEP with a certain kind of really attempting to have no stigma, ease, fluency, kind of communicating without telling you kind of something about me. We’re speaking a shared language. And there’s a communication happening in that that—"

As seen above, this combination of utilizing and embodying queer identity, while avoiding explicit disclosure of therapist sexuality, could place participants in a position suspecting but not being certain whether clients read them as queer. While participants acknowledged the likelihood
that their understanding and familiarity with LGBTQ+ concerns might out them as LGBTQ+-identified, this was often framed in trainee narratives as an unspoken understanding, unable to be confirmed without direct disclosure. In a similar vein, Scott, articulated experiencing this ambiguity with both queer and straight clients:

"It's not even something the clients talk about- but in my head it's always this question of does the client actually know that I'm gay? And that's something that becomes this crazy battleground-- minefield in my mind. I get wrapped up in my head about it and I'm like, "But how much does this matter if they're not bringing it up," "But if they are aware of it, shouldn't we be talking about it?," "But then we shouldn't talk about it because that's me and then we're taking the center of attention off of the client which is supposed to be the biggest thing." So it's like this weird closet-- not closet-- minefield that I put myself in. And I'm like, "How do I navigate this space?"

Here, ambiguity is present in Scott’s uncertainty about how and if his clients perceive his gay identity as well as in his uncertainty around whether or how to address therapist queer identity; what is known or not known by the client, and what or cannot be openly acknowledged, becomes an internal “battlefield” for the trainee to navigate, seemingly without a map. Interestingly, Scott noted that this ambiguity was not limited to engaging with queer clients but took on a different tone with heterosexual, cisgender clients:

“One of my straight clients who I adore... was talking about how one of his roommates who is gay was talking about his experiences on Grindr, and in my head, I was like, "I wonder why he feels so nonchalant about talking about Grindr with me?" I was like, "Is that just the way that he is socialized which is great or is this kind of almost like an implicit wink wink nod nod to mean in some way?" Versus with at least with [my gay identified client]. I haven't necessarily said explicitly I'm gay but I have kind of touched upon-- I'm like, "Oh, the experiences of gay men," or the experience of having to come out. And so I use a lot more we language with him without necessarily just outing myself directly. ”
Scott highlights above how trainees used indirect disclosure or covert signaling of their understanding of clients’ experiences to create safety and connection. This excerpt demonstrates how trainees expressed more comfort with bringing queer identity to the forefront or making indirect references to therapist queer identity with queer clients. It appears, in this instance, that ambiguity around therapist queer identity with straight clients can carry with it concerns around passing versus not passing where with queer clients this ambiguity is more so around whether the therapist’s implied shared identity can be explicitly acknowledged.

The ambiguity described in trainees’ narratives appeared to stem, in part, from the spectrum-like nature of visibility and disclosure of queer identity. Elliot described his experience as follows:

“All something to talk about, about kind of just issues of disclosure of my own kind of sexuality or sexual orientation to my clients and kind of how that happens, this real kind of-- almost feels like a spectrum of experience of not communicating it at all, communicating it verbally so it's really concretely known, and then kind of almost like a playful kind of performance of everything in between of ways in which I either kind of make more visible or less visible something about, yeah, my position or sexuality, orientation really based on - I don't know - how I speak or kind of how expressive I am in my body….

I'm not sure if this is true. I'm not sure if all of my clients are just like, "Yeah. He's gay." But I have the sense that I could pass as a straight man and I can kind of make my gayness kind of more perceptible."

The above excerpt again illustrates the ambiguity around therapist sexuality within the context of working with both queer and heterosexual/cisgender clients, ranging from hidden, to an ‘all-but-named’ understanding of shared queer identity between therapist and client, to explicit disclosure. In Elliot’s account, it appears that this ambiguity can be modulated along “a
spectrum of experience” in service of clinical goals, foregrounding queer identity through use of self or making therapist identity more opaque. However, despite this, uncertainty remains about how he is perceived by clients, marked by the qualifier, “I am not sure if this is true.”

Ambiguity of visibility and disclosure was also present in participants’ examples of communicating with clients through the medium of queer-coded language, non-verbal cues, and self-expression; these interactions, as described, appeared to mirror the ambiguous nature of queer-identity signaling in many LGBTQ+ communities. Due to shared minority identity and culture, LGBTQ+ clients were often understood in trainee accounts as especially primed to pick up on and ‘read’ these signals. Lisa, a returning social work student, described one such scenario, recounting her experience of supporting a trans youth in coming out to their primary clinician:

“I was like, "I'm really proud of you. I know that's a hard thing to do." And he looks at me, the clinician, and he goes, "Well, why do you know that's a hard thing to do?" And I looked at the youth, and I'm like, "Do we really need to explain this to him?"

And the kid just starts laughing. And the clinician is completely out in left field. They have no idea what's going on. I've got a pin on my bag that says, "She, her, hers." I'm obviously stereotypically looking a little bit like a lesbian.”

Lisa’s description illustrates how visibility of therapist queer identity is understood as depending on the beholder; here shared identity becomes an ‘inside joke,’ fostering connection through an unspoken understanding. This account demonstrates how trainees can use indirect disclosure and queer identity markers to signal to other queer people, without being detected in heteronormative spaces, and illustrates the different relational dynamics that are possible
between queer client and therapist. It is also suggestive of the ways in which assumptions of heterosexuality for therapists can obscure these identity markers when they are present.

Participants generally described differing levels of visibility based on stimulus value, specific LGBTQ+ identity, and context. Bisexual/pansexual trainees were more likely to reference the ‘hidden’ nature of therapist queer identity due to heterocentrism; all four of the bisexual/pansexual identified participants voiced that they were typically perceived as heterosexual by clients unless they explicitly disclosed. This could result in trainees experiencing ongoing uncertainty about whether clients had picked up on their use of first-hand queer experiences or indirect signaling. As Leah describes in her work with a lesbian couple:

So there was one—there was one day where I like insinuated, and I wonder if they got it...there were all these levels on which I felt like I could relate to them. And I think I also really wanted them to know that I—either they'd be like, "Oh—" they'd couch their descriptions of their non-monogamy. And like, "We know this sounds like a lot." And I'm like, "No, it doesn't." Not only am I not judging you, I'm not judging you on such a profound level. And I can't even tell you the level on which I'm not judging you.

And so there was a day where they were like, "Oh yes, we went to Pride over the weekend." And they were like, "Oh, all our straight friends--" and I was like, "Oh that's the day when all the straight girls put on their rainbow colors, right?" And they were like, "Yes, oh my God." And I was like, "I know, they're so funny." And that's not normally even something I would say... but I think I wanted so badly to communicate that on some-- to create this like us and them, and establish myself on the us side, so they would know without me saying it. It could have 100% gone over their heads. I don't know. But it made me feel like I had more agency or something.

Leah’s indirect ‘insinuation’ illustrates how trainees may use this ambiguity intentionally to imply shared queer identity without violating perceived trainee expectations or removing the focus from the client. Notably, in contrast to some of the previous accounts, this scenario appears to
be experienced less as a suspected unspoken understanding and more as an ongoing source of uncertainty. Here, Leah indicates both a desire to be perceived and join authentically with her clients through disclosing shared experience as well as alluding to an invisible barrier (‘And I can’t even tell you’) to disclosing queer identity explicitly.

This ambiguity around disclosure also appeared to be heightened in part by ‘mixed messages’ trainees received around personal disclosure. In discussing disclosure, seven of the eight participants stated that they rarely, if at all, explicitly disclosed their queer identity unless directly asked by clients. Five of the eight participants also voiced uncertainty about navigating disclosure as a queer therapist. This uncertainty seemed to stem in part from the confluence of competing messages about disclosure of personal information within training programs and clinical placements and the absence of direct discussion of disclosure of LGBTQ+ identities in training. While participants noted being exposed to a variety of attitudes toward disclosure in therapy through their training programs and clinical placements, expectations that trainees be sparing in their use of personal disclosure were common among participants. Leah discussed the impact of general messaging about personal disclosure:

“General messages about self-disclosure, it's like, "Be really careful. Less is better. Start with less. As you move on in your practice, when you're older, you can make your own decisions." And so I just felt like, well, this would be such a tremendous disclosure, I should probably err on the side of not.

Never received any messages about revealing your sexual orientation, but it's so interesting though, right? Because they encourage us to talk about, well, what is it like to talk to me as a white therapist?... But like this identity is so hidden that you can choose to disclose it or not. And so as a trainee, I'm like, "Well, that falls into the self-disclosure category, and we're not supposed to do that."
As noted above, these frameworks for disclosure often did not directly address or acknowledge disclosure of therapist queer identity. This excerpt illustrates how ambiguous messaging around disclosure and avoidance of discussing queer therapist identity are made sense of by trainees, namely direct disclosure of queer identity being understood largely as “off limits” or inappropriate in most instances. Leah’s use of the word “tremendous” to describe her disclosure, suggests that identifiers outside of heteronormativity, such as ‘queer’ and ‘non-monogamous’ are experienced (or expected to be perceived) as somehow loaded and not neutral, possibly due to the influence of stigma or association with sexuality.

Similarly, Adelaide also voices a hesitation around direct disclosure of queer identity, comparing it to another ‘hidden’ identity she holds (being an atheist within largely Christian location):

“It feels more strange to bring up. It shouldn't be. I think objectively it shouldn't be and maybe it's just societal messages, traditions that I need to overthrow. And thinking that for some reason, that is more private or somehow less professional to talk about than atheism. Yeah. Maybe because it feels more like a part of me than a philosophy.”

Adelaide’s commentary highlights the ambiguity in making sense of and precisely naming the sources of this hesitation. Here, queer identity is framed as less professional and more private or intimate than other ‘hidden’ identities that come to mind, possibly due in part to the influence of ‘societal messages.’

Vague or conservative policies on disclosure were often described as adding to this uncertainty for trainees; this was often expressed as leaving them with a sense of insecurity about what is and is not “appropriate” to talk about with clients in the realm of LGBTQ+ concerns,
particularly as a trainee. These influences appeared to result in trainees regarding direct disclosure of queer identity as a taboo. As such, uncertainty about disclosing or alluding to queer identity with LGBTQ+ clients was often discussed in terms of appropriateness versus inappropriateness. Molly conveys her experience of navigating the appropriateness of disclosure as follows:

“[I disclose] in very limited doses, yes, when appropriate. Though "when appropriate" is an interesting phrase. Because when I say "when appropriate," I don't want it to be about me. And I also question that because there's always, generally speaking, an assumption that if you don't disclose, then you're heterosexual... In terms of my sexuality and self-disclosure, I've never encountered a place that says that I can't, because I think that they know that they can't really say that I can't. And so, generally speaking, I won't bring it up unless it's asked, or it's relevant in the conversation. Though the kids do eventually-- especially the kids that I work with will maybe pick it up if I'm talking about queer theory, or if I'm talking about-- they can sense that I'm engaging in LGBTQ issues in a way that perhaps most straight folks don't.” It feels weird. It feels intimate. And I think it's going to get much more comfortable over time. It's more disconcerting to disclose to other staff members that I think are straight.”

In this excerpt, Molly both articulates a desire to employ disclosure only “when appropriate” and also challenges the framing of assumed heterosexuality through non-disclosure as ‘neutral;’ this latter statement potentially points to a conflict between being openly queer and expectations of neutrality for therapists, particularly trainees. Again, queer identity implied through use of lived experience but directly disclosing is typically avoided. As seen in Molly’s account, participants’ uncertainty generally included concerns about violating norms around personal disclosure, taking the focus off the client, or crossing a professional boundary in directly disclosing queer identity. In a similar vein, Elliot described how messaging within the context of a supervisory relationship could contribute to this understanding of direct disclosure as taboo:
“I feel like the message that I received was that disclosing my sexuality explicitly—\textemdash I was kind of, in a way, rewarded at the end of the working relationship for not disclosing. And I almost got the sense of like, "Wouldn't it be so tempting to disclose? And look at all the good work you did without having to do that." So I interpret that as that there would've been something—almost like it would've been tantalizing for me to kind of talk about myself in this way. And ultimately, that would've been more for me than it would've been for the client.

Thinking about that now, I'm not sure that's true. I think the way that-- I got this client connected to PrEP, talking about apps and hookup culture and sex, there's no way that this-- even if I felt I was maintaining a little mystery around it, I don't believe that this client doesn't know that I'm a gay man. So I don't know. There was something a little confusing in that kind of supervisory experience. In the moment, it feels good to be reinforced. I'm like, "Oh, cool. I did the right thing." But reflecting back on it, I was like, "Why is she protecting nondisclosure?"

This excerpt shows how explicitly naming therapist sexuality in the therapy room can be discouraged in training settings, even when the therapist’s lived experience is present in the room. Elliot points to this contradiction: in his understanding, his use of lived experience as a gay man was crucial to his ability to intervene successfully with this client but this same identity is devalued in this interaction and communicated as something that should be hidden.

Elliot’s account illustrates how trainees can be caught between expectations to be especially reserved regarding disclosure, using their relevant knowledge and experience regarding LGBTQ+ identities, and being authentic in the therapy room. Additionally, it points to a discrepancy between more clear-cut approaches to disclosure of personal information offered by training contexts and the fluid nature of identity expression and non-verbal forms of disclosure in practice. Elliot contrasts this approach to disclosure with one offered by another supervisor:

“Now I have a supervisor who--in terms of disclosure, his general kind of philosophy is like, "Why make things more mysterious than they have to be?"

He's never said, "Disclose," but I feel like he encourages me to just interrogate the idea that shrouding something about myself in mystery is useful and to just kind of get curious about what's useful about of tearing that
down. Does that actually model something to the client like, "We can just talk about things?"

Here disclosure appears to be constructed as a choice, with direct disclosure being one of many potential options, which can serve the clinical function of modeling openness and countering stigma. As seen above, participants seemed to describe more security in navigating visibility and disclosure when able to openly discuss disclosure of queer identity in supervision or when able to develop a framework for disclosure based on their own clinical judgement and personal boundaries.

Those who described developing a decision-making framework for disclosure in these contexts appeared to have resolved some of this uncertainty. These approaches varied widely from direct, straightforward disclosure, to employing disclosure on a case-by-case basis, to a preference for indirect disclosure. Daniela discussed integrating the ambiguous messaging around disclosure into a framework of her own:

“So I've had mixed feelings about self-disclosure only because I've been trained in both sort of extreme ways, being like: use self-disclosure, it's okay; don't use self-disclosure at all, like no, no, no. So I now navigate that as what are the pros and cons of self-disclosing right now?

Because I just started doing more DBT work, there is a part of the DBT work that's called radical genuineness, which is just to be radically yourself. And I'm someone who in like personal settings and communities I'm like, "Yeah. I'm bisexual." Like I said, I make it a thing to insert it somewhere. So it'll be like, "This is who I am. And if you don't like it, all right. But I just want you to know that this is the space that I'm coming from."

But differently-- I think that when I'm working with patients, if I feel like I can just use myself as an agent to propel the work, then I self-disclose, whether it'd be about my bisexual identity or even like my background, my own struggles with mental health more generally speaking, being like, "A lot of people go through these types of challenges too." Sort of in those terms, I find that self-disclosure is very useful.”
These descriptions appeared to be marked by an increased sense of internal agency and choice rather than being a consequence of external expectations. Again disclosure is made sense of here as a choice or place of agency, with different clinical functions; here, Daniela appears re-negotiate her boundaries around disclosure in “personal settings and communities” into an understanding of self-disclosure as a normalizing intervention, providing an example of how trainees may integrate queer and professional identities. For participants with access to training settings that allowed for exploration of disclosure and open discussion of such decision-making, visibility and disclosure appeared to carry less ambiguity and uncertainty.

In parallel, visibility and disclosure could also be experienced by trainees as an ambiguous space when interacting with colleagues and faculty in their training programs and clinical placements. For three of the eight participants, disclosure of queer identity within training settings was a marked source of ambiguity. Daniela described the ambiguity of disclosing her identity in professional contexts:

“I still struggle with coming out to certain people-- even in workspaces-- is it even important for me to bring up my identity, if it's relevant to the work that I'm doing in that particular setting? Because I feel like I so strongly identify with a bisexual identity that-- when I meet people for the first time, it comes out. I have it so that it comes out in some way. It's like my way of being like, "This is who I am. I just want to make sure that you know that this is all of me."

This excerpt illustrates how trainees could experience a sense of ambiguity about where, when and whether to come out in their training contexts and how this will be received. In
describing their experiences of queer identity in professional spaces, these participants alluded to the contextual nature of safety across various training environments and how this impacted their decision making around whether and how to come out in training contexts. As in the therapy context, some participants also struggled with determining the ‘appropriateness’ of coming out in work environments. As Molly, a bisexual social work student, elaborated:

“I think there's actually a specific choice in why I like the word queer versus bisexual, depending on who I'm talking to. I like the ambiguity. I like the politics of it. And also, I do feel the weight of stigma and stereotypes around bisexuality. More so stigma, and the not being taken seriously. It almost feels like bisexuality is seen as something that is adolescent...”

Here Molly frames maintaining ambiguity as self-protective. As can be seen here, these concerns appeared to be particularly true for bisexual/pansexual participants, who expressed concerns about disclosing their identities in professional settings due to the specific stereotypes and stigma associated with bisexuality/pansexuality.

In contrast, gay male participants named a preference for coming out at the outset of supervision due to the clinical material likely to arise, particularly when working with LGBTQ+ clients on identity-based concerns. For example, Scott described his process of coming out in supervision:

“So far, every single time I've had a new supervisor they've always made it a point to ask me in the beginning like, "Okay. Tell me a little bit about yourself." And so I always make it a point to say in that kind of elevator pitch that I am gay. I don't think it's something that I could, again, avoid. I don't think it's a part of myself that it could be easily neglected or just not brought up in supervision. Because I would want to know, at the most basic level, is this someone that I can trust with my safety? Is this someone who-- when I do
TRAINING WHILE QUEER

*have thoughts about my sexuality in regards to the clinical treatment or how*  
*I’m interacting with this client, I need to know that this is going to be*  
*something that isn't going to be an issue. So I make it a point, absolutely, to*  
*bring it up with them.*”

This excerpt frames disclosure as a way of assessing for safety in the training  
environment, cutting through the ambiguity. Taken broadly, these differences in experiences of  
ambiguity in the training environment may be indicative of differential challenges and needs for  
different subgroups of queer trainees.

**Sense of Internal Struggle**

Throughout interviews, participants detailed encountering various identity-based  
challenges within the contexts of working with LGBTQ+ clients and navigating training settings.  
These challenges emerged in areas such as visibility and disclosure, shared client-therapist  
experiences, and heterosexism in training contexts. While trainees endorsed these experiences to  
differing degrees, at the core of these experiences for most participants was an internal sense of  
conflict or dissonance. Largely, the affective and psychological experience of these challenges  
was characterized by a sense of interiority and an absence of outlets for processing these  
concerns. This theme suggests the how intersection of stigma around queer identities, and the  
absence of direct acknowledgement of therapist queer identity in training, creates a context  
where training challenges specific to queer identity are internalized by trainees. Revisiting Scott’s  
xperience of ambiguity around visibility and disclosure with queer clients, this internal struggle  
is made visible:
“\textit{I mean, one \textbf{challenge} that isn’t even necessarily specific because it hasn’t-- it’s not even something the clients talk about but in my head it’s always this question of does the client actually know that I’m gay? And that’s something that becomes this crazy battleground-- minefield in my mind…But then I get wrapped up in my head about it and I’m like, “But how much does this matter if they’re not bringing it up.” But if they are aware of it, shouldn’t we be talking about it?” But then I’m like, “But then we shouldn’t talk about it because that’s me and then we’re taking the center of attention off of the client which is supposed to be the biggest thing.” So it’s like this weird closet-- not in the closet. It’s like this just minefield that I put myself in. And I’m like, “How do I navigate this space?”}

As seen above, participants’ descriptions of the challenges specific to their experiences as queer trainees were pervaded by a sense of murkiness and uncertainty. This theme often presented in the form of participants talking through competing perspectives in their attempts to synthesize contradictions between their training and their experiences as queer trainees; this can be seen in Scott’s internal debate about whether his queer identity as a therapist should or can be addressed with clients. Here, Scott compares this experience of this challenge to precarious scenarios, treading through an internal “minefield” or “battlefield,” evoking a sense of struggle and risk; however, he notes that despite this intensity, the experience remains within his head.

Similarly, participants’ accounts of internal struggle were often marked by a difference between an intense or fraught internal experience and an absence of outward acknowledgment or expression. Scott’s account suggests that training challenges around queer trainee identity which cannot be addressed or resolved externally, appear to take up psychic space for trainees. This often presented as descriptions of rumination, confusion, questioning of self and others, or anxiety in participants’ attempts to resolve training challenges. Scott follows this account by describing a non-productive attempt to address this concern in supervision:
“And it's funny because I recently brought up the same sentiment to my supervisor and she was trying to conclude that I had this-- she's like, "Oh, it seems like you have some internalized homophobia because why are you so worried about people finding out if you're gay or not?

And I was saying, "I'm not worried about people finding out if I'm gay or not, but I think it's an important aspect of my identity that is going to play out in the therapeutic relationship somewhere or the other. So I need to be able to think through how does this actually influence that and how do these interactions mean things to the client?"

As discussed further in Experiences of Training Environment, identity-based challenges for queer trainees were rarely acknowledged or recognized in training contexts, with participants describing a scarcity of spaces to explicitly address these concerns. These challenges seem to illustrate how heterosexism complicates normative training challenges for queer trainees; the difficulties of reconciling training expectations, stigma, and the realities of LGBTQ+ experiences appear to become an added cognitive load for participants. For trainees, internalizing these factors appeared to have an impact on their developing sense of self as a therapist and how, or even whether, queer identity can be integrated. This can be seen in Elliot’s discussion of the felt sense of danger around disclosure of queer identity:

“I think about… what feels dangerous about just coming out and saying it? Is that danger just something that I'm perceiving, and it's not really dangerous? Sometimes it feels like there is this great power for a young gay man to feel kind of cared for by another man...because of how early sexual transactions kind of happen in gay communities where it can be really casual or about saying no to emotional vulnerability...I wonder if some of the dangers of coming out and being like, "I am also a gay man” is making it more possible that that could become kind of sexualized or something? I don't know. There's just some edge there-- like, "Should I be cautious?"

As seen above, metaphorical language involving danger and struggle was common when participants articulated their experiences of these challenges. Participants often described
experiencing a sense of ambiguous danger in negotiating these conflicting realities. Here, Elliot’s account illustrates this difficulty making sense of and fully naming these experiences of internal dissonance and discomfort. The unnamed “edge” and concern about sexualization in this excerpt is potentially suggestive of how the question of disclosure for queer trainees may be complicated by the association of queer identity with sex and sexuality.

As these challenges were rarely normalized in training settings, trainees appeared to experience self-doubt or personalize challenges named by several other queer trainees. This can be seen in Elliot’s internal debate over whether this felt danger is real or “just something [he is] perceiving.”

Visibility and disclosure emerged as common sources of internal struggle for participants. As noted in the section prior, participants discussed the uncertainty of whether their clients were aware that they themselves shared a minority identity and struggled to convey (or whether they should convey) the extent of their understanding of the clients’ concerns at times. When working with LGBTQ+ clients, this dissonance often emerged as a sense of awkwardness, discomfort or uncertainty. Adelaide conveyed this sense of discomfort:

“They assume that I don't get it and they explain stuff. I get that that's normal life for them, so it makes sense. But also, I wish they knew or I wish I was better at bringing it up without feeling awkward... And I feel like they would maybe benefit from knowing or it would strengthen the alliance, but sometimes I'm just not sure how to bring it up in a graceful way.”

As seen Adelaide’s account, participants described clinical moments in which their unnamed shared experiences with LGBTQ+ clients became unwieldy, particularly when they felt unable to find a ‘professional’ way to address these experiences or did not have a template for
how to approach these discussions as a queer-identified therapist. This excerpt captures the tension between trainees’ internal knowledge of shared identity and the uncertainty of how to broach this in a therapeutic context.

Of the eight participants, four expressed a sense of dissonance about being presumed heterosexual by clients (or coworkers) which manifested in an array of affects, including anxiety, discomfort, sadness, and frustration. This dissonance could manifest as a sense of ‘hiding in plain sight.’ Participants described clinical moments in which their inability to acknowledge shared experiences as queer people felt actively restrictive. These moments seem to illustrate how heterosexism and training expectations can converge to form a sort of ‘professional closet’ for trainees. Leah, who identifies as bisexual and non-monogamous, alludes to how the internal struggle around disclosure parallels the experience of ‘being in the closet,’ in her description of working with a non-monogamous lesbian couple:

“So there was that feeling of almost being seen-- not being seen, but that feeling of understanding and being understood. Like, "I know you would understand me if you knew." And this painful aspect of there’s no way for me right now, based on where I feel I am in my training, and the fact that I don't feel comfortable disclosing based on what I've been told. And my own thoughts about that being potentially too much. And so I have to just sort of sit with my own discomfort that you are wondering if I might be judging you. And I'll tell you that I'm not. And I’ll show you that I'm not. And that will have to be enough.

Now that I'm thinking about it, it's like being closeted, right? Like closeted in your own session room. But at the same time, especially with something like non-monogamy, to identify as non-monogamous is like revealing your sexual practices to a client, which-- I don't know.”

In this way, it appears that the perceived expectations of the training program (or supervision) and uncertainty about violating assumptions of heteronormativity can be an unspoken third party in the therapy room. As discussed previously, it is possible that the
opportunity to approach disclosure and visibility from a place of agency can make the difference between feeling exposed or misrecognized, and feeling seen or secure for trainees.

Similarly, the theme of internal struggle was also woven throughout participants’ accounts of visibility and disclosure in training settings and clinical placements. In participants’ accounts, there appears to be a tension between therapist queer identity being perceived as an asset, bringing lived experience and perspective to work with LGBTQ+ client, and a liability, something that might be perceived as incongruous with professional identity or expose them to further heterosexism in the training environment. As discussed in Ambiguity of Visibility and Disclosure, this appeared to be particularly true for bisexual and pansexual identified clients. Molly elaborated on her experience of this internal conflict:

“\text{I think it's all internalized stuff, on top of being taught that you're... this idea that I'm supposed to be some sort of blank slate.}"

\text{You know what else it is? I feel like being bisexual is not, in my mind, some way, perceived as professional. I'm sure that comes from a bunch of places. But yeah, there's a lack of professionalism in it. It's that same thing as not legitimate.}"

In Molly’s account, the tensions between identifying openly as bisexual and the desire to be perceived as professional are made apparent. Similarly, Leah describes:

\text{But just like that being the go to thought about bisexuality was, I think, one of the reasons that I didn't feel comfortable sharing my identity with the supervisors. Peers, yes. No problem. But something that I struggle with on a professional level is I feel like if I share-- this might be me laying a cognitive distortion out on the table., but I feel like if I share that I am of a sexual minority with a professor or supervisor, if I shared that I'm also attracted to women, I feel like they will imagine an intimate part of my life that you don't imagine if someone. says they're straight...And I feel like, if I say I'm bi, I feel like they imagine the sexual context for me.}
And I think that might really just be a me thing, but it's the fear that I have. And that, I think, is part of what keeps me from sharing that with clients, too, is it's so intimate. But then it's also an identity. It's a sexual practice and it's an identity, and it's an attraction, and it's a community. And it's hard to share one without the other from--that's the glitch that I get stuck on.

Here the impact of stigma is apparent in trainees’ experiences of queer identity, with concerns around disclosure of bisexual identity being perceived as inherently sexual in a way that being “straight” is not. Internal struggle manifests here in trainees’ attempts to anticipate how disclosure will be received, particularly when colleagues may not have a context outside for queer identity of stereotypes or heterocentric understandings. Leah refers to both the “intimacy” of disclosure and the struggle to determine whether claiming queer identity is indicating a shared “community” or referencing a “sexual practice.” In connection with Ambiguity of Visibility and Disclosure, Leah’s account also demonstrates how the perceived level of safety and affirmation of training settings can impact trainees’ interactions with queer clients, with trainees sharing that they were more wary of disclosing to clients in less affirming training contexts. These excerpts allude to the challenge of embodying queer identity in “professional” or “respectable” ways when stigma has led these concepts to be often seen as at odds with each other.

While shared experience was generally perceived as an asset by participants, working with LGBTQ+ clients could also be an area of challenge due to overlapping experiences. Common experiences related to stigma, identity formation, discrimination or family rejection could be emotionally impactful and take on personal meaning when therapist and client shared similar, difficult identity related experiences.
In this context, working with specific topics relevant to LGBTQ+ experiences, may involve revisiting sites of pain or trauma for queer trainees. When client experiences overlapped closely with participants’ or involved difficult associations for the therapist, trainees expressed a sense of internal struggle around overidentification and navigating boundaries both in session and emotionally between self and other. Bianca, a queer doctoral student, described working through the emotional impact of overlapping difficult experiences in supervision:

“This is something I've talked a lot about in different supervisions. But if I feel like I connect with a client and we share a lot in common, I get very invested in their case, almost to a point that I'm like, I wouldn't say overstepping boundary necessarily, but I definitely would bring my work home and I think a lot about that client more than I would for others. Usually when it's family and relationship issues, I feel like it's the most likely to stick with me.”

Bianca’s account demonstrates how shared, difficult experiences based in holding a sexual minority identity can evoke strong emotional reactions that extend beyond the boundaries of the training environment; Here the “private” or personal self is impacted within the context of the training therapist role and must be set aside to be processed later. For participants who were able to address these concerns with supervisors, processing personal reactions and seeking support in supervision were perceived as important components of learning to work through these challenges and as having a positive impact on intentionally navigating similar clinical scenarios.

Similarly, previous negative or challenging experiences within the context of queer communities, could also have an impact on trainees’ experiences of working therapy with LGBTQ+ clients. Elliot provided one such scenario he encountered while leading a therapy group for gay men:
“For example, I just led one of my first groups. And then the primary leader was out this week, so I led the group for the first time. And kind of jokingly-- a lot of the guys in this group are in their 50s and 60s, and before we started, one of them was like, "[The group leader] he told us that we're going to give you a grade when this is over." And it was kind of joking, kind of playful. I'm just the new kid on the block or whatever. And then afterwards, he goes, "You get an A minus. And you only get an A minus because of your shoes," because he didn't approve of the shoes that I was wearing.

And in a way, it was kind of very playful and totally harmless. And in a way, it was also like, "Wow. I'm on display in a certain way here." It brings up a certain kind of discomfort that's kind of always been there about being a gay man in communities of gay men... just something that I noticed coming up, particularly in my group settings where it's just navigating my own history of feeling as I think almost all gay men feel [that] pressure.”

This scenario illustrates how events in therapy can bring up emotions or impact ‘countertransference’ with LGBTQ+ clients related to experiences with other queer people, in queer contexts, or with relational modes specific to certain communities. Internal struggle manifests again as interactions with LGBTQ+ clients unexpectedly hit the personal within the context of the professional.

As further discussed in Experiences of the Training Environment, participants described encountering experiences of heterosexism in the training environment, whether first-hand, addressed toward LGBTQ+ clients, or in training material. This appeared to be another site of internal struggle for trainees, who, similar to their LGBTQ+ clients, share a vulnerability to minority stress, discrimination, and stigma in addition to the stressors of graduate school. As Daniela expressed, describing her reaction to transphobic treatment of adolescent clients in a previous clinical placement:

“I just felt angry...this takes me back to the experiences I've had growing up and people making comments about what I was and how I identified and how
Daniela’s experience illustrates how experiences of heterosexism within the training environment can involve revisiting potential sites of trauma for trainees. Here, witnessing heterosexism towards LGBTQ+ clients in the training environment can generate an internal struggle for trainees, who share a queer identity, and may disrupt a sense of safety within the training environment. Again, in these scenarios, participants appear to be negotiating between contexts in which their queer identity is perceived as an asset and those in which it leaves them liable to stigma and discrimination.

The theme of Internal Sense of Struggle, across various identity-based challenges, appears to describe a developmental learning curve for queer trainees. Generally, participants voice a sense of importance in resolving these challenges and engage in seeking out resources and supports to facilitate this process, whether within or outside of their training programs. Over time, participants seemed to describe feeling more comfortable with negotiating these challenges and the ambiguity that accompanies them. This is visible in Lisa’s resolved decision-making stance around disclosure:

“I don’t typically self-disclose with parents. I’ve never said to a child, "Oh, My God. I’m a lesbian." I’ll let them know. I’ll be like, "Man, I get where you’re coming from. I volunteered at the Pride Center. Oh, yeah. You should really go to the pride festival. This is what it's all about." So I don't specifically-- not that I wouldn't wave a flag. But I don't specifically wave a flag. But I give them enough indicators for them to know that either I'm a very strong ally or a member of the community. And with that one specific young lady, I did give enough information, that if she didn't piece that together-- that's quite obvious.
TRAINING WHILE QUEER

But, no, I've never said like, "Yeah. I'm a lesbian." So it's one of those things that's time and place.”

Similarly, Daniela describes her approach to navigating anxiety around training challenges with LGBTQ+ clients:

“If you have that stance, then the patients themselves will notice that and will feel like they are safe to talk and to express themselves in whatever way that is that they want to. However, if you go in feeling anxious and hesitant, they're going to pick up on your discomfort. And that's when you need to stop and ask yourself, "What am I worried about, right? What are the assumptions and own biases I'm having?" And I think that queer therapists are likely to do that work. No one tells us to do that though. And I had to learn it, and I fortunately had a supervisor to guide me through some of that.”

As seen in these excerpts, with increased experience, participants appeared to describe developing more stable frameworks and strategies for working through the unique challenges that can arise with LGBTQ+ clients. Affects and tones here present as settled and more confident while still acknowledging a desire for growth and capacity for mistakes.

Notably, participants pointed to the role of spaces for self-reflection on clinical reactions and choices in gaining an increased sense of clarity and felt agency around these challenges. Supervision spaces in which participants could process affects that arose in relation to shared experiences of stigma, anxiety around difference, decision-making processes about disclosure, and reactions influenced by past negative experiences, appeared to be key in resolving this sense of internal conflict and developing a coherent framework for working with queer clients. Here, it seems that supervision served as a space for supervisees to integrate clinical training and personal experience. Daniela highlighted the role of supportive supervision in normalizing and grappling with identity-based challenges:
“I had all of these questions come up for me, and I didn't know what to do with all that information. I didn't know who to ask these questions of...and I would bring them up with my supervisors. Some of them really helped me explore that, whether it'd be giving me an outlet to talk about it or working on being more cognizant of when it's happening in the room... and not to give myself such a hard time for having these questions, for feeling like I'm going to experience doubt working with these patients and for how that affects me.”

In line with this excerpt, participants characterized openness and initiation of explicit discussions of LGBTQ+ concerns as features of helpful interactions with supervisors, colleagues, and training faculty. Queer identified supervisors and faculty, as well those familiar with and/or specializing in LGBTQ+ concerns, were referenced as playing a key role in normalizing these challenges as part of development, modeling interventions, and scaffolding further development and integration in these areas; when available, LGBTQ+ identified and/or knowledgeable supervisors were often intentionally sought out by participants. Molly captures this sentiment as follows:

“I want to be very strategic in terms of who my supervisors are these next few years, so that I can develop that in positive ways. I think if I-- Does that mean I can't have a straight supervisor? No. But they need to be real educated, they need to be real empowering, they need to be willing to talk about this stuff, or else I'll find myself retreating inside myself. And I don't want to do that.”

Notably, as seen here, trainees may withdraw or be reluctant to bring these concerns to supervision if safety has not been established, has been violated, or if previous efforts have not been fruitful due to factors such as avoidance, heterosexism, or lack of expertise in the training setting. As further discussed in Experiences of the Training Environment, engagement when supervisees did bring up these concerns, addressing heterosexism directly when it emerged in the training environment, and being open to repairs and feedback when ruptures occurred were
described as valuable qualities in supervisors and professors, with many participants expressing the impact (and relief) of finding spaces where they felt able to discuss these concerns openly.

**Experiences of the Training Environment**

Over the course of their degree programs, mental health trainees are exposed to several training contexts, including various classroom and supervision settings, practicums, and internship placements. Additionally, trainees form a number of working relationships with supervisors, colleagues, faculty and peers in these contexts. The present section focuses on the experiences of queer trainees navigating these environments and relationships, with a focus on the impact of these experiences on the quality of their training, perceived growth as clinicians, and work with LGBTQ+ clients. Experiences within the scope the training environment clustered around three themes: Peripheral Nature of LGBTQ+ Training and Absence of Support, Experiences of Heterosexism in the Training Environment and Self-Initiated Efforts to Improve the Training Environment. Additionally, this section touches upon the challenges that trainees encounter, their attempts to resolve them, and relevant supports within the training environment.

**Peripheral Nature of LGBTQ+ Training and Absence of Support**

In describing their experiences of the training environment, all participants described a desire for more in-depth training with regards to LGBTQ+ mental health and affirmative approaches to therapy. While participants generally felt that their programs were well-intentioned and attempted to take an affirmative stance, participants typically characterized training programs as adopting a superficial or avoidant approach to LGBTQ+ identities. In coursework, participants expressed that training around working with LGBTQ+ clients tended to be limited, peripheral to other course foci or often not felt as true to lived experiences and
realities of LGBTQ+ people by trainees. This arrangement was often experienced by participants as a scarcity of training opportunities and information. Scott, a gay doctoral student, articulated his experience as follows:

“Everyone has emphasized the importance of working with LGBT clients, but I find that in this program unless you explicitly are seeking it out at all times, it's a lot of talk and not a lot of walk, which to some extent, I chalk that up to the practicalities and limitations of running such a program as this. There's always a paper somewhere in each of my classes about working with LGBT clients and that's always great...but I don't understand why the effort and energy hasn’t been put into [an LGBTQ+ focused course]. The classes that we actually have regarding any area of diversity are super limited.”

As demonstrated in this excerpt, participants described a general dearth of LGBTQ+-focused or affirmative training in their training programs and many of their training contexts. Generally, participants noted that their training contexts tended to focus on, at least in name, the importance of adopting a general non-judgmental or affirmative attitude in working with LGBTQ+ clients; however, it appears that this in large part did not move past broad, abstract-level, or superficial nods to working with LGBTQ+ people and communities in training and coursework. Adelaide, a bisexual doctoral student, captures this theme in her desire for more direct, pragmatic instruction on working with not only LGBTQ+ clients but also non-dominant identity populations more broadly:

“I would say that in all areas of diversity training, I wish aside from just being like, "Here's the general attitude of openness: we should always take each individual as unique, so we should never make assumptions and always ask, "What was this like for you all as an individual?" I wish we wouldn't be as afraid to get into specifics...

I wish that psychology training as a whole wouldn't shy away from telling people specifics like...do not do this, do not say this. I wish there was some
more specifics like the terminology. It's called ‘gender affirmation’ or things like that. To not be afraid to get into the specific dos and don'ts, even with the caveat that it won't apply to every single individual.”

Here Adelaide connects the superficial nature of engagement with LGBTQ+ concerns to a larger ‘fear of specifics’ with regards to multiculturalism and diversity in her program. In participants’ accounts more generally, specific training on affirmative practices, navigating intersections and diversity within LGBTQ+ communities, and addressing the impact of structural factors on LGBTQ+ mental health tended to be rarely, if at all, addressed in training programs or outside of training contexts that expressly specialized in providing care to LGBTQ+ populations.

As participants recounted their experiences of clinical didactics and coursework, LGBTQ+ identities and concerns were rarely centered, in contrast to the taken-for-grantedness of heteronormativity throughout much of training material. In their accounts of approaches to LGBTQ+ training, participants alluded to a tension between LGBTQ+ focused training being regarded as a specialty area versus a necessity for equitable practice. Generally, these aspects of training were experienced as an add-on to an otherwise heterocentrist curriculum or training atmosphere rather than being integrated or influencing training practices. Elliot, a gay doctoral student, describes this phenomenon and the related diffusion of accountability around integrating LGBTQ+ training as follows:

“It's hard because I feel like, in training, there is this question for issues about any kind of diversity, like, "Should we be making a course to address that? Or should that be kind of integrated across every course?" I get the sense that a lot of professors - and I think that this is across many measures of diversity - kind of choose 1 day of their 15 days that's diversity day.
I almost feel like there needs to be-- if the program is going to say, "Well, every professor should be integrating stuff about kind of sexuality in both theory and intervention courses" there needs to be an audit of the syllabi to see like, "Is it really happening?" because I don't think it's happening."

This excerpt references the tendency of courses to have a ‘one article problem’ in which LGBTQ+ affirmative practices or considerations were relegated to one article or one day in an entire course, often foreclosing the opportunity to learn or discuss these topics in depth. As seen in Elliot’s account, information and material on working competently with populations outside of normed, typically centered, dominant identities are described as crowded into one course and not well integrated into other courses; LGBTQ+ were concerns framed as one of many (intersecting) areas of cultural competency competing for space on the periphery.

More often, inclusion of LGBTQ+ identities, and concerns around gender and sexuality more broadly, were felt to be symbolic nods, rather than opportunities for open or nuanced discussion. Clinical placements and supervision were often described as areas where deeper learning could occur if trainees had access to supervisors or training settings who specialized in LGBTQ+ concerns; participants, however, often described encountering limited options when seeking these opportunities. Daniela, a bisexual doctoral student, described this scarcity of opportunities and lack of guidance in working with LGBTQ+ populations:

"It's really, really difficult and challenging, and I wish that I had more exposure and experience working with the LGBTQ community now at this point of my training and that I had supervisors who could really help me navigate that... I feel like that's sort of been lacking in my experience.

I have had enough patients and clients who identify as LGBTQ+. However, I haven't had supervision to guiding through that as much, and I think that is where I want more experience, want more education because I think that I might be doing this patient or client a disservice...I'm probably missing something, and I want to see
where I can improve in terms of ...being a sensitive therapist as well as being able to adapt to whatever their needs are and to take into consideration all their identities and to offer a safe space, whatever that looks like for them because everyone feels safe in different ways.

I do my own sort of research and reading up on the literature, and I feel like there's a huge lack of that training...that we need more of. I wish that we could get a lot more of it in our graduate training. I'm sure there's a lot of training that there needs to happen afterwards and I would gain more that way.”

As seen in Daniela’s account, participants generally voiced an unmet, and repeatedly frustrated, desire for more pragmatic, specific training on LGBTQ+ issues, identities, and affirmative practices and open discussion of LGBTQ+ identities in courses and training contexts. This was often conveyed as a sense of waiting, ‘holding in’ these needs, until out of training when more in-depth training and exploration of these concerns could be explored. Gaps in training were typically met with a sense of unease as participants described encountering the limits of their lived experiences in working with LGBTQ+ populations. Bianca, a queer doctoral student, captures this sentiment:

“So most of my therapy experience is [through my practicum], and then just reading on my own. There were definitely times where I felt a little bit scared. And I was kind of winging it at times. And kind of just using my own experiences to try to figure things out.”

Here, Bianca conveys how gaps in training could leave trainees ‘on their own’ to navigate the challenges of working with LGBTQ+ clients, contributing to a sense of internal struggle. Similarly, participants described patterns of engaging in attempts to seek out LGBTQ+-focused training, whether through reading or seeking out affirmative training sites, often in response to
hitting the limits of the peripheral training when navigating the realities of working with LGBTQ+ clients.

In parallel, participants, when describing identity-based challenges as queer-therapists-in-training, typically did not find these concerns represented or mirrored in their training contexts. Daniela illustrates how the dynamics of queer therapists working with queer clients were rarely acknowledged:

“So my school program, I think they try to do their best to support queer therapists in training by offering like a student-run peer group and then maybe holding courses trying to educate students in certain LGBTQ-related issues. But when it comes to like queer therapists and our experiences working with these patients, none whatsoever.

Only in terms of supervision I would say, but even then I don’t know that I’ve had supervision where this supervisor was well-educated in that area who can help me navigate my own sort of experience working with those who identify as LGBTQ. If anything, the only experience that I’ve had with even talking about what it means to be a queer therapist and working with the queer community has been run by other queer therapists or allies, which has been amazing. I am very grateful for that.”

Again, this excerpt demonstrates how trainee discussions around training challenges were marked by an absence of support or guidance. For many of these challenges, such as use of lived experience and disclosure of queer identity, participant accounts suggest a scarcity of resources, supports or spaces to discuss these concerns or receive further direction in resolving them. This absence of support was often coupled with a desire for role models, representation, or spaces to discuss concerns specific to queer trainees on the part of participants. Daniela captures this above in describing her experiences speaking with queer-identified and explicitly allied therapists as a rare space where these dynamics were spoken about openly.
In recounting these experiences, participants also described moments in which they experienced gratitude or appreciation when encountering supervisors, faculty or training sites that made space to center LGBTQ+ concerns; however, these occasions were largely offered as exceptions that underscored the scarcity of such engagement with this material. For example, Elliot described:

“I get the sense that at least at [my doctoral program], there's kind of this idea of like, "Well, every professor should be integrating stuff about kind of sexuality kind of in both theory and kind of clinical or intervention courses."
When I think through that, I think there's only one professor...she really made an attempt to include readings that are about a gay male therapist working with a gay man about his experience of intimacy. But there just hasn't really been much talk about sexuality and nonnormative sexuality and difference”

This account highlights again the absence of support and acknowledgement of the experiences of queer therapists in training on LGBTQ+ competencies. Generally, as seen here, the perspective of queer therapists or trainees was absent in training materials or training settings in participants’ accounts. It appears here that the implicit centering of heteronormativity and assumption of therapists as heterosexual and cisgender resulted in experiences of erasure for trainees. Revisiting Leah’s commentary on her training experiences as a bisexual doctoral student, further illustrates this theme:

“I don't feel like that makes a world of sense. I think I'd like to learn how to support queer clients better in a way that--- in such a way that there is a boundary between my own identity and theirs, and my experience and theirs. But it doesn't necessarily need to be shared. It could be, if that's therapeutic. And that I am being sensitive to their identity development and what stage they're in. And I don't feel like that's really been a part of my training here.

I get that there are 500,000 things we could learn how to do in graduate school, and you can't really cover everything, and maybe it's the case that the most appropriate setting in which to learn how to do that is like a practicum setting.
And I've been focusing on getting general training. Kids, trauma, just like a whole huge beast, young adults. So I recognize very much the constraints that [my program] experiences in terms of curriculum development and the APA.”

Here, the lack of guidance around the unique challenges that can arise for queer trainees in developing LGBTQ+ competency, such as disclosure or maintaining a boundary between self and other, is made apparent. This centering of heteronormative perspectives appeared to obscure the ways in which training experiences can differ for queer trainees based on minority identity, leaving them invisible and largely unnamed. As in Leah’s account, in discussing their perspectives on the difficulty of integrating LGBTQ+ training into training settings, participants often made sense of this absence of support on a systemic level, acknowledging the limitations of program resources, training expectations, accreditation requirements and competing competencies as contributing factors.

Participants whose programs provided a specific concentration in LGBTQ+ mental health with faculty specializing in this area, tended to express satisfaction with the depth of their program training on LGBTQ+ identities but often encountered challenges in their clinical placements external to the program; this appeared to be particularly true when, by participants’ accounts, trainees were more familiar with LGBTQ+ issues than staff or when clinical/agency practices conflicted with affirmative practices. Molly, a bisexual social work student, recounts her experience of the differences between her program training and practicum placements with regards to approaching affirmative care:

“I think my professors generally - particularly a couple - have a lot of experience working with queer folks [and] are educated in queer theory. So I never had any concern about that. I think what I've noticed so much, aside from my program-- there's more work to be done.
But generally speaking, particularly from folks, say, even five to ten years-- got their degrees five to ten years ago, there is really not a ton of education on working with LGBTQ folks unless you seek it out. And it's problematic. And I think I could see that particularly in working with my last internship placement, where just everyone came from that sort of program. And so you're left with having awkward conversations, and doing some education, and working with what you got.”

Here, Molly makes sense of the peripheral nature of LGBTQ+ training as a generational problem; this excerpt alludes to how the absence of LGBTQ+ affirmative training appears to be passed down over time with supervisors, faculty and senior colleagues often being limited in their capacity to help trainees navigate the realities of working with LGBTQ+ populations or engage with queer trainees’ concerns. As seen above, this could become a source of discomfort, particularly when supervisees felt they had significantly more familiarity with LGBTQ+ issues than their supervisors, impacting supervisor-supervisee dynamics.

Notably, across interviews, the importance of spaces for support, representation, and role models emerged as key influences in improving participants’ experiences. Participants described reparative experiences when encountering supports such as earnest integration of queer therapist perspectives and LGBTQ+ affirmative training in coursework. Bianca described the impact of encountering explicit affirmation and supports for queer therapists in her internship placement:

“At my internship now though, on the very first day, one of the supervisors mentioned that there is actually a mentorship program for LGBT staff which I'm definitely looking... to get involved in. For example, the supervisor was like 'having a mentor really helped me come to terms with my bisexuality and how that impacts my work as a psychologist.'

It feels a lot more open... I'm not necessarily out to anybody at my internship at this point either. It's comforting to know that that option is there, makes the environment, in general, feel much more welcoming.”
Similarly, Leah recounted a meaningful classroom experience of explicit inclusion of queer identity after disclosing her bi identity in a diversity course:

“I was in [professor’s name] diversity class the following semester, and— I love that she does this. She had everybody do introductions...And I didn't mention being bi in my intro, and she very gently, and lovingly, I want to say, she said, "Would you mind sharing--" I felt like I was being welcomed to share that part of my identity, not forced. I could have so easily said no.

And it just felt really nice to have a professor see that part of my identity. She never talked about it with me, but she had received it from my paper, and then was supportive in me voicing it in a classroom setting. Such a small moment, but it felt like real support to me, and encouraging me to have a voice.”

As these excerpts illustrate, participants referenced experiences with faculty and supervisors who modeled direct and open discussion of LGBTQ+ concerns and invested in LGBTQ+ programming as distinct instances in which they felt recognized and supported. Opportunities to engage with early and later career queer-identified therapists as well as access to supervisors and colleagues with backgrounds in these areas were highlighted as fostering growth and modeling professional development for queer trainees. Molly elaborated on her experience of transitioning to an explicitly LGBTQ+-focused and affirmative training setting:

“It's a breath of fresh air. I'm so used to having no expectations. And then to have folks that are just very much on the same page, and have more knowledge than I do, and have experience navigating certain things that I am currently navigating, is just like-- I've trained myself not to expect much when it comes to that, which is a shame. But it also is a self-protective measure, and just a survival skill. And to have some of that is great. And it feels like I can take care of myself better, and also grow as a future clinician in that way.”
As seen in this account, trainees often described managing expectations and facing doubt about whether their needs can or will be met during their training experience. When opportunities to meet these needs were available, participants’ accounts of these supports were conveyed in terms of relief, security, validation, and the ability to be more fully engaged in training environment. As Molly describes, such supports were typically met with surprise, given their absence in many training contexts; participants tended to describe these moments as emotionally corrective, using narratives of seeking and finally finding space to process, grow or even engage apart from the cognitive and emotional load of managing stigma.

Experiences of Heterosexism

Of the eight total participants, six participants described incidents in which they experienced heterosexism, to varying degrees, in the training environment. These experiences of heterosexism ranged from a sense of erasure due to heterocentrism in the training environment to experiencing more directly disparaging comments about LGBTQ+ people and communities in various contexts. Most commonly, these incidents manifested in trainee accounts as client-directed microaggressions, typically occurring when supervisors, colleagues, or faculty, (who may or may not be aware that the trainee present identifies as LGBTQ+) demonstrated heterosexist attitudes toward LGBTQ+ clients.

Common microaggressions experienced in the training environment included statements that pathologized clients based on LGBTQ+ identity, referenced stereotypes, or conveyed heterosexist attitudes in discussing LGBTQ+ people. In rarer instances, participants also described witnessing interactions where LGBTQ+ clients were subject to heterosexist attitudes or practices; these instances
were described as particularly distressing for trainees. Daniela speaks to the emotional reality of advocating for clients following such incidents while also navigating the personal impact of hetero/cissexism:

"And so we had a recent incident where one of the other staff asked a transgender youth like, "What would it take to get you to go back to your original gender?" So essentially like the choice-- that they're making this choice, and they can easily go back and forth between being transgender and then being just like cisgender.

And I was just shocked. I did not know what to say because in that moment I was like, "I don't want to make things worse or exacerbate it." What I did was I took it to my supervisor, and it was addressed. So it wasn't anything else that I had to do. I just had to report on it. Still I didn't feel safe. And I wasn't the one who was targeted, right? It was one of the patients. I felt very strongly about it-- I just felt angry."

Here, the vicarious impact of witnessing heterosexism on trainees is made apparent; this context appeared to create a dynamic in which trainees simultaneously felt like insiders and outsiders in their training contexts. One source of this dynamic appeared to be the differential awareness of heterosexism and the impact of systemic factors on LGBTQ+ mental health between queer trainees and heterocentrist training environments. As seen here, participants commonly recounted scenarios in which trainees were attuned to heterosexism in ways in which supervisors colleagues and faculty were not cognizant. Similarly, scenarios where senior colleagues discussed LGBTQ+ experiences, that for trainees are lived realities, in abstract or dismissive terms were also highlighted.

As participants tended to describe an acute awareness of the mental health impact of heterosexism on LGBTQ+ people, this first-hand perspective may differ significantly from the
norm in training contexts where the experiences of LGBTQ+ people are contextualized only by the larger culture and limited clinical training. Here, participants conveyed an experience of being ‘insiders’ in their shared mental health professional role with colleagues but also outsiders in the sense of identification with queer clients and people, shared minority identity, lived experience and vulnerability to heterosexism. Similarly, in some instances, trainees alluded to being ‘outsiders’ in the sense of violating implicit expectations or assumptions of therapists as heterosexual/cisgender and clients as LGBTQ+. Molly, describing her experiences of biphobic microaggressions, captures this affective reality:

“Hearing things like, "Oh, it's just a phase," or something that's not taken as seriously, or seen as legitimate as someone who identifies as either straight or gay, is definitely something that I struggled with, and still struggle with to some degree, depending on the setting I'm in. And so to hear that makes me shut down and makes me-- I didn't necessarily feel-- safe is such a strong word. But I didn't feel completely safe, as an intern, to be like, "Actually, these are my experiences, and you talking about this as a phase--" Because there are also some unrealistic fears, I think, of me being pathologized by them.”

This excerpt depicts how instances of heterosexism could be experienced by trainees as a split between an internal awareness of these identifications and of being seen externally by colleagues as ‘clinicians’ not queer people. Trainees tended to report that instances of heterosexism had negative impacts on their sense of safety and belongingness in the training environment. As in Molly’s account, the personal impact of these incidents on trainees appears to remain invisible in many instances.
TRAINING WHILE QUEER

Across narratives of encountering heterosexism, supervisors and peers were often framed as unaware of how trainees were also implicated or included in pathologizing comments about LGBTQ+ clients or people. It appears that trainees’ experiences with and vulnerability to minority stress was made largely invisible by heterocentrism in many training contexts. Leah recounted one such scenario:

“A supervisor said, "Oh, it's so popular to be bi right now." And I was very happy with my response. I was able to say like, "Oh well, let's talk about that a little bit. Could it be that our culture is changing, and so people feel more free to express an identity that they have, and there may have been people who would have identified as bi 10, 20 years ago, but didn't feel comfortable. Isn't that a cool way to think about it?" And the person was really receptive...

So, I didn't share with my supervisor that I'm not straight. I think that's something that I've struggled with”

While Leah describes a positive outcome, this scenario captures how trainees could find themselves in the position of having to provide context for LGBTQ+ identities and the mental impact of heterosexism when supervisors or colleagues were unaware of these lived realities (or how they may also apply to trainees.) In line with this theme, Lisa, a lesbian social work student, illustrates how a heterocentric focus in clinical environments can result in erasure for queer therapists:

"And beyond my own personal take on that, my agency as a whole, we're looking towards whether or not we want to use rainbow lanyards on our ID tags, or if we want to get a lapel type of a pin to identify that we are supporters and allies, without having the word “straight” on it. We had a whole dialog and a meeting about this, without having the word straight ally on it. Because I'm like, 'I'm not wearing a straight ally pin. That's not happening.'"

Lisa’s account illustrates how attempts at affirmative LGBTQ+ practices that presume heterosexual/cisgender therapist identity can be inadvertently othering. Lisa and Leah’s accounts
also allude to how the implicit assumption of a straight therapist/queer client binary can alienate queer trainees.

Participants appeared to be particularly attentive to power dynamics in training contexts, particularly in more hierarchical settings. When experiences of heterosexism occurred within training environments, participants described working through context-based decision-making on how to respond including educating, explaining their perspective, attempting to address the rupture and repair, withdrawing or re-asserting boundaries. In discussing the challenges around responding to client-directed microaggressions at a training site, Daniela described considering her trainee role in determining a course of action:

“It has to do with being a therapist, but currently therapist in training, and working with a multi-disciplinary staff where every person comes from a different background...has different points of views in terms of religion and culture-- like cultural stuff as well as sexual orientation, gender identity.

So when a transgender person comes in and then gets misgendered or their pronouns are not being used, as a therapist in training, what role do I have in those moments? What can I do to not-- At the same time, I don't want to overstep anyone's boundaries if it isn’t my place.”

Here, Daniela highlights the tension between the desire to address heterosexism and advocate for LGBTQ+ clients in training contexts and ‘overstepping’ as a trainee. In less responsive environments, participants discussed the difficulties of addressing microaggressions against the grain of an asymmetrical power dynamic. In the context of supervision, unaddressed or unresolved ruptures around microaggressions were generally described as damaging to the supervisory relationship. Elliot described the outcome of one such scenario:
“I had a supervisory relationship at [a practicum placement] that had to end because I experienced some kind of microaggressive stuff around this one client who I've been talking about. And it ultimately kind of blew up our supervisory relationship in a way where it was not reparable, and I got matched with a new supervisor.”

Trainees also described engaging in failed attempts to address heterosexism in training contexts, which were often experienced as disempowering. Molly recounted her attempt to process an incident where an adolescent client was inadvertently ‘outed’ to their parents by another clinician, resulting in an iatrogenic outcome:

“So I was upset. I was hurt. And that's also where I felt like-- I remember saying to my supervisor, "This is the first time I feel most like the only queer person on a staff full of straight people"... And so there was a-- I remember a few days after that, the head of HR does these Zoom meetings for counselors as professional development opportunities. And so I logged on because I wanted to talk about this.

And that's where the head of HR-- because I was talking about me being really sad and upset about this case. And I remember saying, "I feel like I'm the only queer person" - to her, as well - "on a staff full of people." And she said, "Oh, it seems like there's a lot of countertransference coming up for you." And that's when I stopped talking, and I'm like, "This person clearly doesn't get it, not going to get it. Let me take a step back. Thank you for your time."

As seen here, addressing heterosexism in training contexts could be experienced as a position of vulnerability for trainees due to the personal impact of these experiences. In some instances, this personal impact was met with an invalidating or dismissive response, more significantly compromising trainees’ sense of safety and felt acceptance in the training environment. As a result of these factors, participants appeared to compromise between getting their needs met and engaging self-protective measures in navigating training contexts.
Alternatively, trainees described experiences with superiors who were able to acknowledge heterosexist attitudes or microaggressions and responded with openness to feedback, despite the initial impact of these comments. Elliot describes one such attempt at repair following a rupture with a supervisor:

“For example, this straight white male supervisor I'm seeing, I really like him, and he said one thing recently that made me kind of be like, "Oh, no. Is this not going to work?" I was talking about this client I'm working with who recently came out, and he lives in [rural area], and how he's talking about how it's truly not safe to be a gay person everywhere and to be kind of concerned about your physical safety moving through the world.

And my supervisor, he almost scoffed at that, kind of like, "But it's 2019." And I had this moment where I was like, "It's 2019, and I live in New York City, and I feel unsafe." I feel unsafe in the kind of biggest metropolis in the world that's supposed to be incredibly progressive. So we were able to kind of talk through that rupture and calm it down. I don't even know if I could say totally repair yet.”

As seen above, participants described examples in which supervisors were receptive and accountable to feedback, allowing for, at very least, the possibility of repair. Elliot’s account also suggests, however, that microaggressions could be particularly jarring when disrupting an otherwise positive supervisory relationship.

Microaggressions appeared to occur most often in the context of supervisory or senior staff relationships in trainees’ accounts. However, three of the eight participants also recounted experiencing microaggressions when interacting with peers, faculty, or colleagues in their training programs and clinical placements. As Scott recounted:

“I did have one experience in a group supervision...where my sexuality came up in a way that made me-- it was just a really awkward micro-aggression against me from another classmate where I was showing a tape
for my session with a client...And so then one of my peers had said-- oh, I really can't recall the reason why she said this but we were talking-- it was some dialogue about my identity.

And then she was like “Well, yeah. He knows you’re gay.” And I was like, "What?" It was like me, her, and this other classmate, and the supervisor and she was like, "Yeah. He knows you're gay. Doesn't everyone know you're gay?" And I was like, "What are you talking about? And it was like very awkward moment for me.”

Here, Scott conveys his experience in terms of a shift from a clinical discussion about therapist identity to unwelcome commentary on his stimulus value. This scenario provides an example of how heterosexism could emerge in the context of professional interactions with peers and generate discomfort for queer trainees.

A final dimension of trainees’ experiences of heterosexism included participants’ descriptions of the contextual nature of safety and affirmation across training environments. Overall, participants varied with respect to how supportive or affirmative they perceived various training contexts to be; this variation occurred both between participants and often between different training environments for individual participants. Lisa captures this aspect of the theme in contrasting past and present clinical contexts she has encountered:

“For myself, it only comes up in regards to policy and procedures of places I've been. So we can go back to [clinical setting], where all the heterosexual women could have the pictures of their wedding day on their desk. And like, "Okay. But I'm in a relationship too. How come I can't have my partner on my desk?" So the bureaucracy component has kind of come up in that fashion. Where I'm at now, I could walk into work with a SuperLesbian and cape on, and they would applaud me and stand up. So you have the various different levels of support.”
As Lisa described, trainees tended to report encountering context-specific challenges with regards to heterosexism. Generally, participants made distinctions between settings in which they experienced repeated incidents of heterosexism, those which were heterocentrist but nominally LGBTQ+ friendly, and those in which they felt well supported or could openly discuss identity-based challenges.

Notably, six of the eight participants expressed that affirmative messaging had a marked, positive impact on their sense of belongingness in training contexts. Witnessing queer identity and LGBTQ+ expertise being valued in the training environment, as well as opportunities for receiving mentorship and guidance from affirming supervisors, were experienced as particularly meaningful. Adelaide described the impact of explicitly affirmative training on her own process of coming out:

“So I didn't question my identity carefully until I was-- well, it would have been my fifth year in training, so pretty late. And I think that having been in such a firm, diversity affirming program is a lot of what helped to lead me to that place where I could.

Sometimes I think about how it would have affected my journey as a queer person to have been in a field that's not that way. There are some fields where whatever company you work in is very hit or miss or some fields that are generally across the board not very affirming or very entrenched in their gender roles. And yeah, I think having been in a field and always having been a field that's so open and affirming has affected my personal journey a lot.

And I almost think it's-- because in some fields it's a barrier. If you have a minority identity, it's a barrier in the workplace. You have to go in there, work harder than everyone else to get the same amount of recognition and stuff like that. Whereas I feel like me being queer is treated-- I mean, I guess, in a sense it's seen as an asset rather than a barrier. And that's such a wonderful thing that I wish for all my clients to have, but I know it doesn't exist.”
Adelaide’s experience suggests that explicitly affirming attitudes when communicated in training contexts can have an invisible impact on queer trainees, who may be in varying stages of identity development with regards to queer identity. Here, it appears that visibility of queer colleagues and peers, explicit affirmation, and investment in competent care for LGBTQ+ clients often serve as markers of safety for participants in assessing their training contexts.

**Self-Initiated Efforts to Improve the Training Environment**

In response to these challenges, participants across interviews described engaging in self-initiated efforts to improve their training environments. This often manifested as an investment in filling in training gaps and improving access to LGBTQ+ affirmative training in their training contexts. Participants described engaging in self-initiated efforts to seek out training on LGBTQ+ affirmative care; trainees also discussed utilizing clinical placements, supervision settings, and graduate school extracurriculars to seek out specialized training in working with LGBTQ+ clients or expand their familiarity with concerns in this area not addressed by their program.

Trainees appeared to respond to the relative absence of support and peripheral nature of LGBTQ+ training, with a piecemeal approach to filling in training gaps. Revisiting Bianca’s account of seeking outside sources to supplement training gaps illustrates how trainees made efforts to compensate and broaden their understanding beyond what their training contexts could provide:

“So I think one of the challenges is just honestly, not having a whole bunch of training in working with LGBT [people].... So most of my therapy experience is [through my practicum], and then just reading on my own. There were definitely times where I felt a little bit scared. And I was kind of winging it at times. And kind of just using my own experiences to try to figure things out.”
As Bianca describes, these self-initiated efforts were often made sense of as a necessity to counter the limitations of training, particularly when this training did not address working with the lived realities of their LGBTQ+ clients. Similarly, Scott described his process of seeking out an explicitly LGBTQ+ focused training site:

“I think the only other thing that-- as a queer or as a gay clinician in training, I think it's really important for other clinicians in training across programs to really seek out an LGBT exclusive type of practicum. This was my first time going through the process... And I was really dismayed and shocked by the very, very, very, very few practicum that were explicit about being LGBT friendly and/or saying like, "This is a very LGBT-focused place." There [were two sites] which I found, one of which I'm going to next year. And other than that, there really wasn't any other type of practicum that was more LGBT heavy."

As demonstrated above, these efforts took on many forms across interviews, including reviewing relevant literature to address client concerns and intentionally seeking out queer-identified and/or specializing supervisors and clinical placements focused on working with LGBTQ+ populations.

Participants described a process of intentionally seeking out alternative avenues when encountering the limitations of their training settings, often a result of outgrowing what was offered in the capacity of LGBTQ+-focused training. In trainee narratives, this often looked like seeking out LGBTQ+-aware clinicians or mentors for consultation outside of supervision when available, exchanging information with peers, and intentional selection of supervisors or settings offering expertise in LGBTQ+ concerns. Elliot described this stance of finding support ‘where you can’:
“Even kind of door side, ad hoc supervision, seeking out nontraditional supervisor relationships to consult because you don’t always have control over who your supervisors are. I want to say other students are a support... I can think of a couple examples where we're formally sharing case material about working with queer clients and problem-solving together. But I don't even know if that's happening as much as it could be... I guess the short answer to your question is just seeking out kind of allies wherever you find them, whether that's in supervisor relationships or kind of friendships.”

As Elliot conveys, self-initiated efforts often presented as participants working within their means as graduate students, using or repurposing spaces available to them to improve or expand training in line with their interests and clients’ needs.

Across interviews, participants described engaging in adaptive responses to address heterosexism in the training environment and advocate for queer trainees and clients. For many participants, this appeared to involve taking on an educator-advocate role. Activities in this scope ranged from educating peers on LGBTQ+ concerns and affirmative care, marking training environments with LGBTQ+ affirmative signals, and developing programs for staff on LGBTQ+ affirmative care. Participants also described efforts to update paperwork and recommending policy changes to be more inclusive of LGBTQ+ clientele. Daniela captured this theme while detailing her efforts to make her training settings more explicitly affirmative:

“I mean like concretely putting up posters that indicate that this is a safe space, that you can identify in whatever way that you want, and I wish I could see more of that at my own school. But doing that has been something that I've been like wanting, just the visual representation of acceptance and safety. And that's what I've been doing recently at my own externship. I created a gender and sexuality questionnaire that is used as part of the screening for the intake--the whole team has been very receptive to it and now it's a part of the intake process, asking these sensitive questions.”
This excerpt demonstrates how trainees reframed the spaces and resources available to them as opportunities to carve out more explicitly affirming spaces for LGBTQ+ clients. In some instances, these actions were also framed as stemming from a desire to create spaces that countered the limitations and heterosexism present in training environments. In this way, participants appeared to construct these efforts as a way of reclaiming agency following disempowering experiences.

In several instances, trainees discussed advocating on their clients’ behalf in the context of clinical discussions, particularly when policies were perceived as counter to LGBTQ+ clients’ wellbeing. Molly captured this aspect of this theme in her description of advocating for clients within the context of a previous training setting:

“I found that I was advocating for particularly trans kids at first. And some staff members - not so much clinicians, but other staff - really struggling to understand what being trans means in general. And so just, really, it seems like there's a lack of training.

I can think of one specific thing where there was an adolescent patient that came in where I noticed a lot of staff members were struggling with misgendering this patient. And so I went up to my supervisor to figure out if we can develop a plan of, "What should we do when staff misgender this patient?" Because it's going to happen, and it's going to happen in a group setting. Can we make sure that other staff are comfortable being like, "Hey, actually, their pronouns are XYZ"?"

These efforts could also translate into developing programs for staff on LGBTQ+ affirmative care, as Molly added:

“And here, [at my current practicum setting] I'm doing a bunch of stuff, but we're working on doing a hospital-wide training for staff and clinicians and psychiatrists on competence working with LGBTQ+ folks. The early trainings will be specifically about new pronoun policies, but also developing empathy, and why this knowledge and education is important.”
In line with this account, participants described working to incorporate didactics on LGBTQ+ mental health in their courses and training settings out of a desire to ensure LGBTQ+ clients received accessible, adequate, and affirming care. Likewise, participants described intentionally utilizing presentations and class discussions to engage peers on LGBTQ+ concerns. Bianca described how an affirming classroom setting allowed her to initiate these discussions:

“Just having more open discussion about these issues [was helpful]. I feel like there were times in my classes where I would get a little bit preachy about [LGBTQ+ issues] and people would be annoyed, honestly. But in those environments and with those professors it was welcome.”

Similarly, Daniela elaborated:

“If there's a course that needed me to present on something, I would always try to relate it to how can I educate my peers, and how can this relate to the LGBTQ community?... So I feel very strongly that in my graduate training there's been a lack ... even though it’s increasing in sensitivity and understanding of the importance of knowing these things, it’s still not giving the attention, that it warrants.”

As these excerpts illustrate, improving the accessibility of training on LGBTQ+ affirmative care, through class discussion and trainings, was seen as a way of filling in the gaps for peers and colleagues and thus contributing to a more affirming experience for LGBTQ+ clients seeking mental health services. This theme was also apparent in participants’ use of queer identity and lived experience to challenge misconceptions and share information with peers on LGBTQ+ identities. Lisa, a returning student and mid-career social worker, described taking on this role in her experience of attending LGBTQ+ trainings:
“Obviously, all of the work I've done with the LGBT community, including all of my trainings that have related to that, whether I'm going to a diversity training or an LGBTQ-specific training, because I need to know what the clinicians are being trained on, and what they're being told... So when there is misinformation, I can help to perpetuate positive education.”

In this sense, participants were able to be representation ‘in the room’ when LGBTQ+ identities were discussed in training settings. In some instances, as Lisa shares, participants described embracing this role as an opportunity to positively impact and counter heterosexism in training contexts.

Similarly, supervisory and peer relationships were framed as opportunities to engage in productive discussions on this front, if these parties were perceived by trainees to be receptive. Adelaide discussed her use of self while supervising a younger trainee who expressed discomfort in working with LGBTQ+ clients:

“So I definitely told her on our first supervision "Yeah. And I'm bisexual, so" because I think it's important to her development if she wants to be a therapist, she's going to have to work some of these things. She's very, open-minded. She's like, "Yeah. I want to learn to work with this population. I know it's something I need to do." So when I disclosed that, I almost felt optimistic about it I think because part of me is like, "The best thing for her is to work with a queer supervisor on this...maybe what she needs is a close mentor who's queer.”

Here, Adelaide demonstrates how participants could use the roles available to them as trainees to model affirmative practices and create spaces where new trainees could be supported in developing LGBTQ+ competencies.

Participants also expressed a desire to create or contribute to affirming spaces for LGBTQ+ trainees and clinicians. Participants described implementing, maintaining, and participating in
LGBTQ+ affirmative programming to varying degrees within the context of their training programs. For example, Scott provided an account of his efforts to create a space specific to queer trainees and allies in his program:

“I started, as part of the [LGBTQ+ student organization] last semester, [peer processing groups] because I figured... it would be lovely to have that format exclusively for LGBT clinicians and training or allies... And when I floated the idea to several people across cohorts, everyone was like, "Yes. This is such a great idea. I want to come. Let's do it."... So I went through the entire process of starting this group up and no one came to the meetings...So that's been my experience. Trying to create the space to give support and then no one taking advantage of that for whatever reasons which is totally fine. I understand. We're all busy. I hope someone will try to take that up some other time."

As Scott articulates, one challenge in this area appeared to be logistical barriers to access; overall, participants tended to describe difficulty attending or consistently holding events due to graduate school schedules. When this programming was successful, however, having a “space” for queer trainees could be particularly impactful. Leah expressed the reparative experience of such a space, after implementing an online community that connected queer and allied students and alumni:

“I felt like we were underground, and how nice to be a part of this community now. How nice to be loud about it and have a space. A lot of people have said like, "I'm looking forward to discussing the intersection of my own identity and the world of psychology."

So it's not just about-- it is about working with queer clients, but it can also be about being queer yourself. And I feel like that was something-- that feels big to me, to have that space. ”
This excerpt underscores both the significance and rarity of ‘having a space’ in which the experiences of queer trainees are centered and openly discussed. While these endeavors were often framed as fulfilling and an outlet to channel frustration, it appears that they could also become a source of stress as trainees’ attempt to balance them with the demands of graduate school. It was observed that the impetus for these supports was largely student-led, with much of the initiative coming from the bottom up. As Leah describes:

“I think leading the [LGBTQ+ Student organization] has really helped me with that cognitive dissonance of like, "I'm not learning enough about how to support people in my own community"... of course being so busy, I haven't been able to do as much as I've wanted to. And then I get into a cycle of like, "Well, we don't have enough LGBTQ things because you didn't do them." And then I go to a place of, "Well, it shouldn't be on me." I'm so glad that I've been able to do that, but it shouldn't be that if I'm too busy, we don't have didactics and talks...it shouldn't be that if a student is too busy, it doesn't happen.”

Here, Leah describes this work as rewarding but difficult to sustain. As seen here, in describing their experience of implementing or interacting with these supports, participants questioned whether these programs are sustainable without broader program support, as existence of these student-led supports was described as ebbing and flowing based on student availability.

Generally, training contexts were described as providing encouragement but less often structural or practical support for individual students engaging in efforts outside of standard expectations and programming. Additionally, the absence of LGBTQ+-identified or specializing faculty in some instances meant that desires for mentorship or guidance were often unmet in
student led programs. Daniela discussed this perceived gap in investment between trainees and their training contexts:

“Still it highlights the fact that the younger generation or at least those who are in training are the ones who are spearheading this, which is really exciting, and those who are more seasoned, who have been in the field a little bit longer—not that they're less on board but more so just don't have that understanding and can't really provide that sort of support in the same way, which I get. And I still I wish there is more push for it...

I think that if the student-run groups had like an identifiable one or two-- a psychologist or staff or professor or advisor, what have you, who was also spearheading that group, I think it would make a stronger impact not only within our program, but I think that this is something that can be implemented in other programs where there is-- I guess you could say there is more power of being like higher up, right, like this. As students, you only have so much say. There's only so much we could do. And I wish there was just like more active support from professors and staff to really get involved.”

This excerpt highlights the limitations of trainees self-initiated efforts to create affirmative spaces for queer trainees from the “bottom up” and trainees’ perceptions of their training contexts relying solely on queer trainee initiatives to provide these supports. Overall, these efforts tended to be marked by a conflict between managing graduate school stressors, including those specific to queer students, and pushing to expand the scope of supports offered by their training programs through taking on additional projects. While participants generally found using the agency available to them to improve their training environment to be reparative, they also acknowledged that the scope and impact of these efforts was often dependent on how receptive their environment was to these changes and the supports provided.
Summary of Relationships between Themes

The following section summarizes the inter-domain and intra-domain relationships between the eight themes found in the analysis. A visual representation of the relationships between the eight themes is provided in Figures (Figure 2).

Personal Meaning and Use of Lived Experience

Within the domain of Experiences with LGBTQ+ Clients, the themes of Personal Meaning and Investment and Use of Lived Experience appear to mutually influence one another. Shared lived experience between queer trainees and clients lends personal meaning and creates an investment in working with LGBTQ+ clients for trainees. In particular, trainees’ awareness of heterosexism and personal experiences moving through the world as queer people drive a sense of connection and desire to create an affirming space for LGBTQ+ clients within the context of therapy. In tandem, trainees draw from lived experience in their interventions to create this safety, normalize milestones, validate experiences of heterosexism, and demonstrate an affirmative stance.

Use of Lived Experience and Awareness of Difference

The themes Use of Lived Experience and Awareness of Difference also appear to play complementary roles in trainees’ experiences of working with LGBTQ+ clients. Trainees describe balancing their familiarity with LGBTQ+ experiences and concerns from lived experience with an awareness of difference, both between themselves and their clients, as well as within LGBTQ+ communities broadly. Trainees describe navigating dynamics of sameness and
difference in terms of the applicability and limits of lived experience when working with LGBTQ+ clients.

**Ambiguity of Visibility and Disclosure and Sense of Internal Struggle**

Themes within the domain of the Intersection of Queer and Professional Identity overlapped substantially, with Ambiguity of Visibility and Disclosure appearing to contribute to Sense of Internal Struggle. Visibility and Disclosure were common sites of internal struggle for clients given the often ‘hidden’ nature of queer identity due to heterocentric assumptions, taboos against personal disclosure and avoidance of discussing therapist sexuality in the training environment, leaving trainees uncertain how to broach (or name their discomfort around) disclosure of therapist queer identity.

**Use of Lived Experience and Ambiguity of Visibility and Disclosure**

The theme of Ambiguity of Visibility and Disclosure also intersected with the theme of Use of Lived Experience. Trainees’ use of lived experience in their work contribute to their perceived visibility as ‘queer’ when working with LGBTQ+ clients. Trainees’ lived experiences and queer aspects of identity tended to more present in work with LGBTQ+ clients due to its relevance, with trainees describing that they often felt they had come out indirectly to LGBTQ+ clients in order to create safety or normalize their experiences. This indirect disclosure could at times create an ambiguous space in which trainees were not entirely certain if clients were aware of their shared minority identity.
**Use of Lived Experience, Personal Meaning and Investment, and Sense of Internal Struggle**

The themes of Use of Lived Experience and Personal Meaning and Investment overlap with Sense of Internal Struggle. While shared lived experience and investment were generally perceived as positive aspects of trainees’ work with LGBTQ+ clients, shared painful or challenging experiences between trainee and client could have a personal impact on trainees, contributing to a sense of internal struggle. Due to the client-focused nature of therapy, this often manifested as a private, personal struggle where the personal or private self was impacted by an experience with a client in the context of the therapist self or role. Supervision, when experienced as affirming and safe, was described as an important outlet for processing these reactions outside of therapy.

**Peripheral Nature of LGBTQ+ Training and Absence of Support, Use of Lived Experience and Awareness of Difference**

In the domain of Experiences of the Training Environment, trainees’ experiences of the Peripheral Nature of LGBTQ+ Training and Absence of Support were linked to the themes of Use of Lived Experience and Awareness of Difference in their work with LGBTQ+ clients. Trainees described encountering the limits of using lived experience to fill in training gaps when working with LGBTQ+ populations and generally expressed a desire for training that addressed difference and intersectionality in LGBTQ+ communities.
Peripheral Nature of LGBTQ+ Training and Absence of Support and Sense of Internal Struggle

The theme of Peripheral Nature of LGBTQ+ Training and Absence of Support and the theme of Sense of Internal Struggle were also related in trainees’ accounts. Absence of support and limited training on LGBTQ+ identities appeared to contribute to trainees’ sense of internal struggle; the training environment was often described as failing to address the challenges that trainees encountered in working with LGBTQ+ clients. The heterocentric focus of training contexts was often experienced as exacerbating trainees’ sense of internal struggle, particularly when trainees were not able to access outlets in the training environment capable of helping them process these concerns; this appeared to create a context in which the experience of these training challenges remained largely internal and where training challenges were likely to be personalized rather than normalized.

Peripheral Nature of LGBTQ+ Training and Absence of Support and Ambiguity of Visibility and Disclosure

The themes of Peripheral Nature of LGBTQ+ Training and Absence of Support also intersected with the theme of Ambiguity of Visibility and Disclosure. In trainees’ accounts, the absence of open discussion of therapist LGBTQ+ identity and mixed expectations around personal disclosure for trainees often heightened the ambiguity around visibility and disclosure when working with LGBTQ+ clients, as trainees struggled with the appropriateness and clinical utility of disclosure.
*Experiences of Heterosexism, Sense of Internal Struggle and Ambiguity of Visibility and Disclosure*

The theme of Experiences of Heterosexism also intersected with the theme of Sense of Internal Struggle. Trainee’s experiences of heterosexism within their training contexts were often portrayed as a source of internal struggle. Client-directed microaggressions often also applied to trainees, which was often not picked up on by colleagues and supervisors or directly addressed by trainees. Additionally, client-directed microaggressions or experiences of witnessing LGBTQ+ clients encounter heterosexism in their training contexts tended to be distressing to trainees, possibly due to trainees’ personal awareness of the impact of heterosexism as well as their desire to create therapy as an affirming space (Deep Personal Meaning and Investment).

These themes were also linked to Ambiguity of Visibility and Disclosure. Trainees’ experiences of heterosexism appeared to contribute to an experience of safety and affirmation in their training environments as contextual; this resulted in a subset of trainees (3 of the 8) struggling with whether or how to disclose their queer identity to supervisors and colleagues in their training contexts. This appeared to be particularly true for bisexual/pansexual trainees, who tended to express concerns around stigma or being perceived as unprofessional and described engaging in impression management in their training contexts to this end.

*Peripheral Nature of LGBTQ+ Training and Absence of Support, Experiences of Heterosexism and Self-initiated Efforts to Improve the Training Environment*

Within the domain of Experiences of the Training Environment, the themes of Peripheral Nature of LGBTQ+ Training and Absence of Support and Experiences of Heterosexism were interwoven with the theme of Self-Initiated Efforts to Improve the Training Environment.
Trainees reported finding alternate avenues to fill in training gaps, seeking out LGBTQ+ affirmative practicums and supervisors in order to address their training needs in working with LGBTQ+ clients. Additionally, trainees described advocating for LGBTQ+ clients in their training settings and engaging in an educator-advocate role. Trainees also described developing and/or participating in self-initiated programming and supports for queer trainees, such as student support groups, in response to the absence of support for queer trainees’ needs and the experiences of heterosexism encountered in their training contexts. Trainees engaged in developing programming and supports described these efforts as bottom-up endeavors with limited support from their training programs.

**Discussion**

The present study sought to understand how queer mental health trainees experience working with LGBTQ+ clients and navigate related challenges in their training environments. While attention has increasingly been paid to developing LGBTQ+ competencies at the graduate level, the experience of queer mental health trainees with regards to working with LGBTQ+ clients has largely remained a ‘black box’ in the literature. Additionally, inquiries into the experiences of queer mental health trainees in their training contexts, and the extent to which training programs meet trainee needs around working with LGBTQ+ clients, have been scarce.

The findings of this study indicate that queer trainees experience distinct dynamics in their work with LGBTQ+ clients, based in shared minority identity. Trainees derive personal meaning from their work with LGBTQ+ clients and are invested in creating therapy as an affirming space for LGBTQ+ people. This analysis indicates that queer trainees use lived experiences and contextual knowledge of queer communities in their work with LGBTQ+
TRAINING WHILE QUEER

clients. However, trainees also demonstrate an awareness of differences in experience among LGBTQ+ people.

Furthermore, these results support that queer trainees experience distinct challenges with LGBTQ+ clients and in the training environment, related to queer identity. Several areas related to queer identity, including ambiguity of visibility and disclosure, shared experiences, and experiences of heterosexism, emerged as potential challenges for queer trainees. Identity-based training challenges often manifested as an internal struggle for queer trainees, due to the absence of direct discussion of therapist sexuality, taboos around disclosure, and often a scarcity of outlets to process these concerns.

With regards to the training environment, these results suggest that training around LGBTQ+ identities is experienced as peripheral and limited by queer trainees. Trainees described an absence of support and guidance for queer trainees, especially around LGBTQ+ competencies. The majority of trainees also described experiences of heterosexism within their training contexts. Notably, in response to these concerns, trainee described engaging in self-initiated efforts to access more in-depth training and improve their training environments.

Queer Trainee Experiences with LGBTQ+ Clients

By centering the experiences of queer trainees, this analysis highlights how therapist-client relationships with LGBTQ+ clients are often experientially different for queer trainees due to shared minority identity. These findings underscore how trainees’ experiences, identifications and social locations (and the extent to which these overlap or differ from their clients) impact the qualitative experience of ‘doing therapy.’ These factors also shape the dynamics that can emerge within the therapeutic relationship. For queer trainees, these salient features may center around trainee experiences and understandings, both general and personal, of queer identity and
heterosexism, and how these overlap with or are disparate from client experiences. Visibility and disclosure of therapist queer identity and the relationship of queer identity to other intersecting identities between client and therapist also appear to be implicated in shaping queer trainees’ experiences of working with LGBTQ+ clients.

The distinct qualitative features articulated by participants corroborate that many of the documented experiences of queer therapists are also experienced in some form by queer trainees. This suggests that these challenges, and possibly the development of frameworks for negotiating them, begin in training. In the domain of Experiences with LGBTQ+ Clients, participants’ narratives around deriving deep personal meaning and connection from shared experience with LGBTQ+ clients mirror similar findings for early and later-career queer-identified therapists (Pearlman 1996; Porter, Hulbert-Williams, & Chadwick 2015). For example, Porter et al. (2015) found that gay male therapists expressed a desire “to compensate for negative experiences which the gay therapist had ‘insiders knowledge’ about, by creating a therapeutic space which could be more productive for the client to reach self-actualization” (p. 13).

More broadly, these findings also parallel the sense of intimacy, awareness of structural oppression, and sensitivity to lived context described in other studies of therapists who share minority identities with their clients (Goode-Cross & Grim, 2016; Porter et al., 2015). These results further support that the dynamics that can emerge when therapist and client share a minority identity are often qualitatively distinct in a manner often overlooked by approaches to training competencies with specific marginalized populations (Goode-Cross & Grim, 2016). For queer trainees working with LGBTQ+ clients, a sense of unspoken understanding and shared experience as ‘outsiders to heteronormativity’ are often present in the room. Despite the expanding diversity of mental health trainees recruited into training programs, these nuances of
relating as queer people in the context of therapeutic relationship and therapist-client identification as minorities, within a majority culture, are not discussed in extant training models for developing competencies with LGBTQ+ clients.

With experience, and guidance where available, these differences also appear to lend themselves to unique clinical strengths in working with LGBTQ+ clients. The salience of lived experience and personal significance that queer trainees describe in working with LGBTQ+ clients create unique opportunities for use-of-self interventions that normalize LGBTQ+ experiences, model self-acceptance and can counter internalized stigma (Glassgold & Iasenza, 1995). Trainee’s experiential accounts of their personal relationship to LGBTQ+ identities, communities and understandings of queer identity external to the clinical training environment demonstrate how this can be a different space to gain LGBTQ+ competency from, resulting in distinct training needs. Trainees’ often intuitive use of lived experience also highlights the importance of culture and awareness of systemic oppression in contextualizing client experiences, a context which is often not provided within training environments (Ali & Sichel, 2014).

Interestingly, the desire to construct therapy as a refuge, particularly for younger and or otherwise vulnerable LGBTQ+ clients connects with ideas about community resilience, namely the “culture of survival and resilience” present in many queer communities (Parmenter, Galliher, & Maughan, 2020, p. 1032). This suggests that queer modes of relating and cultural solidarity may influence how queer trainees and therapists conceptualize therapy with LGBTQ+ clients and develop ‘insider’ interventions.

The salience of lived experience and awareness of difference on the part of queer trainees indicate that, while trainees do not approach learning about LGBTQ+ communities and concerns
as outsiders, they also do not arrive to their training programs with fully-formed LGBTQ+ competencies. Lived experiences differ among queer people, particularly the diverse identities housed under the LGBTQ+ umbrella. The learning curve and challenges described by trainees indicates that having salient lived experience is not necessarily the same as knowing how to translate this lived experience into clinical interventions (Shipherd, 2015). In considering the training needs of queer trainees, it is important to acknowledge that trainees may be at different stages of identity development and have differing levels of exposure to queer communities. Additionally, trainees hold different levels of privilege in terms of their intersecting identities, which in turn shape their experiences of queerness.

Notably, the tentative patterns observed among trainee sub-groups in the present study mirror similar findings in the literature for queer therapists, highlighting the importance of recognizing the diversity of LGBTQ+ communities as well as how differential and/or compounded stigmas may generate different challenges for queer trainees. For example, bisexual trainees were more likely to describe experiencing invisibility in their work with LGBTQ+ clients and express concerns about bi-specific stigma in their training contexts consistent with Petford’s findings on the experiences of bisexual therapists (Petford, 2006). Similarly, queer trainees of color more often referenced drawing from their experience with multiple marginalized identities when working with LGBTQ+ clients (Greene, 2007). While the broad scope of this study did not allow for a detailed exploration of these differences, the variability within queer trainees demonstrates the need for inquiries into the diverse needs of queer trainees, particularly those with multiple non-dominant identities.
Identity-based Challenges

In addition to experiencing key qualitative differences in their relationships with LGBTQ+ clients, these results also suggest that queer trainees encounter distinct challenges specifically related to queer identity in their work with LGBTQ+ clients and the surrounding training environment. Foremost among the challenges encountered with queer clients were navigating visibility and disclosure of queer identity and identification around shared difficult experiences between training therapist and client. Coping with heterosexism, the absence of training around LGBTQ+ identities and representation of queer trainee needs, and taking on the responsibility of improving the training environment for queer trainees comprised common challenges for participants in navigating their training contexts.

Disclosure and visibility of queer identity were central in trainee accounts of working with LGBTQ+ clients and navigating clinical settings, in line with many of experiential accounts of queer therapists in the existing literature (Gabriel & Monaco, 2000; Kronner & Northcut, 2015; McPherson, 2020). The current study suggests that messaging around disclosure in training contexts has an impact on queer trainees’ understandings of the appropriateness of disclosing queer identity. Specifically, the absence of direct discussion of therapist queer identity, particularly in the context of working with LGBTQ+ clients, and mixed messaging around the appropriateness of self-disclosure of trainees appears to translate to an understanding of direct disclosure of therapist queer identity as (perceived to be) inappropriate, taboo or implicitly discouraged by training contexts.

Given the historic framing of queer identity as pathological, shameful or perverse, both in the dominant discourse and mental health fields, it is worth considering what meta message this communicates to queer trainees (Bidell, 2016). It is possible that unexamined bias, stigma, and
TRAINING WHILE QUEER

messaging around disclosure in the training environment intersect such that queer identity (or the therapist having an explicit sexual orientation) is implicitly associated with sexual inappropriateness or boundary violations. The relative silence around disclosure for queer trainees may also be tied to a general avoidance of discussing sex and sexuality documented within mental health training programs or doing so only in a pathological light (Burnes, Singh, & Witherspoon, 2017).

Discussing queer identity involves acknowledging the therapist as having a ‘sexual orientation’ while the “heterosexual assumption” can persist as an unnamed, taken for granted feature of the training environment (Cole, 2006; Gabriel & Monaco, 2000, p. 163; Lane, 2020). This would be consistent with critiques in the literature around flat understandings of LGBTQ+ identities as primarily ‘sexual orientations.’ This stands in contrast to a more complex view of queer identities as involving romantic/affectional attachments and cultural identifications in addition to sexuality (Godfrey, Haddock, Fisher & Lund 2006; Scrivner, 1997). An alternate, but not mutually exclusive possibility may be that the implicit framing of therapist queer identity as ‘off-limits’ is the result of supervisor and training program discomfort, or lack of familiarity with helping trainees navigate disclosure of queer identity or the dynamics of queer therapist-client relationships. What is outside the comfort zone or competency of the training environment is marked as ‘other’ or ‘controversial,’ despite the existing resources and frameworks around disclosure of queer identity available in the literature.

Regardless of the sources of this absence, the failure of training contexts to address therapist sexuality and frameworks for disclosure appears to create a sort of de-facto ‘don’t ask, don’t tell’ policy within the therapy context for many trainees, foreclosing opportunities to develop clinically informed frameworks around disclosure as well as a potential basis for
connecting with clients. This avoidance of discussing disclosure may also have consequences for LGBTQ+ clients, with trainees ‘maintaining an artificial distance’ or inadvertently playing into idea of therapy as a heteronormative space (Gabriel & Monaco, 2000). Despite this absence, therapist queer identity remains relevant, informing interventions and communicated indirectly by trainees, furthering the argument that queer trainees need guidance in navigating disclosure of therapist queer identity.

A central component of participants’ experiences was the interiority of emotional experiences, personal reactions, and attempts to reconcile training struggles related to queer identity. This was evident in the domain of Intersection of Queer Identity and Professional Identity where participants described a sense of internal struggle around various unacknowledged identity-based challenges and gaps between their experiences with LGBTQ+ clients and training. On an experiential level, the cognitive-emotional load of managing queer identity and the focus on appropriateness and danger described by trainees parallels phenomenological accounts of queer identity development and internal navigation of heterosexist spaces in the literature (Rosenberg, 2018; Lane, 2020). Internalization and concealment of queer identity, while associated with negative mental health outcomes, is often described as a survival strategy for LGBTQ+ individuals in the literature on queer identity development, particularly in environments that are expected (or have demonstrated themselves to be) inhospitable (Feinstein, Xavier Hall, Dyer & Davila, 2020; Pachankis, 2007; Schmitz & Tyler, 2018). It follows that heterocentrist training environments may be particularly conducive to trainees internalizing training needs and challenges due to the expectation that attempts to address these needs will be unsuccessful at best or result in aversive experiences at worst.
This internal struggle is also informative of how minority stress operates for queer trainees within the contours of the trainee role (Meyer, 2013). Within the training environment, queer trainees appear to navigate both heterocentrism, in the form of absence of support and the peripheral nature of LGBTQ+ training, and heterosexism, in the form of microaggressions in training and supervision. These “every-day” stressors seem to contribute to an erasure of queer trainee needs, an internal sense of struggle and in some contexts, a compromised sense of safety in the training environment (Sue, 2007, p. 271). Microaggressions have been demonstrated as damaging to rapport and safety both within the context of therapy with LGBTQ+ clients and supervision with non-dominant identity supervisees (Constantine & Sue, 2007; Russell & Greenhouse, 1997; Shelton & Delgado-Romero, 2013). It is reasonable to expect that pathologizing messages around LGBTQ+ identities would also impact trainees’ sense of wellbeing and belonging in the training environment. While the literature on queer trainee experiences is limited, Moon (2011) similarly found that queer therapists reflecting on their training described their experiences moving through training environments as often “isolating” or othering (p. 202).

Notably, in the present study, trainees often named experiencing client-directed microaggressions in the context of supervision or training contexts, pointing to the existence of unexamined bias on multiple levels. This indicates that how supervisors talk about and conceptualize queer clients appears to impact what trainees may be willing to share and the perceived safety of processing training needs related to queer-identity in supervision (Russell & Greenhouse, 1997). The impact of pathologizing messages around LGBTQ+ clients on trainees connects with the suggestion that minority stress is based not only in direct experiences of heterosexism but also the expectation of experiencing heterosexism or mistreatment.
TRAINING WHILE QUEER

(Hatzenbuehler, 2009). Considering that those who engage in microaggressions often remain unaware of their impact, it likely that these incidents remain an invisible injury, unless trainees broach them directly (Sue, 2007; Shelton & Delgado-Romero, 2011).

It also is worth considering the broader contextual factors which may contribute to the internal struggle and lack of representation described by participants. One striking feature of participant’s accounts was the description of the peripheral nature of training on LGBTQ+ identities, despite increased attention and demand for competency training in these areas. The relegation of LGBTQ+ issues to the periphery is well established as a common practice in mental health training programs, resulting in lost opportunities for growth for trainees and accessibility to competent care for LGBTQ+ clients (Bidell, 2016; Hope & Chappell, 2015; Moon, 2011). As Moon (2011) notes, “the ‘other’ is often dislocated from the ‘real’ content of the course and made subordinate to more mainstream models,” centering heteronormative experiences as the modal human experience (p. 203).

Significantly, queer trainees’ self-initiated efforts to improve the training environment in response to such challenges appear to be a novel contribution to the literature on queer mental health trainees. These self-initiated efforts present an example of resilience and coping on the part of trainees, at both the individual (seeking alternate avenues for in-depth training) and community (creating programming for queer trainees) levels (Meyer, 2015). This is consistent with findings that LGBTQ+ professionals, in various fields, often take on the burden of making environments more affirmative within the agency their role affords (Eliason, Streed, & Henne, 2018). It is hoped that these findings make the extent of this labor more visible and encourage further structural and material support for such programming in training programs.
The results of this study have a number of theoretical and training implications. With regards to LGBTQ+ competencies, queer trainee accounts are revealing of the implicit assumptions in models of trainee development. Shifting the focus to queer trainee perspectives calls attention to what is lost in the attempt to ‘generalize’ trainee needs, which often involves implicitly centering the needs of dominant identity trainees. In considering the needs of queer trainees with regards to developing LGBTQ+ competencies and navigating their training contexts, the major implications of these findings are two-fold. Firstly, queer trainee experiences and associated training needs, particularly with queer clients, are outside of extant heterocentric training practices and not wholly accounted for by LGBTQ+ competency models that focus on cis-heterosexual trainees. Secondly, heterosexism, hetero-centrism and stigma in training contexts adversely impacts queer trainees’ wellbeing, felt safety, professional development, and in some instances, their work with LGBTQ+ clients.

These findings highlight the value of centering non-dominant identity trainee and therapist perspectives, particularly in acknowledging difference and identity-specific needs among the increasingly diverse body of students entering the mental health fields. In particular, queer trainees’ accounts demonstrate the need for models of LGBTQ+ competency and diversity training that include shared minority-identity experiences between therapist and client (Seward 2007). A tentative model of queer trainee needs might include learning to make use of salient lived experiences in the context of the therapist-client relationship, developing use of self-interventions and personal frameworks for disclosure, and channeling shared experiences and related affects in the service of clinical growth. One example of a training model that centers queer experiences is Singh & Chun’s (2010) QPOC Resilience-Based Model of Supervision. This
model’s emphasis of reflecting on the impact of one’s personal histories of privilege and oppression in supervision as well as referencing past experiences of personal resilience for empowerment and guidance could likely be tailored to the meet needs of queer trainees.

Other models, such as that proposed by Mitchell (2009), emphasize the importance of “unearthing” one’s “own attitudes, including prejudice and limiting beliefs” for all trainees in developing LGBTQ+ competencies (p.13). Similarly, the findings of Godfrey et al. point to the importance of ongoing “self-of-the-therapist” work, which emphasizes “examining one’s own constructions of gender and sexual identity and the origins of these constructions and identities (e.g., family, peer norms, religion)” as well as reflecting on personal bias around LGBTQ+ identities (Godfrey et al., p 500.). These approaches may also be relevant to queer trainees in understanding the potential impact of their own experiences of heterosexism, both external and internal, on working with LGBTQ+ clients. Additionally, these approaches may be well suited to exploring potential bias around difference in LGBTQ+ communities. Engaging in the vulnerability required by this exploration, however, requires sufficient safety and competent supervision. As Goode-Cross and Grimm (2016) asserted in their phenomenological study of black therapist-client dyads, queer trainees also require supervisors who can help them “manage the emotional valance” of shared minority identity and “help them discern between feelings of solidarity and ineffective emotional boundaries” (p. 48).

Centering the dynamics between queer trainees and clients also brings into focus the diversity of experiences among LGBTQ+ people. This diversity demonstrates the need for nuance and understanding of difference in training on affirmative practices, which a ‘zoomed out’ view of LGBTQ+ communities does not provide. While queer trainees made use of their lived experience to make sense of client concerns, they were often most familiar with queer
TRAINING WHILE QUEER

experiences and contexts related to their own identities and communities. Representing the diversity of queer communities in training would provide trainees with opportunities to expand their understandings of queerness beyond their immediate lived experience. This is especially relevant given the distinctions between competencies for working with trans, non-binary and gender non-conforming clients and those for working with cisgender queer clients. Additionally, this approach takes into account the evidence that queer people of color face different intersecting stigmas and may have access to different sources of resilience and support (American Psychological Association, 2015; Meyer, 2010; Singh & dickey, 2016).

Most broadly, the disconnect between queer trainees’ lived experiences and current training practices draws attention to the implications of focusing on dominant identities in both training and our conceptualizations of mental health, healthy sexuality and human experience. It is also particularly revealing of who we assume mental health trainees to be. As Greene (2007) asserts, the tendency to “universalize” human experience, while side-stepping the discomfort of facing difference, reduces therapists’ “awareness of themselves and the clients with whom they work” (p.47). This also appears to be true in considering the diverse needs of mental health trainees. These implications demonstrate the importance of queer representation in the mental fields, in both expanding our understanding of gender and sexuality beyond the heteronormative and interrogating the impact of unexamined norms on LGBTQ+ clients. In expanding training models to meet the needs of non-dominant identity trainees, it is also crucial to remember that no trainee is ‘just queer.’ Trainees present with a multitude of identities, privileged or marginalized, which may impact their experiences with clients (Greene, 2007).

In terms of practical applications, these findings raise several questions: How can we integrate queer trainee experiences into our understanding of developing LGBTQ+ competencies
and trainees’ needs more broadly? How can we make training environments more affirmative for queer trainees and clients? Given the heterocentrist bias in current training approaches, what does it mean to de-center heteronormativity in the training environment? The accounts of affirmative experiences provided by trainees may offer some direction in this regard:

Integrating the perspectives of queer therapists into didactics and training contexts may be one step towards better meeting the needs of queer trainees: this could be accomplished by including the perspectives of queer therapists in coursework, through various media and discussion, organizing speaking panels of queer therapists, and generating similar opportunities to discuss concerns related to disclosure, shared experiences related to queer identity and other identity-based aspects of working with LGBTQ+ clients. Hope and Chappell (2015), in their argument for inclusion of LGBTQ competencies in multicultural training, make the case for both integration and separation of LGBTQ+ training. This would involve integrating LGBTQ+ competencies across coursework as an aspect of multicultural training as well as providing opportunities for more in-depth training with separate courses on LGBTQ+ concerns and affirmative therapies (Hope & Chappell, 2015). It also crucial that LGBTQ+ competency training acknowledges the complexity and diversity of LGBTQ+ identities and communities, which can be accomplished by centering the voices of a diverse range of queer therapists in didactics on working with LGBTQ+ clients.

A related consideration is the importance of queer representation and LGBTQ+-specific expertise among training staff, program faculty and supervisors at clinical placements. Trainee accounts point to a marked need for guidance around queer therapist-client dynamics. Such guidance, modeling, and normalization of challenges can be provided by experienced queer therapists in supervisory or training roles. Supervision emerged as a key space for growth in
trainee narratives, underscoring the necessity for supervisors who can facilitate queer trainees’
growth from a place of experience and provide in-depth training on extant affirmative therapies.

Comparing the experiences of affirmative and non-affirmative training experiences found
in participant accounts, open discussion of sexuality and LGBTQ+ identities, access to
supervisors with LGBTQ+ expertise, and mentorship opportunities with LGBTQ+-identified
therapists stood as key markers of affirmative spaces. Additionally, staff and faculty with
LGBTQ+-specific expertise may play a role in creating and generating programming, with
student input and leadership, while also not relying solely on student efforts. While access to
supervisors and faculty with LGBTQ+ expertise would likely benefit all mental health trainees in
developing these competencies, the presence of openly queer-identified therapists and allies with
expertise crucially provides much needed mirroring and representation for queer trainees. This is
a particular consideration for multiply marginalized queer trainees who are least likely to have
their experiences mirrored or normalized in existing training contexts (Singh & Chun, 2010).

Finally, these findings point to the need for a top-down investment in making training
contexts more explicitly affirming for queer trainees and clients. In addition to supporting
student-led initiatives, there is a current need for developing systems of training, support and
accountability for disseminating accurate information on LGBTQ+ identities and affirmative
practices, as well as interrogating heterocentrist bias and addressing heterosexism in the training
environment. A number of recommendations for defining and measuring competency, such as
those provided by Boroughs, Bedoya, O’Cleirigh, and Safren (2015), have been developed that
may be referenced in this process. Trainee accounts also demonstrate the necessity of instructors
and supervisors to have familiarity with lived queer realities, communities, culture, diversity and
history of oppression in order to contextualize students’ needs and experiences.
TRAINING WHILE QUEER

Creating an explicitly affirming space requires that the value of LGBTQ+ people and experiences, particularly experiences with heterosexism, are acknowledged as a consensual reality rather than being the sole responsibility of students to broach or provide context for. A top-down commitment may also look like staff and faculty playing an active role in facilitating open discussions on sexuality and gender diversity and actively addressing heterosexism in training environments. This may include training contexts investing in affirmative training for staff and supervisors to better support them in these efforts. While certainly not exhaustive, these steps may offer a path to more applicable training for queer therapists, reducing the impact of heterosexist bias in programs on trainees, and a greater commitment to understanding the lived realities of queer clients for all trainees.

Limitations

It is important to acknowledge the limitations of this study in seeking to interpret and apply the above findings. Most notably, the voices of transgender, non-binary, and gender non-conforming trainees are absent from this analysis, due to limitations in scope of recruitment and the nature of purposive sampling. This is a significant limitation that warrants further study in order to more fully represent the experiences of queer trainees. In future endeavors, it will be crucial to evaluate the extent to which recruitment materials are explicitly trans-inclusive and explore accessibility of the mental health training programs to trans and gender-nonconforming applicants. Additionally, the participant demographics comprise a diverse but incomplete cross-section of sexual minority (LGB+) communities. This is likely due in part to the nature of purposive sampling as well as the distribution of queer mental health trainees in the mental health fields. As a result, some sub-groups are better represented than others, such as bi/pan women and white, cisgender identified LGBTQ+ trainees, while others are less present (gay
men, lesbian trainees) or absent (Bi/pan men, trans trainees, lesbian and gay participants of color).

Due to its exploratory nature, this study elected to cast a wide a net, including participants across the LGBTQ+ spectrum as a starting point in understanding the broad commonalities in experiences of queer trainees. Additionally, due to in part to the challenges of recruiting a relatively small population, recruitment was inclusive to a variety of mental health training programs, including doctoral and masters-level degrees in Clinical Psychology, Social Work and Counseling. Through purposive sampling, the study included both doctoral-level Clinical Psychology students and masters-level Social Work students. In analyzing and presenting these results, efforts were made to portray both commonalities and areas of divergence, in line with IPA’s focus on both the nomothetic and idiographic (Smith, Flowers, Larkin, 2009). As a result of these recruitment choices, however, distinctions between different groups may be somewhat obscured by the wide scope. As with many IPA-based studies, generalizability may be also constrained due to the small, purposive, geographically-limited sample of participants and the limited sample of respective training contexts (Smith, Flowers, & Larkin, 2009).

**Future Research Directions**

Given exploratory nature of this study, the present findings generate several openings for further research on the experiences of queer therapists-in-training. Foremost, future research should seek to add the perspectives of transgender, non-binary and gender non-conforming trainees to the dialogue of queer trainee experiences. Further research of the lived experiences of specific sub-identity groupings within the broad and diverse category of queer mental health trainees is recommended to better understand within-community differences and specific needs of queer mental health trainees of various backgrounds and intersecting identities.
While the present study took a broader, ‘bird’s eye view’ of queer trainee experiences due to the dearth of research in this area, it may be useful to conduct more in-depth interviews focused on areas that emerged as salient to queer trainees, such as disclosure, to assist in developing more applicable training models. It may also be relevant to study the impact of factors such as identity development, ‘outness,’ and strength of identification with queer identity on queer trainees’ needs. Finally, further research comparing trainee experiences of training contexts with or without factors that appeared to be markers of affirmation in the present study (i.e. open discussion of sexuality, access to supervisors with LGBTQ+ expertise) is warranted. Gaining a better understanding of these factors will be useful to better assist mental health training programs in prioritizing the training needs and wellbeing of queer trainees.

Conclusion

In summation, the present study sought to better understand the experiences of queer mental health trainees in their work with LGBTQ+ clients and in navigating their training contexts. Trainee experiences manifested in three domains: experiences related to working with LGBTQ+-identified clients, experiences of the training environment, and the intersection of queer identity and professional identity. Themes in the domain of experiences related to working with LGBTQ+ clients included Deep Personal Meaning and Investment, Use of Lived Experience, and Awareness of Difference. Within domain of training environment experiences, themes included the Peripheral Nature of LGBTQ+ Training and Absence of Support, Experiences of Heterosexism, and Self-initiated Efforts to Improve the Training Environment. Finally, themes related to the intersection of queer and professional identity included Ambiguity of Visibility and Disclosure, and Sense of Internal Struggle.
These themes suggest that queer trainees experience qualitative differences in their work with LGBTQ+ clients as well as distinct challenges related to queer-identity in both clinical and training contexts. Recommendations have been provided to better account for the training needs of queer trainees and create more explicitly affirming training contexts. These findings present a call to examine heterocentrist bias in training environments and integrate the perspectives of queer trainees in LGBTQ+ competency training. Ultimately, listening to the perspectives of queer and non-dominant identity trainees within the mental health fields has implications for communicating whose experiences are valued, whose needs are acknowledged, and who is welcome.
Appendices

Appendix A: Semi-structured Interview Schedule

Opening

Thank you for your time and willingness to talk.

For in-person interviews:

Please take a look at the consent form I sent you, which I am going to ask you to fill in and sign. It contains details of how the information will be used and who will be able to read it. I will walk you through the form and make sure that you agree with what is on there. If there is anything you do not understand, then please ask me. (Review consent form with participant). Please take your time to read through the form again and when you’re ready, initial each page and sign.

For video conferencing interviews (researcher has received signed consent form):

Thank you again for sending me your signed consent form prior to this interview. Before we get started, do you have any questions regarding how your information will be used and who will be able to read it?

You may choose to stop the interview at anytime and or elect not to answer certain questions without explanation. If you wish, you can also withdraw your information and remarks from the study after the interview without having to explain why.

For the purpose of this interview, the word queer is used as an umbrella term to refer to a variety of LGBT+ identities. Please let me know if there is there another term that you would prefer me to use.

Do you have any questions before we get started with the interview?
Interview Protocol:

Warm up Questions:

1. To start off the interview, I would like to get to know more about you. This study, as mentioned, focuses on the experiences of queer therapists-in-training. Can you tell me a little bit more about how you identify?

2. Can you tell me a little about your specific interests in the field of psychology/social work/counseling? Do you have a specialty?

3. How long have you been seeing clients? What treatment venues have you worked in?

Opening Question:

1. Can you tell me about your experiences working with LGBTQ+ clients?


Follow Up Question:

2. What are some of the challenges that have come up in your work with this population? Advantages?


Follow Up Question:
3. Are there differences between the way you approach/experience working with LGBTQ+ clients, as opposed to heterosexual/cisgender clients?

Prompts: Topics? Language? Use of self?

**Follow Up Question:**

4. Has the topic of queer identity (i.e. sexual orientation, gender identity) come up in your work with LGBTQ+ clients? How so?

Prompts: Client concerns? Self-disclosure?

**Follow Up Question:**

5. Have your personal experiences been relevant in working with this population? How so?

Prompts: Knowledge of community? Identity? Experiences of being non-heterosexual? Self-disclosure? If not, were shared experiences unhelpful or hard to bring up?

**Follow Up Question:**

6. Have you self-disclosed your queer identity to a client?

Prompts: If so, how did you decide to? If not, why not? What was that experience like? Do you have a policy/decision-making process about self-disclosure?

**Follow Up Question:**
7. What has been your experience of your program's training approach to working with LGBTQ+ clients?


**Follow Up Question:**

8. How would you describe your program's approach to supporting queer students?

Prompts: Resources available? Peers? Supervision? Are there areas where you could use more support?

**Concluding Question:**

9. Is there anything that I missed in this discussion that you would like to add?
Appendix B: Data Analysis Steps with Examples

1. Each transcript is individually analyzed prior to looking for themes across transcripts. This stage involves reading and re-reading of individual transcripts, followed by initial noting of possible patterns with attention to “lived experience” and how participants appear to be “making sense” of their experiences. Individual transcripts are annotated with exploratory comments as seen below:

Analysis Stage 1: Initial Noting of Individual Transcripts

<table>
<thead>
<tr>
<th>Original Transcript</th>
<th>Exploratory Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1: “So it's like this weird closet-- not in the closet. It's like this just minefield that I put myself in. And I'm like, &quot;How do I navigate this space?&quot; But then I'm like, &quot;It doesn't matter.&quot; Ultimately, &quot;It doesn't matter. As long as they don't bring it up, I don't need to bring it up. Unless I decide to bring it up in which case I would probably be bringing it up in a meaningful way that I thought was helpful to the client. So as you can tell, by the way I'm speaking about it, it gets very complicated in my head very quickly.”</td>
<td>Comparison to closet, can queer identity be talked about? Uncertainty about whether it does or does matter Internal experience, decision about disclosure minefield metaphor anxiety? High stakes? Must tread carefully, hard to know how to navigate Struggle, back and forth dialogue “in head”</td>
</tr>
</tbody>
</table>
2. Emergent themes for individual transcripts are identified based on initial noting and researcher’s interpretation of participants’ experiences; these interpretations are supported by and grounded in the data. This step includes chunking transcripts into units of meaning based on themes.

Analysis Stage 2: Developing Emergent Themes by Analyzing Individual Transcripts

<table>
<thead>
<tr>
<th>Emergent Themes</th>
<th>Original Transcript</th>
<th>Exploratory Comments</th>
</tr>
</thead>
</table>
| Internal Conflict/Dialogue?                          | Participant 1: “So it's like this weird closet-- not in the closet. It's like this just minefield that I put myself in. And I'm like, "How do I navigate this space?" But then I'm like, "It doesn't matter." Ultimately, "It doesn't matter. As long as they don't bring it up, I don't need to bring it up."  
  Unless I decide to bring it up in which case I would probably be bringing it up in a meaningful way that I thought was helpful to the client. So as you can tell, by the way I'm speaking about it, it gets very complicated in my head very quickly.” | Comparison to closet, can queer identity be talked about? Uncertainty about whether it does or does matter  
  Internal experience, decision about disclosure minefield metaphor→ anxiety? High stakes? Must tread carefully, hard to know how to navigate  
  Struggle, back and forth dialogue “in head”                                                                 |
| Disclosure as Inner Struggle/Closet?                 |                                                                                                                                                                                                                                                                                                                                                      |                                                                                                          |

Comparison to closet, can queer identity be talked about? Uncertainty about whether it does or does matter  
Internal experience, decision about disclosure minefield metaphor→ anxiety? High stakes? Must tread carefully, hard to know how to navigate  
Struggle, back and forth dialogue “in head”
3. Emergent themes across transcripts are compared for commonalities and overlap. Variations on themes are condensed under super-ordinate themes.

Analysis Stage 3: Looking for patterns in emergent themes across analyzed transcripts

<table>
<thead>
<tr>
<th>Emergent Themes from Participant 1</th>
<th>Emergent Themes from Participant 2</th>
<th>Emergent Themes from Participant 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclosure as Internal Struggle</td>
<td>Use of Shared Experience/Shared Struggles</td>
<td>Deep Personal Meaning/Care</td>
</tr>
<tr>
<td>Indirect Disclosure</td>
<td>Use of Disclosure to Create Safety</td>
<td>Concern about Stigma and Appropriateness of Disclosure</td>
</tr>
<tr>
<td>Visibility as Ambiguous</td>
<td>Managing Assumptions/Being Open to Difference with LGBTQ+ Clients</td>
<td>Indirect Disclosure, Ambiguous Visibility</td>
</tr>
<tr>
<td>Pre-existing Interest, Strong Investment in Working LGBTQ+ Clients</td>
<td>Deep Meaning, Desire to create therapy as Refuge</td>
<td>Struggle around Invisibility/Disclosure</td>
</tr>
<tr>
<td>Desire to create safety with LGBTQ+ Clients</td>
<td>Awareness of Difference among LGBTQ+ Clients</td>
<td>Desire to create therapy as refuge</td>
</tr>
<tr>
<td>Changing/thwarted Expectations of Working LGBTQ+ Clients</td>
<td>Witnessing Heterosexism in the Training Environment</td>
<td>Balancing personal experience and difference with LGBTQ+ Clients</td>
</tr>
<tr>
<td>Use of Personal Experience/Past Selves</td>
<td>LGBTQ+ Training as peripheral</td>
<td>Experiencing Heterosexism in Supervision</td>
</tr>
<tr>
<td>Navigating Sameness and Difference</td>
<td>Absence of Support/Guidance for Queer Trainees</td>
<td>LGBTQ+ training as peripheral, not meeting needs</td>
</tr>
<tr>
<td>Experiencing Microaggressions</td>
<td>Internal Struggle around challenging shared experiences and training doubts</td>
<td>Creating Supports, Spaces for Queer Trainees</td>
</tr>
<tr>
<td>Absence of/Desire for LGBTQ+ Training Experiences</td>
<td>Internal Struggle around experiences of heterosexism</td>
<td>Disclosure of Queer identity as taboo, liability</td>
</tr>
<tr>
<td>Creating/Seeking out Supports and Training Opportunities</td>
<td>Invisibility/Ambiguous Visibility; Mixed messages about Disclosure</td>
<td></td>
</tr>
</tbody>
</table>


4. Emergent themes that are endorsed by at least half of the participants are organized into a cohesive narrative that describes key experiential features of the experience of queer trainees:

**Analysis Stage 4: Master List of Emergent Themes**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Theme</th>
<th>Key Features</th>
<th>Applicable participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiences with LGBTQ+ Clients</td>
<td>Personal Meaning and Investment</td>
<td>Desire to create therapy as refuge</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Personal Meaning based in shared experience</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre-existing Personal Investment</td>
<td></td>
</tr>
<tr>
<td>Use of Lived Experience</td>
<td>Use of Specific First-hand Knowledge of Queer subcultures</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sensitivity to Heterosexism</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of Lived Experience in Interventions with LGBTQ+ Clients</td>
<td></td>
</tr>
<tr>
<td>Awareness of Difference</td>
<td>Awareness of Intersecting Identities and Privilege</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Awareness of Diversity within LGBTQ+ Community and Diversity of LGBTQ+ Experiences</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Balancing Lived Experience with Openness to Difference</td>
<td></td>
</tr>
<tr>
<td>Intersection of Queer and Professional Identity</td>
<td>Ambiguity of Visibility and Disclosure</td>
<td>Ambiguity of Visibility and Disclosure with Clients</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------------------------------------</td>
<td>---------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indirect Disclosure</td>
<td>Disclosure as Taboo</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conflicting Messages around Disclosure</td>
<td></td>
</tr>
<tr>
<td>Sense of Internal Struggle</td>
<td>Uncertainty, discomfort, dissonance around queer-identity specific training challenges</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manifests as anxiety, rumination, self-doubt around visibility and disclosure, difficult shared experiences with clients, experiences of heterosexism</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scarcity of outlets to process, processing in supervision helpful in resolving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiences of the Training Environment</td>
<td>Peripheral Nature of LGBTQ+ Training and Absence of Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Training on LGBTQ+ identities experienced as superficial, peripheral</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Absence of queer therapist perspectives, supports for queer trainees</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Importance of Affirming Spaces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiences of Heterosexism</td>
<td>Experiencing client-directed microaggressions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Exceptions: Bianca                          | 7 of 8                                 |

| Exceptions: Lisa                            | 7 of 8                                 |

| Exceptions: Adelaide and Bianca            | 6 of 8                                 |
| Self-Initiated Efforts to Improve the Training Environment | Seeking out alternate avenues to fill in training gaps  
Educator-advocate role in training contexts  
Creating spaces and programming for queer trainees and to improve LGBTQ+ training | All |
Table 1: Participant Demographics

<table>
<thead>
<tr>
<th>Participant</th>
<th>LGBTQ+ Identity</th>
<th>Ethnicity/Race</th>
<th>Age Range</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1 “Scott”</td>
<td>Gay cisgender male</td>
<td>White</td>
<td>Early 20s</td>
<td>Doctoral-Clinical Psychology</td>
</tr>
<tr>
<td>P2 “Daniela”</td>
<td>Bisexual/Pansexual cisgender female</td>
<td>Latina</td>
<td>Mid 20s</td>
<td>Doctoral-Clinical Psychology</td>
</tr>
<tr>
<td>P3 “Leah”</td>
<td>Bisexual/Pansexual cisgender female</td>
<td>White</td>
<td>Late 20s</td>
<td>Doctoral-Clinical Psychology</td>
</tr>
<tr>
<td>P4 “Bianca”</td>
<td>Queer cisgender female</td>
<td>Afro-Latina</td>
<td>Mid 20s</td>
<td>Doctoral-Clinical/School Psychology</td>
</tr>
<tr>
<td>P5 “Elliot”</td>
<td>Gay cisgender male</td>
<td>White</td>
<td>Early 30s</td>
<td>Doctoral-Clinical Psychology</td>
</tr>
<tr>
<td>P6 “Lisa”</td>
<td>Lesbian cisgender female</td>
<td>White</td>
<td>Early 40s</td>
<td>Masters-Social Work</td>
</tr>
<tr>
<td>P7 “Molly”</td>
<td>Bisexual Cisgender female</td>
<td>White</td>
<td>Late 20s</td>
<td>Masters-Social Work</td>
</tr>
<tr>
<td>P8 “Adelaide”</td>
<td>Bisexual Cisgender female</td>
<td>Asian</td>
<td>Late 20s</td>
<td>Doctoral-Clinical Psychology</td>
</tr>
</tbody>
</table>
Table 2:  

**Cross-Participant Themes**

<table>
<thead>
<tr>
<th>Use of Lived Experience</th>
<th>Awareness of Difference</th>
<th>Deep Personal Meaning and Investment</th>
<th>Ambiguity of Visibility and Disclosure</th>
<th>Sense of Internal Struggle</th>
<th>Peripheral Nature of LGBTQ+ Training and Absence of Support</th>
<th>Experiences of Heterosexism</th>
<th>Self-Initiated Efforts to Improve the Training Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>P2</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>P3</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>P4</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>--</td>
<td>X</td>
<td>X</td>
<td>--</td>
</tr>
<tr>
<td>P5</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>P6</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>--</td>
<td>X</td>
</tr>
<tr>
<td>P7</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>--</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>P8</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
**Figures**

### Experiences with Queer Clients

1. **Deep Personal Meaning and Investment**
   
   "I think that my experiences directly relate to my desire to be a permission giver, a smash of shame."

   "But there was a way with this client where talking about Grindr or talking about PrEP with a certain kind of really attempting to have no stigma, ease, fluency, kind of communicating without telling you kind of something about me. We’re speaking a shared language."

2. **Use of Lived Experience**
   
   "But sometimes, that self-identification piece, specifically in the LGBTQ population is huge. As soon as you have a kid that goes--they feel like nobody understands. And you’ve got to let them know, "Yeah. I clearly understand."

   "I even brought up "I’m wondering if you’re experiencing shame right now... Because I know that that’s something that I struggled with""

3. **Awareness of Difference**
   
   "As a Latina woman, I know that there is a lot of stigma in our community to identify as lesbian or gay or bi or pans because if you come from a religious background, there is that added layer."

   "I mean, I think it’s interesting how just LGBTQ, under one umbrella, we all share something. There is something common to our experiences. But then when it gets down, are the experiences of a white gay man the same as a trans person or a lesbian woman?"

### Intersection of Queer and Professional Identity

1. **Ambiguity of Visibility and Disclosure**
   
   "In my head it’s always this question of does the client actually know that I’m gay?"

   "I can’t speak for all queer therapists, but I can speak for myself and say that I still struggle with coming out to certain people--even like in workspaces"

2. **Sense of Internal Struggle**
   
   "It’s like being closeted, right? Like closeted in your own session room."

   "I think it’s all internalized stuff, on top of being taught that you’re... this idea that I’m supposed to be some sort of blank slate. You know what else it is? I feel like being bisexual is not, in my mind, some way, perceived as professional. I’m sure that comes from a bunch of places. But yeah, there’s a lack of professionalism in it. It’s that same thing as not legitimate."

### Experiences in the Training Environment

1. **Peripheral Nature of LGBTQ+ Training and Absence of Support**
   
   "So there are definitely times where I felt a little bit scared. And I was kind of winging it at times. And kind of just using my own experiences to try to figure things out."

   "It’s really, really difficult and challenging, and I wish that I had more exposure and experience working with the LGBTQ community now at this point of my training and that I had supervisors who could really help me navigate that."

2. **Experiences of Heterosexism in the Training Environment**
   
   "I didn't necessarily feel—safe is such a strong word. But I didn't feel completely safe, as an intern, to be like, “Actually, these are my experiences, and you talking about this as a phase—” Because there is also some unrealistic fears, I think, of me being pathologized by them."

3. **Self-initiated Efforts to Improve Training Environment**
   
   "I think leading the [LGBTQ+ Student organization] has really helped me with that cognitive dissonance of like, "I’m not learning enough about how to support people in my own community.""

*Figure 1. Emergent Themes.*
Figure 2. Model of Theme Relationships.
References


TRAINING WHILE QUEER


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