Psychodynamic Psychotherapy and Same-Sex Sexual Orientation: An Empirical Investigation

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Declaration

I declare that this thesis is my own work and has been generated by me as the result of my own original research. Where I have consulted the published work of others, this is always clearly attributed. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work. I have acknowledged all main sources of support and help. Small portions of this thesis have been published previously as articles in *New Associations*, the British Psychoanalytic Council (BPC) tri-yearly magazine. These include:

- Full, W. (2018). Conversing, not conversion, with same-sex sexualities. *New Associations,* Issue 26: 14.

- Full, W. (2015). Pink on the couch: it's time to think about surveying the relationship between psychoanalysis and homosexuality. *New Associations*, Issue 17: 10.

- Anderson, D. and Full, W. (2015). Queering analysis: sexuality linking group analysis and psychoanalysis. *New Associations*, Issue 17: 4.

Signed:

[Signature removed]

Date: 30/03/2021

Dedication

This thesis is dedicated to three people:

- My husband, Dr Stephen Davies

Thank for all your love, support and patience over the last five years. I will be forever grateful for all the sacrifices you have made so this research could happen. I love you very much.

- My mother-in-law, Megan Davies (21st June 1924–17th January 2020)

Thank you for all the friendship and love you showed me over the years. It was a pleasure having you come to live with us, and we miss you so much. Although you will never see the finished thesis, I know you would approve of the hard work that went into it.

- My therapist, Anna Ioannou

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Abstract

Background. Historically, psychodynamic psychotherapy has pathologised same-sex sexual orientation and excluded lesbian, gay and bisexual (LGB) individuals from training as psychodynamic therapists. A mixed-method study aimed to clarify: (1) how UK psychodynamic therapists working today understood and thought about same-sex sexual orientation both theoretically and clinically; and (2) how the role of institutional psychodynamic training shaped the views and practice of UK psychodynamic psychotherapists working with LGB clients.

Methods. A self-completion clinical attitudes questionnaire was distributed to registrants of the British Psychoanalytic Council (BPC). Questionnaires were sent to 1403 registrants, 287 registrants returned valid responses — a 20% response rate. Descriptive statistics and chi-squared (χ^2) tests were used to examine the quantitative data; open-ended responses were thematically analysed. Using a purposive sampling technique, 36 psychodynamic therapists were interviewed. A Framework Analysis identified ten overarching themes.

Results. The data suggests that, on the whole, psychodynamic therapists are now better informed about the ways in which societal stigma, family rejection, internalised homophobia, anti-LGB discrimination and the 'coming out' process contribute to the anxiety, depression and relationship conflicts reported by LGB clients in therapy. However, the research also indicates that therapists may not be as fully informed about specific aspects of LGB lives and norms as perhaps they could be, particularly in relation to sexual practices and relationship diversity. Many therapists continue to work within a predominantly heteronormative and monosexual understanding of love, relationships and sex. Therapists also showed less understanding of their bisexual clients compared to gay men and lesbians, and transgender emerged as an unexpected area of theoretical and clinical interest to therapists. Therapists continue to overvalue Oedipal, developmental and environmental theories for explaining the 'origins' of same-sex sexual orientation, despite empirical evidence showing that these types of explanations hold very little scientific weight, and that developmental and environmental factors play a negligible role in the development of same-sex sexual orientation. However, psychodynamic concepts about sexuality, such as the Oedipus complex, may still be useful therapeutic ideas for thinking about aspects of sexuality and relating (e.g., thirdness, identification, rivalry/exclusion) so long as they are understood more abstractly and metaphorically and are not assumed by practitioners to be 'scientific' theories of causation or aetiology of non-heterosexuality. The results further show that psychodynamic therapists' clinical work with LGB clients oscillates between good practice in line with existing psychotherapy guidelines for this client group (APA 2012; BACP 2017; and BPS 2019) and practice that is biased, out-dated and potentially harmful. While the majority of therapists participating in the research no longer accept same-sex desire as an indicator of pathology or perversion, such thinking does not appear to be fully reflected in broader professional attitudes or psychodynamic trainings. Many clinical trainings do not appear to adequately cover LGB-specific issues or fully engage with other relevant disciplines (e.g.,

biogenetic studies, biopsychosocial studies, queer theory and social constructionism to name a few). While a few psychodynamic training organisations appear inclusive and are actively addressing issues of diversity and difference, anti-LGB discrimination persists at other training organisations and across the profession more generally. Quantitative analyses revealed some associations between therapists' personal (e.g., gender, sexual orientation and age) and professional (e.g., therapeutic modality, theoretical affiliation) attributes and their theoretical thinking and clinical attitudes towards same-sex sexual orientation (e.g., Jungians were significantly more likely to acknowledge that their theories of same-sex desire needed updating than therapists with a purely psychoanalytic perspective).

Conclusions. In addition to their psychodynamic theories about same-sex sexual orientation, psychodynamic therapists may benefit from being better acquainted with the wider cultural and scientific evidence about sexual orientation that more fully accounts for and reflects LGB sexualities, including the evidence base demonstrating that: (1) sexuality has some biological and genetic basis; and (2) its meaning is inextricably shaped by cultural, social and historical factors. UK psychodynamic training organisations must continue their efforts to create a learning and professional environment that is non-discriminatory to LGB individuals. This may involve a broadening of the psychodynamic curriculum on sexuality and further institutional reform consistent with the BPC equality and non-discrimination polices in this area. The study contributes to knowledge by providing an up-to-date, descriptive analysis of UK psychodynamic therapists' theoretical and clinical thinking about same-sex sexual orientation, consolidating findings from previous empirical attitudes research in this area.

Impact Statement

This research provides a strong evidence base on which the UK psychodynamic psychotherapy profession can reappriase its approach to theory, technique and training in relation to same-sex sexual orientation. The findings may be used to:

1. Identify limitations and gaps in existing psychodynamic teaching provision on sexuality and sexual orientation in order to update this provision to include material that more fully reflects LGB lives.

2. Upskill teaching staff within accredited psychodynamic training organisations who are involved in course delivery or in the supervision of LGB trainees but who may not be fully informed about LGB-specific issues and concerns.

3. Validate and add to existing empirical data used as part of psychodynamically informed clinical practice guidelines for working effectively with LGB clients.

4. Inform continuous professional development (CPD) workshops for psychodynamic therapists who qualified some time ago but may not have been adequately taught about same-sex sexual orientation.

5. Review recruitment practices, candidate selection procedures and general institutional policies at psychodynamic training organisations to ensure they are non-discriminatory to LGB individuals wishing to train and/or who are already qualified as psychodynamic psychotherapists.

6. Provide a sound evidence base on which to challenge prejudice and outdated clinical practice where it continues to exist.

7. Contribute to policy debate and interdisciplinary knowledge exchange with academic institutions as well as with public and governmental bodies that have an academic or policy interest in the area of mental health and gender, sexuality and relationship diversity.

Key audiences for the research include:

1. UK psychodynamic psychotherapy training organisations.

2. UK psychodynamic psychotherapy regulatory bodies with a theoretical, clinical and policy interest in this area such as the British Psychoanalytic Council (BPC), the Council for Psychoanalysis and Jungian Analysis (CPJA), part of the United Kingdom Council for

Psychotherapy (UKCP) and the British Association of Counselling and Psychotherapy (BACP).

3. Psychodynamically – and psychosocially – informed university departments across the UK with stated research interests in sexuality and gender such as the Department of Psychosocial Studies, Birkbeck, University of London.

4. Psychotherapy bodies working directly with LGB clients such as Pink Therapy and the Albany Trust.

5. LGB advocacy bodies with an interest in LGB-specific research such as Stonewall, and other third-sector agencies involved in promoting well-being and mental health services for service users from minority or marginalised backgrounds such as Mind and the Mental Health Foundation (MHF).

6. LGB-specific press and media outlets with remits to cover stories of interest to the LGB community such as *Gay Times* and *The Pink Pap*er.

As part of the public engagement and dissemination plans, the research findings will be tailored for specific audiences and communicated in several formats including:

1. Peer-reviewed journal articles aimed at psychodynamic clinicians, academics and researchers.

2. Presentations for psychodynamic audiences at appropriate conferences and symposia.

3. Teaching materials for students on psychodynamically informed clinical programmes as well as relevant MSc/Doctorate programmes.

4. Thought-leadership papers for academic partners and policy organisations.

5. Policy briefings for relevant government departments and public support agencies.

6. Articles and features to encourage LGB-specific press and news coverage.

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1 Introduction

This chapter sets out: (1) the research questions; (2) the contextual background; (3) the scope of the research; (4) the use of terminology; and (5) the thesis structure.

1.1 Research Questions

Two research questions are at the heart of the study:

1. How do UK psychodynamic psychotherapists understand and conceptualise same-sex sexual orientation both theoretically and clinically?

2. In what ways has psychodynamic training on sexual orientation shaped the views and practice of UK psychodynamic psychotherapists working with lesbian, gay and bisexual (LGB) clients?

1.2 Background and Context

In relation to same-sex sexual orientation, the field of psychodynamic psychotherapy has been historically tainted by a reputation for: (1) pathologisation (reflected in theories which describe same-sex sexual orientation as a mental disorder); (2) conversion therapy[1] (reflected in the use of reparative techniques to 'cure' LGB clients in treatment); and (3) discrimination (reflected in institutional policies that exclude LGB candidates from training as psychodynamic therapists). As an openly gay man who has been in twice-weekly psychodynamic psychotherapy since 2010 and who wishes to train as a psychodynamic psychotherapist in the future, I have always found this historical context deeply troubling. Although my MSc dissertation (Full 2013)[2] found that psychodynamic theory and practice has become less pathologising, I believe the subject remains ripe for empirical investigation and further reappraisal. The timeliness and relevance of my research was confirmed in January 2017 when the issue of conversion therapy, once again, took centre stage in UK therapeutic debate. Several leading UK psychotherapy organisations signed a Memorandum of Understanding (MoU)[3] condemning conversion therapy as unethical, harmful and unsupported by evidence.

Although psychological therapies of all types increasingly articulate affirmative therapeutic approaches for clinical work with LGB clients and although clinical attitudes are changing globally (see American Psychological Association (APA) 2012; British Association for Counselling and Psychotherapy (BACP) 2017; British Psychological Society (BPS) 2019)), there is evidence to suggest that a minority of mental health professionals, including psychodynamic

[1] Conversion (or reparative) therapy is the term for therapy that assumes certain sexual orientations (and genders) are less desirable than others and seeks to change or suppress them on that basis.
[2] My MSc dissertation took the form of an extended literature review examining psychodynamic theories of same-sex sexual orientation with a focus on gay men.
[3] You can read the MoU here (Last accessed: 09.07.2020).

psychotherapists, still try to change the same-sex attraction of LGB clients (Twomey 2003; Smith, Bartlett and King 2004; Cramer et al 2008; Serovich et al 2008; Bartlett, King and Smith 2009; King 2011; Beckstead 2012; Newbigin 2013; Panozzo 2013; Lingiardi, Nardelli and Tripodi 2015). The continuation of such therapy is questionable because it is inconsistent with empirical evidence showing that same-sex sexual attraction cannot be altered through therapeutic means (APA 2009). Furthermore, several studies demonstrate that such therapies are damaging to mental health and often increase levels of shame, guilt, depression and even suicide amongst LGB clients exposed to them (Haldeman 2002; Shidlo and Schroeder 2002; Smith, Bartlett and King 2004).

Given the evidence that a minority of mental health professionals continue to use reparative techniques in clinical practice with LGB clients, it is reasonable to ask: how far has the field of psychodynamic psychotherapy actually 'moved on' theoretically and clinically? The research aims to clarify the theoretical and clinical models used by UK psychodynamic clinicians working with LGB clients in a variety of settings, including in private practice, the NHS and the third sector. The research questions whether therapists' current theoretical and clinical approaches are fit for purpose or require updating.[4] Additionally, the research examines the role of psychodynamic training programmes in preparing trainees for clinical work with LGB clients as well as for creating professional and learning environments where sexuality and sexual orientation may be discussed openly and without censure. The British Psychoanalytic Council (BPC)[5] and its Task Group on Gender, Sexuality and Relationship Diversity (GSRD)[6] supported the research.[7]

1.3 Scope of the Study

In order to keep the research manageable, the study's primary focus is on psychodynamic therapists' theoretical models and clinical practices with LGB clients (i.e., people who experience sexual attraction to the same sex or both sexes). The study does not explicitly set out to address: (1) transgender; (2) other genders such as non-binary or gender fluid; (3) other sexual orientations such as heterosexuality or asexuality; or (4) relationship diversity such as kink, BDSM or polyamory. However, research participants often reflected on wider issues linked to gender, sexuality and relationship diversity (GSRD). Where research participants shared wider reflections, I have reported these as part of the results. Also, the study does not explicitly examine

[4] This can be determined by comparing my research data with the research-based guidelines that already exist for the psychotherapy and counselling professions outlining best practice for clinical work with LGB clients (APA 2012; BACP 2017; BPS 2019).

[5] The British Psychoanalytic Council (BPC) is a professional association, representing and regulating the profession of psychoanalytic and psychodynamic psychotherapy in the UK. The organisation is itself made up of 14 member institutions, which are training institutions, professional associations in their own right and accrediting bodies. Individual psychoanalytic and psychodynamic psychotherapists are members of these organisations and are 'registrants' of the BPC. See: https://www.bpc.org.uk

[6] The Task Group on Gender, Sexuality and Relationship Diversity (GSRD) was set up in 2014 and tasked with developing policies and interventions to make the UK psychodynamic psychotherapy profession more accessible to individuals who are LGB and who wish to train, are training and who train others in psychodynamically informed practice.

[7] BPC support included disseminating and promoting the research to all BPC registrants and encouraging BPC registrants to participate in the research. The Task Group acted as an informal forum for the researcher to discuss the research with interested and supportive psychodynamic colleagues. While members of the Task Group offered advice and critical feedback on questionnaire development, there was no BPC involvement in the data analysis or interpretation of results. A Partnership Agreement with the BPC was created in 2015, clearly setting out the BPC involvement in the research project. This is discussed fully in chapter three. The BPC did not provide any financial support.

intersectionality,[8] although intersectional issues were occasionally raised by research participants. The study focuses on the perspectives of psychodynamic therapists: data was not collected from LGB clients who are or have been in psychodynamic psychotherapy. The thesis, then, only presents one side of the story.

1.4 Use of Terminology

I wish to clarify the terminology in the thesis. As ideas in the field of sexuality and gender have grown and expanded over the last few decades, so have the definitions and terms used by specialists. Debates about correct terminology are not resolved and disagreements continue, so it is anticipated that terminology will continue to evolve and transform.

As the results chapters demonstrate, many of my research participants struggled to separate broader issues, such as gender and relationship diversity, from their reflections on sexuality and same-sex sexual orientation. In hindsight, my research study may have benefitted from a wider focus addressing what is now increasingly referred to as Gender, Sexuality and Relationship Diversity (GSRD). I only became aware of this more appropriate and inclusive term in July 2019. In their recent guidelines, the British Psychological Society (BPS) defines GSRD as encompassing:

> people…who do not identify as heterosexual, monogamous or cisgender (a cisgender person is a person who is content to remain the gender they were assigned at birth). This includes lesbian, gay, bisexual and transgender (LGBT) people. However, it also includes people who: identify as asexual (do not or rarely experience sexual attraction); engage in BDSM (bondage and discipline, dominance and submission, and sadomasochism); are agender (have no gender); have a non-binary gender (have a gender other than male or female); are pansexual (have attraction irrespective of gender); and many other groups… The identities and practices considered here [in these guidelines] are not in themselves pathological and are part of human diversity. (BPS 2019, p. 4)

While the BPS term is more reflective of the research participants' concerns and interests as described in the results chapters, it is not without its limitations. In some respects, it seems counter-intuitive to separate heterosexual, monosexual and cisgender from the other sexual, gender and relationship identities outlined in the above definition: surely heterosexual, monosexual and cisgender identities are part of human diversity too? Ultimately, I opted to retain the original definitions I used during the research design stages in 2015. For the purpose of this thesis, I predominantly use definitions from the American Psychological Association (APA)'s Guidelines for Psychological Practice with Lesbian, Gay and Bisexual Clients (2012).

[8] Intersectionality relates to how a person's experience of their sexual orientation intersects with other aspects of their identity such as gender, race, class, disability, cultural background, faith, age etc.

In these guidelines*, sexual orientation* refers to:

> the sex of those to whom one is sexually and romantically attracted. Categories of sexual orientation typically have included attraction to members of one's own sex (gay men or lesbians), attraction to members of the other sex (heterosexuals) and attraction to members of both sexes (bisexuals). While these categories continue to be widely used, research has suggested that sexual orientation does not always appear in such definable categories and instead occurs on a continuum… In addition, some research indicates that sexual orientation is fluid for some people; this may be especially true for women. (APA 2012, p. 11).

Sex refers to:

> a person's biological status and is typically categorized as male, female, or intersex (i.e., atypical combinations of features that usually distinguish male from female). There are a number of indicators of biological sex, including sex chromosomes, gonads, internal reproductive organs and external genitalia. (APA 201, p. 11)

Where possible, I aim to avoid using the term *homosexuality.* This is because the term was often used pejoratively within psychiatric, medical and clinical settings during the twentieth century. Furthermore, very few LGB people today, including myself, would use the term *homosexual* to describe themselves (Clarke et al 2016). I use the term *same-sex sexual orientation* to refer specifically to sexual and/or romantic attraction to someone of the same sex as oneself and the term is intended to be inclusive of lesbian, gay and bisexual individuals. The terms *same-sex desire* or *same-sex sexuality* are used occasionally to add variety to the reporting. When referring solely to gay men, I use the term *gay male sexuality* rather than *male homosexuality*. Similarly, when referring solely to lesbians, I use the term *lesbianism* rather than *female homosexuality*. However, I acknowledge that the term *gay* on its own may refer to both men and women who are sexually and romantically attracted to people of the same sex (Richards and Barker 2013).

As mentioned earlier, my research participants often discussed sexual orientation in connection with broader issues, particularly gender and gender identity. For consistency, I will use APA definitions when referring to *gender* and *gender identity* in the thesis.

In the APA guidelines*, gender* refers to:

> the attitudes, feelings, and behaviours that a given culture associates with a person's biological sex. Behaviour that is compatible with cultural expectations is referred to as gender-normative; behaviours that are viewed as incompatible with these expectations constitute gender non-conformity. (APA 2012, p. 11)

Gender identity refers to:

> one's sense of oneself as male, female, or transgender. When one's gender identity and biological sex are not congruent, the individual may identify as transsexual or as another transgender category. (APA 2012, p. 11)

Where possible, I have also opted to use the term *client* instead of *patient.* The psychodynamic psychotherapy profession has historically pathologised same-sex sexual orientation, so the term *patient* evokes notions of illness and implies a medical model. Although more corporate and consumerist in tone, the term *client* is preferable as it does not have any medical connotations and implies choice and agency. The term *client* suggests a mutual agreement between the LGB individual seeking therapy and the therapist delivering that therapy.

The terms *psychodynamic psychotherapist* and *psychodynamic psychotherapy* are used to cover the main BPC categories of registrants, including Psychoanalyst, Psychoanalytic Psychotherapist, Psychodynamic Psychotherapist or Counsellor, and Jungian Analyst or Analytical Psychologist. Both terms are used to refer to clinical work with adults, children, adolescents, couples, families, groups and organisations as well as clinical work of different frequencies or intensities. Although I realise that my use of the terms *psychodynamic psychotherapist* and *psychodynamic psychotherapy* may not recognise the full range of BPC members' clinical practice and training, I needed an umbrella term to simplify the reporting. The terms *clinician*, *practitioner* and *professional* are occasionally used to add variety. These terms are meant to be inclusive and to cover all individuals working within the profession regardless of their specific modality.

When I cite research participants or quote important passages by other theorists, it is important to note that I use the terms these individuals themselves employ. These terms may differ substantially from my own preferred use of language as outlined in this section.

1.5 Thesis Overview

The thesis adheres to the presentational conventions of IMRaD (Introduction – Method – Results – and – Discussion), the established format for structuring empirical theses and papers in the social sciences. Chapter one introduces the reader to the research questions and provides relevant background information. The study's scope is presented, and I have, as far as possible, clarified key terminology.

Chapter two provides an overview of psychodynamic and non-psychodynamic literature in relation to same-sex sexual orientation. As the literature on this subject is extensive and growing, the review is necessarily selective. Attention is limited to major theorists whose contributions remain relevant today or are of historical importance as well as to the main theoretical, clinical and interdisciplinary debates. Freudian theories of sexuality are the mandatory starting point. The review then covers classical and contemporary psychodynamic perspectives on gay male

sexuality, lesbianism and bisexuality. The review also briefly addresses some Lacanian and Jungian ideas and concepts, scientific research (e.g., twin studies, neuroanatomical studies and evolutionary theory) and psychosocial perspectives (e.g., social constructionism, queer theory and bisexuality studies). There is a review of key debates in relation to clinical work with LGB clients, including whether LGB therapists should self-disclosure their own sexual orientation to their LGB clients and transference and countertransference dynamics. There is also a brief overview of some of the conflicts and dilemmas facing LGB trainees and qualified therapists within psychodynamic training organisations.

Chapter three outlines the research methodology and methods. Underpinned by a pragmatic philosophy, the research study adopts a mixed-method design. Delivered within a cross-sectional time frame, my two-part study consists of a self-completion attitudes questionnaire and 36 semi-structured interviews. The questionnaire was distributed to all BPC registrants, providing a clear and objective sampling frame. In order to obtain a broad range of views, I used a primarily purposive sampling strategy for the semi-structured interviews. Both the questionnaire and interviews were thoroughly piloted. I used the Statistical Package for Social Sciences (SPSS) to analyse questionnaire data. Descriptive statistics and chi-squared (χ^2) analyses of cross tabulations were undertaken to examine the quantitative data, which was mostly categorical. Qualitative data from the open-ended responses were thematically analysed. Data analysis of the semi-structured interviews involved the use of the software package, NVivo. A five-staged Framework Analysis identified ten overarching themes. The questionnaire demonstrated a high level of validity and reliability with a close fit between its component parts. The interview data were quality assured to ensure rigour and transparency. The study meets robust ethical standards with attention focused on informed consent, confidentiality, partnership working, data ownership and researcher reflexivity.

Chapter four presents the results of the self-completion clinical attitudes questionnaire. It reports data relating to: (1) respondents' personal demographics (e.g., gender, age and sexual orientation); (2) respondents' professional demographics including current training status (e.g., trainee, qualified), workplace setting (e.g., private, NHS), training organisation (e.g., British Psychotherapy Foundation, British Psychoanalytical Society), therapeutic modality (e.g., Jungian Analyst, Psychoanalyst) and theoretical affiliation (e.g., Kleinian, Relational); (3) theoretical questions covering clinicians' theoretical assumptions about same-sex sexual orientation; (4) clinical questions covering respondents' perspectives on specific aspects of clinical practice with LGB clients (e.g., conversion therapy, LGB therapists' self-disclosure of their own sexual orientation, transference and countertransference dynamics); (5) training and institutional issues including attitudes within training organisations towards LGB trainees and colleagues. Results from chi-squared (χ^2) analyses are reported: some associations are found between respondents' personal and professional attributes and their therapeutic and professional attitudes. On the whole, the questionnaire findings are best viewed as generating questions to be clarified in the interview study.

Chapter five presents the ten overarching themes identified from a Framework Analysis of 36 interviews undertaken with psychodynamic psychotherapists. The interviewees describe the psychodynamic and non-psychodynamic theories they find useful for understanding and thinking about same-sex sexualities. Also, interviewees outline their thoughts about working clinically with LGB clients (e.g., clinical issues they consider unique or specific to the LGB community, similarities and differences they perceive in their clinical practice with lesbians, gay men and bisexuals, reflections on how clinical work differs between LGB and non-LGB clients). Finally, interviewees describe the training they received on sexuality and sexual orientation and their training organisations' attitudes towards LGB colleagues and trainees.

Chapter six revisits the research questions and offers some provisional answers. The chapter begins with a reflection on the research participants before reviewing the strengths and limitations of my methodology and methods. I then present and discuss 16 main findings from the research, integrating data from the questionnaire with insights from the interviews. In order to assess where my results fit within the wider field, I compare and contrast the results with the theoretical, clinical and interdisciplinary literature examined earlier in the thesis. I then reflect on and discuss the findings more broadly: my own understanding of the findings and their implications for the profession. I consider what the findings tell us about the current state of thinking about sexuality within the profession and the role played by institutional psychodynamic training in shaping this thinking. This chapter ends by setting out the study's contribution to knowledge and highlighting potential directions for future research. Some brief concluding remarks are made.

Throughout the thesis, I have included cross references so the reader can quickly refer back to previous sections or to relevant tables, charts and figures.

2 Literature Review

This chapter provides an overview of psychodynamic and related literature on same-sex sexual orientation. The chapter does not aim to be comprehensive but rather offers a representative sampling of the main theoretical, clinical and interdisciplinary debates. My intention is to provide a descriptive survey of how the main schools of thought represented within the BPC membership conceptualise sexuality and sexual orientation. Because of their representative presence in the BPC population, the review covers ideas from the Freudian/contemporary Freudian, Kleinian/contemporary Kleinian and Independent traditions in addition to ideas from the Lacanian, Jungian/post-Jungian, relational and self-psychological traditions. I begin the review with Freud because his theoretical formulations about sexuality, and indeed gender, are the basis of all future theoretical formulations whether these confirm and extend Freud's initial insights or revise, reformulate or reject them. I then move on to address theories of same-sex sexual orientation more specifically. Since contemporary psychodynamic perspectives (1980s onwards) often build on or critique classical psychodynamic perspectives (pre-1980s),[9] I present both periods of thought throughout the chapter and adopt a thematic approach. This combined historical and thematic approach traces how psychodynamic thought on same-sex sexual orientation has shifted over time. My literature search strategy is outlined in Appendix A (see below).

2.1 Freud's Theories of Sexuality

Freud theorised extensively about sexuality but did not consider his theoretical propositions about sexuality to be definitive. The primacy of sexuality in Freud's formulation of psychoanalysis and the unconscious is evident throughout his work. This section will examine some of Freud's main ideas about sexuality.

Infantile Sexuality and Psychosexual Development

In the *Three Essays on the Theory of Sexuality*, Freud (1905a) expounds his theory of infantile sexuality. Freud (ibid.) proposes that sexual impulses are present from childhood and widens the concept of sexuality to cover more than just genital intercourse between a male and a female. Freud's proposition of an infantile sexuality challenged the accepted wisdom of his time that sexuality was something restricted to adulthood or only served the purposes of reproduction. As Knafo and Lo Bosco (2020, p.73) indicate, the idea of sexuality beginning in early infancy is simply assumed today but in Freud's time, this idea would have been shocking and in sharp conflict with Victorian sensibilities. For Freud (1905a), sexuality could be understood more broadly: the possibilities for sexual pleasure and gratification could be diffused across the entire body (and

[9] I designate psychodynamic theories from the 1980s onwards as 'contemporary' because it was from this period that LGB therapists became more visible within the profession and began to challenge the (mostly) pathological bias of previous psychodynamic theorising of same-sex sexual orientation. Social and cultural attitudes were also changing at that time. Interdisciplinary perspectives (e.g., psychosocial) and scientific research (e.g., biogenetic studies) on sexuality and sexual orientation also become more prominent from the 1980s onwards.

not just concentrated in the genitals) and could be expressed in a wide range of activities and behaviours. Central to Freud's conceptualisation of infantile sexuality was the concept of psychosexual development. Freud (1905a) viewed psychosexual development as a series of libidinal phases through which a child's sexuality progresses. Each libidinal phase - the oral phase, the sadistic-anal phase and the genital phase - is biologically determined and corresponds to the primacy of particular erotogenic zones. However, as Quinodoz (2005) indicates, Freud did not arrive at a fully-fledged understanding of psychosexual development but rather continued to update and develop his thinking in this area with new observations and conjectures. Roughly speaking, Freud (1905a) presented the oral phase as lasting from birth to two years and relating to the bodily function of obtaining nourishment. Pleasure in this phase is linked to the mouth and lips and is attained through thumb sucking, suckling and biting. Freud (ibid.) understood the sadistic-anal phase as lasting between two and four years and relating to the bodily function of defecation. Pleasure in this phase is linked to the anus and achieved through the evacuation or retention of faeces. The genital stage, according to Freud (ibid.), lasts between four and seven years and is linked to the function of urination, which Freud perceives as an inherent source of pleasurable sensation and as a precursor to orgasm. During this phase, sexual curiosity is awakened, the genitals become the sexual focus and the child begins to masturbate.

Contemporary theorists, such as Quinodoz (2005) and Craib (2001), note that Freud did not view the psychosexual phases as distinct and linear but rather as overlapping. Due to excessive frustration or excessive gratification, Freud (1905a) suggested that the libido or sexual drive could become fixated at particular stages of psychosexual development. Furthermore, Freud (ibid.) observed that the child's preoccupation with specific erotogenic zones never fully ceased but rather persisted and could be discerned in adult sexuality. Oral impulses, for example, might express themselves in adult sexual practices such as fellatio, cunnilingus and anilingus as well as in erotic kissing and licking. As Craib (2001, p. 49) states:

> They [the stages] are there all the time, although perhaps at different times one is more dominant than the other, and they return in different disguises throughout life.

Other theorists, such as Fonagy and Target (2003), have argued that psychodynamic models for understanding infantile sexuality and psychosexual development have become much more complex and nuanced than Freud's initial formulations and have criticised empirical studies that link character pathology to the specific psychosexual phases proposed by Freud. Craib (2001) shares this view, highlighting the ways in which theorists since Freud, such as Erikson, have presented a more sophisticated understanding of each of Freud's stages (i.e., the oral phase as a negotiation for the child between basic trust or mistrust, and the anal phase as the child's struggle between autonomy and shame). Other commentators, such as Quindeau (2013), have extended the idea of the erotogenic zones to include the skin. According to Quindeau (ibid.), children can derive immense pleasure from touching and being touched, caressing and being caressed, rocking and being rocked, and washing and being washed. Post-Freudian practitioners, such as Quinodoz (2005), have defended Freud against claims of pan-sexualism (i.e., he

perceived human behaviour as being ultimately motivated by sex), while simultaneously valuing the important role Freud placed on sexuality in his model of the mind.

Polymorphous Perversity

Freud (1905a) postulated that sexuality was largely disorganised and fragmented. As Dimen and Goldner (2012, p. 142) indicate, for Freud, sexuality 'arrived in pieces rather than all at once and comprised three innate but initially disparate elements: drive, aim and object.' According to Freud's model, the sexual drive derives from a somatic source and is experienced as a non-specific pressure or tension that pushes for bodily discharge. For Freud (ibid.), the sexual drive did not have an inborn aim (i.e., reproduction) or object (i.e., someone of the opposite sex) but rather had multiple aims and could direct itself at variable objects. Freud (ibid.) also posited that the sexual drive could be divided into a number of component or partial instincts. These component instincts operate independently at first and are connected to the erotogenic zones. Constant interfusion occurs between them as well as alternation between active and passive aims. Before they combine to form mature, genital sexuality, Freud (ibid.) observed that these component instincts frequently appeared as opposing pairs such as scopophilia and exhibitionism, or sadism and masochism. Freud (ibid.) referred to this interplay between drive, aim and object as polymorphous perversity. He considered polymorphously perverse activities to be a universal and defining characteristic of childhood sexuality. For Freud (ibid.), one of the main features of this polymorphously perverse disposition was that it was auto-erotic rather that object related (i.e., the child derived pleasure through recourse to its own body). While many contemporary therapists continue to value the concept of polymorphous perversity, other practitioners have been more critical. According to Richards and Barker (2013), Freud seems to suggest that 'healthy' adult sexual development involves a shift away from an initially polymorphously perverse disposition towards something more fixed and 'resolved' (i.e., the choice of one gender over another as sexual object, typically male or female). This implies that the sexual choices of individuals who identify as bisexual or as sexually fluid (i.e., those who are or can be attracted to multiple genders) are somehow pathological or abnormal.

Childhood Sexual Research

Freud (1905a) proposed that childhood sexual research was another indication of infantile sexuality. At around the ages of three to five years, Freud (ibid.) postulated that the drive to knowledge in children was aroused and that children became preoccupied with sexual matters. For Freud (ibid.), sexual research was a core component of the child's mental life in which impulse, desire and anxiety were inextricably linked. In his case study of Little Hans, for example, Freud (1909a) attempts to provide observational evidence of how the child's sexual curiosity manifests itself. For Freud, one of the main areas of infantile sexual research was related to sexual difference. In the Little Hans case study, Freud (1909a) illustrates how the five-year-old Hans becomes interested in the question of who does and does not have a penis. What is striking to Freud is that there is sufficient case material to suggest that Hans is already aware that girls

do ***not*** have a penis, yet Hans denies this anatomical reality. Although Hans has observed his baby sister's genitalia on several occasions and his play activities with his doll suggest a rudimentary awareness of female genitalia, Hans remains ambiguous about sexual difference. It is clear that, at this stage in Hans' sexual research, the opposition between the sexes is not yet distinguished as male and female; sexual difference is associated instead with possession of a penis or being in a castrated state. Freud uses Hans' inability to integrate his own observations to establish a phallocentric model of sexual difference, where the polarity between the sexes is understood as a matter of possessing or not possessing a penis. Freud's 1905 proposition that children have particular infantile theories about procreation, pregnancy and birth is also illustrated in the Little Hans case study. The case material (Freud 1909a) again appears to affirm Freud's conjectures that children have a deeper interest in sexual processes than imagined. Hans notices his mother's physiological changes during pregnancy and intuits the birth process in a rudimentary way. We learn from Freud (ibid.) that Hans is both aware of and intrigued by his mother's pregnant state. Hans' unconscious procreation fantasies involve boxes and bathtubs, which can be interpreted as representations of where babies are found. Hans equates the heavily laden horse carts in the street with the maternal body weighed down with a baby. Furthermore, Hans has phantasies that babies are born through the anus, associating stools with children. Through the Little Hans case study, Freud (ibid.) highlights the ways in which infantile sexual theories reflect both the rich phantasy life and unconscious sexual organisation of children.

Oedipus Complex

The Oedipus complex occupies a central organising role within Freud's theory of sexuality and can be understood as a constellation of (mostly) conflictual mental processes, phantasies, desires, defences and identifications the child experiences in relation to both parents (Freud 1905a, 1923a, 1923b, 1924, 1925, 1931). In Freud's classical model, the Oedipus complex begins with the perception of castration. In the case of the little boy, he is initially attached to the mother in the pre-Oedipal phase and his libidinal desires are directed solely toward the maternal figure. The little boy views the father as an obstacle to and a rival for the mother's affections and, as his affections for the mother intensify, the little boy's hostility toward the father becomes a murderous wish to get rid of the paternal figure. However, on observation of the female (castrated) genitalia, the little boy begins to fear that the father may 'castrate' him for his incestuous desires towards the mother. As a result, the little boy relinquishes the possibility of the mother as love object and instead develops a masculine identification with the father. In the classical literature, the scenario described here is referred to as the little boy's 'positive' (heterosexual) Oedipus complex. The 'negative' (homosexual) version of the Oedipus complex occurs when the little boy develops an affectionate, feminine attitude toward the father and adopts an antagonistic relationship with the mother. I will discuss the processes underlying the 'negative' version of the male Oedipus complex in more detail below (see subsections on gay male sexuality).

In the case of the little girl, she too is libidinally attached to the mother in the pre-Oedipal phase.

However, on realising she is ‘castrated’, the little girl turns away from and becomes hateful towards the mother because she feels that the mother has inadequately equipped her. The little girl then experiences penis envy and becomes dissatisfied with her own genitals, developing a longing to have the genitals of a male. The little girl’s erotic attention now turns to the father as a result of her disappointment with the mother and she develops a desire to have a baby with the father. Her wish for a baby can be viewed as a form of compensation for a lack of a penis. The little girl’s subsequent rivalry with the mother for the father’s affections helps her establish a feminine identification with the mother. In the classical literature, the scenario described here is the little girl’s ‘positive’ (heterosexual) Oedipus complex. The ‘negative’ (homosexual) version of the Oedipus complex occurs when the little girl retains her affectionate, feminine attitude toward the mother and develops an antagonistic attitude to the father. I will discuss the processes underlying the ‘negative’ version of the female Oedipus complex below (see subsections on lesbianism). In those sections, I will outline how the concepts of female castration and penis envy have been critiqued and reworked by subsequent generations of analysts and thinkers.

Having reviewed several observational, experimental and developmental studies involving young children of roughly Oedipal age, contemporary commentators Fonagy and Target (2003) conclude there is very little empirical evidence to support the Oedipus complex. Coming from a sociological perspective, Craib (2001) questions the universality of Freud’s conception of the Oedipus complex, which he views as being rooted in a Western framework and therefore as assuming a particular form and structure. In other words, Craib understands Freud’s Oedipal model as being ethnocentric. Craib (2001) also criticises Freud’s Oedipal model for its underlying assumptions about and attitudes towards women and non-heterosexuals (these points will be discussed more fully in subsequent subsections). Despite these criticisms, the Oedipus complex remains a foundational concept within psychoanalysis. The enduring value psychodynamic therapists ascribe to the Oedipus complex may be because it represents one of the first detailed attempts to map out and understand the contents of the unconscious and is one of the first models of the mind to emphasise internal psychological motivation over solely external causes of mental events (Auchincloss 2015). The meanings psychodynamic therapists attach to Oedipal theories today are often overdetermined and may be understood in several ways. Therapists may use Oedipal theories to describe: (1) repressed unconscious motivations and phantasies rather than what a person is actually thinking or feeling in an ordinary, conscious sense about their sexuality; (2) one’s psychic reality (e.g., Oedipal content in this instance may be understood as an internal representation or phantasised third space where differences between the sexes, the parental couple and the generations are psychically elaborated) (Britton 1998); and (3) one’s negotiation of inner and outer worlds with Oedipal content representing both externality (i.e., structures of law and society) and internality (i.e., the psychological structures of the mind) (Frosh 2012). Auchincloss and Vaughan (2001) have offered a compelling ‘middle position’ for thinking about the Oedipus complex. They (ibid.) criticise psychodynamic therapists who continue to erroneously conflate specific Oedipal psychodynamics (i.e., unresolved parent-child conflicts in both their psychic and ‘real-life’, external manifestations) with the causation or aetiology of non-heterosexuality. Auchincloss and Vaughan (ibid.) suggest that Oedipal theory is useful for thinking

more abstractly or metaphorically about conflictual or dysfunctional psychodynamics within families or child-parent relationships (e.g., issues of thirdness, rivalry, exclusion), and how these might influence a child's wider personality development, but they are wholly inadequate for explaining the development or 'origins' of same-sex sexual orientation. Auchincloss and Vaughan (ibid.) question whether psychoanalysis even needs a theory to explain same-sex desire.

Psychic Bisexuality

Bisexuality was a central concept within Freudian thought (Freud 1905a, 1905b, 1908, 1909a, 1909b,1918 and 1920). According to Storr (1999, p. 21), bisexuality is 'the mysterious heart of Freudian psychoanalysis' and, for Freud himself, it was 'the mysterious heart of human sexuality.' Freud made 44 references to bisexuality in his published work (Perelberg 2018). The term first appeared in an 1896 letter Freud wrote to his friend and early collaborator, Wilhelm Fliess (ibid., 2018). Despite the close friendship between the two men, a dispute arose over who originated the term 'bisexuality' and, therefore, who had intellectual ownership (Storr 1999; Rapoport 2019). The dispute ultimately led to the dissolution of their friendship and professional partnership. Freud openly admitted that his relationship with Fliess had homoerotic overtones (Rapoport 2019) and that the falling-out was emotionally painful for him. This difficult break-up may partially account for what is widely perceived to be Freud's failure to articulate a fully coherent theory of bisexuality.

Freud's most detailed exposition of bisexuality appeared in his seminal work, *Three Essays on the Theory of Sexuality*, which he continually revisited and expanded during his lifetime (Storr 1999). Freud (1905a) initially understood bisexuality as a combination of maleness and femaleness in a biological and anatomical sense, under the influence of the idiosyncratic ideas of Fliess. Subsequently, Freud (1905b, 1909a, 1918, 1920) developed it as a psychological capacity to identify with the parents of both sexes. He understood these identifications with parental objects as foundational to an individual's sense of their gender identity, and sexual orientation. He regarded femininity and masculinity as entangled with passivity and activity and came to believe that the desire to repudiate a passive position, equated with femininity, was 'bedrock' (i.e., a tendency in everyone). Freud believed that everyone could inhabit the position of either sex, and feel desire for the opposite one, but ultimately in adolescence the matter should be settled by a heterosexual outcome and a gender identification in line with biology. This belief in 'internal bisexuality' as a psychological property was shared by Jung, who developed the notions of 'anima' and 'animus' as the cross gendered aspects of a man and woman's internal world. Perhaps because of this theory of bisexuality as a universal aspect of individual psychology, actual bisexuality as a sexual orientation received very little theoretical development in post-Freudian psychoanalysis (Rapoport 2019).

Freud (1908) also thought that hysterical phantasies and bisexuality were inextricably linked and conjectured that hysterics often played both the active role (as a man) and passive role (as a woman) in their rape phantasies. In all of his major case histories, Freud observed the mobility of identifications, both masculine and feminine, in his patients' material. In the Dora case history

(Freud 1905b), Dora's cough is interpreted as both an identification with her father (i.e., showing sympathy and concern for her sick father) but also with Frau K (i.e., an unconscious phantasy of having oral sex with a woman). In the Little Hans case study (Freud 1909a), Hans identifies with the mother when he demonstrates a strong desire to give birth to babies of his own and identifies with the father when he has phantasies of marrying his mother and possessing a big penis like his father. The Wolf Man (Freud 1918) displays a feminine identification with the mother in the primal scene when he has phantasies about being anally penetrated by the father. The Wolf Man shows a masculine identification with the father through his sadistic tendencies and his cruelty to animals/horses. These alternating identifications, frequently observed in clinical material, confirmed for Freud the centrality of a psychic bisexuality in all human beings.

It is only in his later theorising about the Oedipus complex that Freud (1923a) begins to view bisexuality as a capacity for sexual desire for both sexes. As Heenan-Wolff (2011) points out, Freud gradually formulated what is called the 'complete' Oedipus complex, which allowed the 'positive' and 'negative' versions of the Oedipus complex (discussed earlier) to interact with one another in a dialectical manner, resulting potentially in a bisexual (sexual) orientation. What was important to note, according to Heenan-Wolf (2011, p. 1216), was that Freud did not view a bisexual orientation as 'structurally more pathological than another drive destiny.'

Ultimately, Freud's thinking about bisexuality was not fully resolved and, depending on the context and period of his writing, he either understood bisexuality as something biological/anatomical, psychic/mental or erotic/sexual. Freud made no formal attempt to clarify his position and all three definitions continued to co-exist and overlap in his theories. Towards the end of his career, Freud (1930, p.106) acknowledged that his understanding of bisexuality remained incomplete and was shrouded by 'many obscurities'. However, prominent commentators, such as Perelberg (2018), believe that it was Freud's idea of a universal psychic bisexuality, an interplay between masculine and feminine identifications, that was his most enduring formulation.

Primal Phantasies

Another strand of Freud's theorising about sexuality concerns primal phantasies (Freud 1915; 1918). Primal phantasies are 'typical phantasy structures … which psychoanalysis reveals to be responsible for the organisation of phantasy life' (Laplanche and Pontalis 1973/2006, p. 331). Freud (1918) fully elaborates his thinking about primal phantasies in his case history of the Wolf Man. Through analysis of the Wolf Man's dreams, memories and associations, Freud (ibid.) intuits the existence of three main primal phantasies. The first primal phantasy is organised around what Freud terms the 'primal scene': this is the act of sexual intercourse between the parents which the child often misunderstands to be an act of aggression perpetrated by the father against the mother and/or as anal coitus. Case material suggests to Freud (1918) that the Wolf Man may have observed or overheard his parents having intercourse at an age when he did not have sufficient knowledge about the difference of the sexes and/or the existence of female genitalia. This might explain why the Wolf Man's anal desires were so pronounced and why he had

developed disturbing phantasies of being anally penetrated by the father. The second primal phantasy is that of the 'seduction scene': this is the child's phantasy of having been sexually (and passively) assaulted by an adult in childhood. Freud (1918) speculates from the case material that the Wolf Man may have been seduced either by his sister or his Nanny when he was a child, and/or harboured phantasies that these seductions had actually occurred. The third primal phantasy Freud proposes relates to 'castration', which has already been discussed above in connection with childhood sexual research and the Oedipus complex. The case material suggests to Freud (1918) that the Wolf Man may have been subject to several castration threats when he was growing up and, as a consequence, developed a strong castration anxiety. All three primal phantasies have sexuality at their core. While the primal scene can be understood as a phantasy about parental sexuality and the origins of the individual, the seduction scene and phantasy of castration can be understood as symbolising the origins of sexuality and sexual difference respectively (Perelberg 2005). Central to Freud's theory of 'primal phantasies' is the concept of 'deferred action' or 'nachträglichkeit'. Freud's concept of 'deferred action' implies that primal phantasies which cannot be meaningfully understood at the time they are experienced are later reworked, with new and often traumatic meanings being attributed to them (Perelberg 2005; Quindeau 2013). Freud's primal phantasies highlight that there are aspects of our sexuality that may be disruptive, disturbing and traumatic.

2.2 Gay Male Sexuality: Classical Psychodynamic Perspectives

Attention now turns to Freudian and post-Freudian (classical) theories relating to same-sex sexual orientation. Classical theories of gay male sexuality were mainly based on small samples of individual gay men who were in therapy or who were mentally unwell (Mitchell 2002). The conclusions drawn from these limited samples were often erroneously taken to be representative of the wider gay male population, who were not in treatment or mentally unwell. Furthermore, classical accounts were underpinned by two predominant theoretical biases: (1) adult heterosexuality was normal, non-pathological and the most desirable form of human sexual expression; and (2) same-sex sexual orientation represented developmental arrest caused by early traumas, conflicts or disturbances in family relationships (Drescher 2002, 2008). Classical perspectives on gay male sexuality can be grouped into six main theories.

Theory One: Negative Oedipus Complex

Freud offered three major hypotheses linking gay male sexuality with an unresolved or negative Oedipus complex. In his first hypothesis, Freud (1909) posited that, on discovering the mother was penis-less, some young boys experienced an intense castration anxiety, leading them to withdraw their libidinal interest from the mother and to regress to an earlier, narcissistic form of object relations. In his second hypothesis, Freud (1910) speculated that some young boys developed powerful fixations on the mother and became overly identified with her. These young boys subsequently sought out partners of their own sex who they then aimed to love in the same way their mothers loved them. Freud's third hypothesis (Freud 1918) proposed that, instead of

identifying with the father, some young boys took the paternal figure as their sexual object, regressing to anal eroticism and developing a passive, feminine disposition and/or attitude. The next generation of psychoanalysts interpreted many of the unconscious Oedipal motifs expounded in Freud's three hypotheses (i.e., mother fixation, castration anxiety, passive attitude to the father and regression to anality) as indicative of severe psychopathology when exhibited by gay men in therapy (Gillespie 1956; Glover 1960; Bieber 1962; Ovesey 1969; Limentani 1979).

Theory Two: Pre-Oedipal Conflicts

Klein (1932) proposed that gay male sexuality was pre-Oedipal in origin, emerging in the paranoid-schizoid position and characterised by: (1) part-object relating to the breast-penis; (2) destructive phantasies arising from the failure to achieve the depressive position; and (3) the inability to form whole object relationships. Klein's analyses of infants also indicated to her that infants could harbour cannibalistic phantasies towards the mother's breast and body. Klein speculated that some male infants unconsciously equated the vagina with the mouth and that the vagina could then be perceived in phantasy as a castrating and devouring organ. This could cause some male infants to recoil in terror from the female object, and in adulthood, to exchange the breast for the penis, leading to a same-sex attraction. Klein's conjectures are important to consider as they date the origins of same-sex sexual development much earlier than Freud's Oedipal configurations, and her formulations also imply oral sadism as being characteristic of gay male sexuality. Nunberg (1938) also described same-sex phantasies and activities between men (e.g., fellatio) as representing a displaced oral sadism that was originally directed towards the mother's breast. Nunberg viewed oral sadism in gay male relationships as an expression of unresolved ambivalence towards the mother (or the mother's breast) from infancy. Using clinical material from his own analyses of gay men, Bergler (1944) supported Klein's (1932) conjectures and suggested that gay male sexuality represented a pre-Oedipal fixation on the mother, underpinned by primitive oral impulses and wishes. In Bergler's theorising, gay men suffered from a breast complex, initiated at weaning, and sexual activity between men, such as fellatio, symbolised a form of revenge against the breast or an expression of aggression towards the mother. In a similar vein, Socarides (1968) proposed that deficient mothering in the early oral-symbiotic phase led the male infant to develop an ambivalent and anxious pre-Oedipal attachment to the mother, often resulting in the failure to fully separate from her. Instead, the male infant experienced a suffocating and engulfing sense of merger with the mother. Socarides posited that the infantile desire for fusion partially explained the symptomatology many adult gay men exhibited in therapy, such as excessive separation anxiety, severe ego disturbances and difficulties in differentiating the self from the object.

Theory Three: Perversion

Freud had mixed views about whether same-sex sexual orientation was perverse. In his earliest accounts, Freud (1905a) considered same-sex sexuality to be a deviation in respect of the sexual object and placed it alongside paedophilia and bestiality. Yet, simultaneously, he maintained a

preference for describing same-sex sexuality as an inversion rather than a perversion. In other words, Freud viewed same-sex sexuality as 'a turning inside out' rather than 'a turning away' from what is deemed 'normal' as is implied by the term perversion. Freud (1905a) also claimed that penis-in-vagina (PIV) intercourse was the healthiest and most mature expression of adult sexuality and that any deviation from this, including gay male sexuality and anal eroticism, was a form of perversion. Yet, this claim was at odds with his theory of polymorphous perversity (see subsection above), which posited that the sexual instinct did not have a 'natural' aim (i.e., we do not just have sex to procreate) or a 'natural' object (i.e., we do not necessarily select partners of the opposite sex) (Freud 1905a). Many of the early post-Freudian theorists, however, adhered to the view that gay male sexuality was a perversion. This was because gay male sexuality either: (1) deviated from heterosexual (reproductive) intercourse (Gillespie 1956); (2) retained high levels of pregenitality (i.e., oral, anal and phallic elements) (Balint 1956; Bak 1956); or (3) represented sexualised aggression (Glasser 1979). Limentani (1979) claimed that many of his gay clients exhibited perverse character structures or symptomology, such as psychotic anxieties, dread of mutilation, bizarre acting out, marked identification with the opposite sex and sexual compulsivity.

Theory Four: Narcissism

Gay male sexuality and narcissism were sometimes conflated in classical theory. Freud (1910, 1914) used the term narcissism in two ways: (1) to designate the gay man's preference for a same-sex sexual object (i.e., choosing a partner in one's own image); and (2) to designate a phase of psychosexual development between autoeroticism and object relations (i.e., taking one's own body as the sexual object). With the first definition, Freud contrasted a (homosexual) narcissistic object choice with a (heterosexual) anaclitic object choice. While Freud considered a (homosexual) narcissistic object choice to be less advanced, he did not go as far as saying that it was pathological. With the second definition, Freud made it clear that the phase of narcissism was a normal and necessary stage of everyone's psychosexual development and was not an exclusive phase for gay men. According to Lewes (2009) and Friedman (1988), post-Freudian theory pathologised the link between same-sex desire and narcissism. Since the narcissistic object choices of gay men involved selecting sexual partners who were like the self and not like the other, some post-Freudians argued that same-sex relationships could not be truly object-related. Furthermore, if same-sex impulses could be traced back to an intermediate phase between autoeroticism and object relations, then same-sex desire had to be a borderline state or at least a fixation at the narcissistic stage.

Theory Five: Paranoia

In his Schreber case history, Freud (1911) conjectured that paranoia was the outcome of a complex unconscious process, whereby intolerable same-sex impulses and wishes were negated and projected, resulting in defensive, delusional ideation. Freud proposed a famous equation to capture this process. The intolerable thought, 'I (a man) love him (a man)', is transformed, via reaction formation, into the thought, 'I don't love him, I hate him'. In turn, this thought is converted

into the delusional or projective idea, 'I hate him because he persecutes me'. Many of the early followers corroborated these initial Freudian formulations linking paranoia with same-sex sexuality (Ferenczi 1912; Shackley 1913; Payne 1915; Gardner 1931; Brill 1934). Drawing on Kleinian theory, Thorner (1949) and Rosenfeld (1949) emphasised the persecutory and paranoid phantasies they perceived to pervade same-sex relations between men.

Theory Six: Femininity and Passivity

Classical theory frequently equated gay male sexuality with femininity and passivity. Although Freud (1909, 1910) initially interpreted passive identifications with the mother as evidence of an underlying same-sex desire for the father, he subsequently indicated that the connection between gay male sexuality and femininity/passivity did not always apply. Freud (1920, p. 147) dubbed it 'the mystery of homosexuality', acknowledging that 'masculine' or 'active' men might choose men over women as their sexual objects. Similarly, 'feminine' or 'passive' men might select women over men as their sexual objects. As Freud and the post-Freudians did not have the terminology we use today, they were less equipped to distinguish issues of sexual orientation from gender identity. According to Friedman and Downey (1998), the classical psychodynamic equation passive-feminine-homosexual was, therefore, an inevitable development. Stoller (1968, 1976), a clinician extremely experienced in the variants of sexuality and gender, postulated an initial period of primary femininity for both boys and girls. In Stoller's model, the boy must disidentify with the mother (and with his primary femininity) in order to establish his masculinity and develop a heterosexual orientation.

2.3 Gay Male Sexuality: Contemporary Psychodynamic Perspectives

From the 1980s onwards, psychodynamic theories about gay male sexuality were substantially reformulated in response to several, overlapping social, cultural and scientific developments (Friedman 1986; Friedman and Downey 1998; Drescher 2008). These included: (1) an increase in empirical studies contradicting classical psychodynamic formulations about gay male sexuality (see section 2.8); (2) positive shifts in cultural and societal attitudes after World War 1; (3) decriminalisation of same-sex sexual acts; (4) the rise of LGB political activism from the late 1960s; (5) the gradual de-pathologisation of same-sex sexuality from the early 1970s; (6) increased visibility of openly gay male psychodynamic therapists whose clinical input reshaped psychodynamic models of LGB sexuality; and (7) increased engagement with critical disciplines such as social constructionism and queer theory (see section 2.9). Contemporary psychodynamic perspectives on gay male sexuality may be categorised into four main areas of revised theory.

Revised Theory One: Reformulating Oedipus

Isay (1989), one of the first openly gay psychoanalysts, revises classical Oedipal theory to more accurately reflect the sexual experiences of gay men as they grow up. Isay (ibid.) suggests that for some gay boys, erotic attachment to the father and rivalry with the mother is their primary and 'positive' Oedipus complex rather than their secondary and 'negative' Oedipus complex. For Isay

(ibid.), most gay boys experience same-sex desires and phantasies from an early age and as ego-syntonic. Similarly, Goldsmith (1995, 2001) proposes a non-pathological developmental pathway specific to gay boys. Goldsmith reconceptualises the negative Oedipus complex as the Orestes complex,[10] also indicating that most gay boys' normative experience involves taking the father as the libidinal object and developing antagonistic feelings towards the mother. In a similar vein, Lewes (1998) postulates the existence of a plicate or 'folded' Oedipal configuration for some gay boys, where the father both incites and prohibits same-sex desire. Other theorists reject Oedipal theory, arguing that it has an in-built bias that reinforces conventional gender norms and overvalues heterosexuality (Leavy 1985; Schwarz 1999; Izzard 2006; Barden 2015).

Revised Theory Two: Reconceptualising Masculinity

Contemporary psychodynamic theorists aim to broaden our understanding of what it means to be gay and masculine. Corbett (1993) theorises that both the young gay boy's desire for and identification with the father leads to fluidity between active and passive sexual roles and aims. In Corbett's (1993, p. 345) model, gay male sexuality is a 'differently structured masculinity, not a simulated femininity'. Likewise, Frommer (2000, p. 204) urges psychotherapists to abandon theories that frame gay male sexuality as 'offending gender'. He encourages practitioners to embrace and work with 'non-normative versions of masculinity that incorporate same-sex desire'. In other words, cross-gendered identifications and dispositions are not necessarily incompatible with masculinity and maleness. Referring to the 'bear'[11] sub-culture within the LGB community, Lingiardi (2015) perceives 'bearness' as representing a kind of hypermasculinity as well as a compensation for the effeminacy often associated with gay male sexuality. Blechner (1998) questions the assumption that the receptive partner in anal intercourse between men experiences anal sex as passive or as compromising their sense of masculinity. Guss (2010, p.137) supports Blechner's perspective:

> The wish to be filled, although seemingly passive, can be subjectively experienced as highly active, demanding and even voracious. The conflation of psychological passivity with receptive desire considerably underestimates the complexity of both.

Drawing on queer theory (see section 2.9), Grossman (2002) encourages practitioners to challenge the binary thinking (i.e., masculine/feminine, active/passive) that has previously distorted psychodynamic theories about sexuality and gender. While some gay men may have a predominantly feminine identification and others may have a predominantly masculine identification, queer theory proposes that gay men can experience a fluid range of identifications.

[10] In Greek mythology, Orestes murders his mother to avenge the death of his father, perhaps reflecting the gay boy's sexual conflicts more accurately than the Oedipus myth.
[11] Bear is 'an identity term for a heavy set, often hairy gay man' (Richards and Barker 2013, p. 221). Bears often present an image of rugged masculinity.

Revised Theory Three: Reconsidering Perversion

Contemporary theorists offer alternative narratives for thinking about sexual practices that classically would have been considered perverse. For illustrative purposes, I will focus on cruising[12] and anal sex. Shelby (2002) criticises theories equating cruising with gay male sexuality and sexual compulsivity. First, he points out that cruising occurs in heterosexual contexts too (e.g., straight singles bars, dogging, swingers' parties). Secondly, Shelby suggests that gay men may cruise because they feel a deep sense of *being lost.* Rather than representing a compulsive need for multiple sexual partners, cruising may symbolise an acute desire to connect with, and be found by, another. Often negatively conflated with transgression and disgust, Lynch (2015, p. 144) notes how anal sexuality, like female sexuality, is often viewed by psychodynamic therapists as 'another dark continent'. However, as Guss (2010, p. 125) points out, there are multiple, relational meanings connected with anal sexuality, including 'creativity and destructiveness, ownership and loss, mastery and surrender, tension and relaxation, and that quality most mysterious to many boys and men: interiority.' Denman (2004, p. 184) also describes how anality offers 'a heterosexually structured world a radically different vision of the erotic imagination'.

Revised Theory Four: De-Pathologisation and Natural Variance

Contemporary psychodynamic theorists and researchers have revisited and cite with approval several landmark empirical studies that were largely overlooked by psychodynamic therapists at the time of their publication (Kinsey et al 1948; Ford and Beach 1951; Hooker 1957). These studies from the classical period contested the link between gay male sexuality and psychopathology and provided compelling evidence that gay male sexuality was a natural variation of sexual development. Kinsey et al's (1948) study found that 37% of its total sample of approximately 5,300 male individuals had experienced a same-sex sexual encounter in adolescence or in later life. This finding suggested that same-sex sexual activity and impulses were more common and perhaps less deviant than classical psychodynamic theory claimed. Ford and Beach's (1951) study observed that same-sex sexual behaviour existed in almost all non-human species and was socially sanctioned across many non-Western cultures. Hooker's (1957) study[13] demonstrated that little difference could be detected between the level of pathology found in gay and heterosexual men. Drawing on an extensive range of contemporary research, two recent reports (APA 2009, 2012) conclude that there are few differences between LGB and non-LGB individuals in various measures relating to psychological functioning, cognitive ability and psychological well-being. Where empirical data does identify differences in the mental health of LGB and non-LGB people, both APA reports indicate that these differences can often, but not universally, be associated with the side effects of anti-LGB stigma and discrimination.

[12] In gay contexts, cruising is typically understood as 'looking for sex in public areas, commonly parks and nightclubs.' (Richards and Barker 2013, p. 222)

[13] Hooker's research studied 30 gay males and 30 heterosexual males. She administered three projective tests to both groups, measuring their patterns of thoughts, attitudes and emotions. Two independent experts blindly evaluated the test results. The experts classified two-thirds of the heterosexual men and two-thirds of the gay men in the three highest categories of mental adjustment. These results undermined the perceived wisdom that gay men were less mentally adjusted than heterosexual men.

2.4 Lesbianism: Classical Psychodynamic Perspectives

Compared with gay male sexuality, there are fewer theories about lesbianism in classical psychodynamic literature (O'Connor and Ryan 1993). This is possibly linked to the prevailing attitude in the classical period that female sexuality was a 'dark continent' (Freud 1926). When female sexuality was discussed in the classical literature, it was largely theorised by male therapists and conceptualised from a phallocentric perspective. Additionally, Friedman and Downey (2002) note that before 1990, psychodynamic theories of same-sex desire between women were based on a limited clinical sample of 68 lesbian cases discussed across 21 analytic texts. As with gay male sexuality, the conclusions drawn from these samples were erroneously considered to be representative of the wider lesbian population, who were not seeking treatment or mentally unwell. Classical perspectives on lesbianism may be grouped into four main theories.

Theory One: Masculinity Complex

With the exception of the Dora case history (Freud 1905b), Freud's main theoretical and clinical account addressing lesbianism focused on an 18-year-old woman who, on discovering her mother was pregnant, experienced a deep Oedipal disappointment that it was her mother and not her, who was having the father's baby (Freud 1920). In response to this perceived rejection from the father, the young woman refocused her libidinal interest on the mother, reigniting her infantile fixation on the maternal figure. This, in turn, led the young woman to identify with the father and develop a masculine disposition and attitude. Freud speculated that the young woman suffered from a masculinity complex. As Vaughan (1998) points out, it is extraordinary that this one case history – based on one lesbian patient – became the basic, and mostly unchallenged, template for theorising lesbian desire for the next 60 years. Echoing the ways in which psychodynamic theory conflated gay male sexuality with passivity and femininity, a similar but inverse pattern was discernible in classical accounts of lesbianism: lesbians either acted like men or wished to be like men (Suchet 1995). Similarly, lesbian desire was understood as loving like a man and being active and dominant in the sexual role. Classical theories of lesbianism imposed a gendered split between identification and desire: lesbians could not simultaneously desire a woman and identify as a woman (O'Connor and Ryan 1993; Domenici and Lesser 1995).

Theory Two: Penis Envy

Classical theory also proposed that lesbians experienced an excessive penis envy (Freud 1920; Jones 1927). However, as noted earlier in the chapter, the concept of penis envy did not exclusively relate to lesbian sexual development. Freud (1905a; 1924; 1925; 1931) proposed that, on discovering they were penis-less, all little girls considered themselves castrated and perceived their own genital organs as inferior, resulting in penis envy. In addition to penis envy, Freud suggested that women were generally masochistic, passive, dependent and narcissistic. It is surprising how many of Freud's early female followers (Lampl De Groot 1927, 1933; Deutsch 1925, 1930; Bonaparte 1951) did not question Freud's propositions on female sexuality. We might

speculate that this reflected the general attitude of the period that women were inferior and lacked power in a patriarchally structured society. However, by the early 1930s, several dissenting voices contested Freud's phallocentric bias (Horney 1932, 1933; Klein 1932; Jones 1927, 1932). These dissenters proposed an alternative theory that girls experienced their femininity as primary and innate rather than as a failed masculinity, and that girls also had an intuitive, early knowledge of their genital organs, insides and reproductive capacities. Although Jones (1927) downplayed penis envy as a determining factor in female heterosexual development, he continued to theorise lesbianism as being shaped by penis envy. As late as 1978, Socarides (1978) was still emphasising penis envy in his clinical formulations about lesbian clients.

Theory Three: Oral and Pre-Oedipal Fixation

According to Klein (1932), same-sex desires between women were underpinned by oral anxieties and unconscious phantasies about being devoured and poisoned by the mother. Jones (1927) also emphasised the intensity of oral sadism in lesbian sexuality, arguing that the tongue was a substitute for the penis in sexual acts between women. Similarly, Deutsch (1933) corroborated Jones' conjectures, describing lesbian sexual activities as predominantly oral in nature, with particular attention focused on the role of sucking and biting. Deutsch (ibid.) argued that oral activity was pregenital and, therefore, any oral expressions of sexuality could not be considered mature. In the 1950s, Bergler (1956) also wrote about lesbian sexuality as being infused with oral impulses, discernible in the lesbian sucking on or biting on the female partner's breast. Socarides (1978) described lesbians as being fixated on the pre-Oedipal mother and unable to negotiate the conflicts linked to the phase of separation-individuation. According to Socarides (1978), lesbians became pathologically merged with the pre-Oedipal mother and through their sexual relationships with other women, lesbians sought to recapture the intense symbiotic union at the heart of the pre-Oedipal mother-daughter relationship.

Theory Four: Mental Disorder and Sexual Deviance

As with gay male sexuality, classical accounts theorised lesbianism as a mental disorder or as sexual deviance. Some of the classical theories were quite extreme and can be painful and upsetting to read from a contemporary perspective. According to Bacon (1956), lesbian relationships were a phobic avoidance of heterosexuality and represented a defence against entering the Oedipal phase. Bacon perceived lesbianism as perverse and as a turning away from normal and healthy heterosexual female development. Based on a single case study, Khan (1964) depicted lesbianism as a pathological condition marked by high levels of castration anxiety, excessive penis envy and body-image distortions. Khan speculated that his one and only lesbian client's pathology was linked to unresolved pre-Oedipal conflicts with her depressed, hypochondriacal mother. Similarly, Limentani (1979) proposed that lesbianism was a syndrome underpinned by a severe mother fixation. He further suggested that narcissism, denial and projection were often discernible in lesbian symptomatology. Both McDougall (1964, 1980) and Quinodoz (1989) posited that lesbianism was a borderline condition, neither psychotic nor Oedipal

in structure. McDougall enumerated the severe psychopathology she observed in her lesbian clients, including depersonalisation, bizarre bodily states, deep depression and psychotic rage. Reviewing clinical work with 12 lesbian clients, Siegal (1988) claimed that lesbianism was the result of severe mental illness and she perceived that most of her lesbian patients suffered from disturbing psychiatric problems, such as suicidality, psychosis and confused gender identity.

2.5 Lesbianism: Contemporary Psychodynamic Perspectives

Theories of lesbianism were reformulated in response to the same overlapping social and cultural shifts outlined in the introduction of section 2.3. However, as Dimen (1995) notes, contemporary accounts of female development and lesbianism were additionally informed by three other theoretical developments: (1) a move away from psychosexuality towards relationality, particularly emphasising the mother-daughter relationship; (2) dialogue with feminist thought in all its richness; and (3) an engagement with postmodern ideas challenging conventional accounts of gender and sexuality.[14] As more feminist and lesbian therapists entered the profession, they rejected the masculinist theories of the past, where female sexuality was conceptualised as something in deficit (i.e., women as castrated) and delineated their own model of female sexuality, not defined in relation to men or masculinity. Contemporary psychodynamic perspectives of lesbianism may be categorised into four main areas of revised theory.

Revised Theory One: Phallocentrism Reinterpreted

Although some female analysts writing in the classical period were critical of the phallocentric bias underpinning psychodynamic theories of female sexuality and lesbianism (Horney 1932, 1933), this bias was only directly challenged or critiqued from the 1970s onwards. In her landmark text, *Psychoanalysis and Feminism*, Mitchell (1973) argues that penis envy and female castration are not determined by anatomy but rather are symbolic constructs, signifying the powerlessness, inferiority and inadequacy women endure under patriarchy. As Baraitser (2015a: pp. 151-154) elaborates:

> [Mitchell's] text famously conjoined two bodies of thought and practice, with the aim of seeing what one (psychoanalysis) could bring to the other (feminism) around the question of the persistence of patriarchy… The answer Mitchell found in her reading of Freudian psychoanalysis had to do with the differential management of the Oedipal complex: the unconscious ways that girls and boys come to see themselves as different from one another through their attempts to negotiate their place in relation to a parental couple, operationalised through the threat of castration.

Drawing on Lacanian theory, Verhaeghe (1999) argues that because children negotiate the conflicts around sexual difference at a pre-linguistic stage of their development, they come to

[14] Theories of gay male sexuality have also been shaped, to some extent, by some of these theoretical developments.

understand sexual difference as either being the presence (in the case of boys) or absence (in the case of girls) of a penis. When children subsequently enter the world of language and signifiers, they discover there is no female-specific signifier to represent the female sexual organs. In Verhaeghe's theory, not only does a woman not exist, but female sexuality is unsymbolised. Verhaeghe, like Mitchell, shows how classical psychodynamic concepts, such as penis envy and female castration, can be reworked to offer a new perspective. While Friedman and Downey (2002) suggest that unconscious penis envy may be observed as a transient or mild symptom in clinical practice with female clients, they emphasise that there is no empirical evidence to suggest that penis envy is linked with lesbianism and/or is more common in lesbians. Fonagy and Target (2003) also note that studies investigating penis envy have not found evidence that women view their bodies as any way inferior to men's bodies.

Revised Theory Two: Object Choice Distinct from Gender Identity

The psychodynamic propensity to link gender identity with object choice is problematic for conceptualising lesbianism. Suchet (1995, p. 44) highlights that in psychodynamic theory:

> lesbianism does not refer to a female-to-female connection but rather to a woman (who identifies as a man) having a relationship with another woman (whose identification is never stated). The gender identification of the 'other' woman is assumed to be feminine to fit into the phallocentric view that all 'normal' relationships are heterosexual… thus female homosexuality is merely a distorted heterosexuality… If both lesbians are assumed to be male identified, then female homosexuality would be distorted male homosexuality!

In order to avoid the type of confused thinking Suchet describes here, Burch (1997) proposes that sexuality and gender should be sharply differentiated when theorising about lesbianism. Drawing on her extensive research and clinical experience, Burch argues that, once gender identity is decoupled from object choice, it becomes easier to perceive the classical prejudices equating lesbianism solely with masculinity and to recognise that lesbians are actually capable of expressing all kinds of gender identifications. Once sexuality is not defined in connection with gender, theories about female desire become greatly expanded and richer. For example, theorists such as Chodorow (1994) began to conceive of homosexualities (plural) and heterosexualities (plural): female or lesbian sexuality could be thought of as multiple rather than as monolithic and homogenous. Other examples of this new theoretical possibility could be seen in Fast's (1984) theory relating to a period of gender over-inclusiveness during the phase of separation-individuation. According to Fast (ibid.), this is the phase when little girls identify with both parents' genders before having to renounce gender multiplicity on entering the Oedipal phase. Other theorists (see Dimen and Goldner 2012), however, suggest that pre-Oedipal gender multiplicity is never fully relinquished and can continue to be a rich source of psychic creativity into adulthood. Harris (1991) puts forward the idea of gender as contradiction. She suggests that our sense of

gender is not fixed and immutable, but is fluid and shifting, causing us to sometimes experience our gender as paradoxical and ambiguous.

Another valuable concept is Benjamin's (1991) identification with difference. This is the process whereby the pre-Oedipal girl identifies with the father who, to her, embodies the 'phallic' world of agency, power and autonomy. This identification with difference (i.e., with the opposite gendered parent) does not necessarily signify a 'masculine' or pathological cross-gender identification but rather the little girl's deep desire to be recognised as a separate, independent and individuated person herself, much in the same way as her father appears to be. Benjamin (1998) subsequently develops a broader relational and intersubjective theory of gender. As part of this theory, Benjamin describes how the Oedipus complex may be reconceptualised to allow males and females to experience multiple gender identifications rather than a dichotomous (either male or female) identification. She explains how the capacity for identification with others enhances our ability to recognise and accept otherness and difference. Introducing the term 'complementarity', Benjamin describes a dialectical process whereby opposites (e.g., male/female, masculine/feminine) interact with one another or are held in tension so that a third space or a sense of multiplicity can be experienced.

Revised Theory Three: Oedipal and Pre-Oedipal Dynamics Reconceptualised

Burch (1997) proposes that the Persephone myth[15] offers an alternative developmental framework for thinking about lesbianism. The Persephone myth allows not only the possibility of an intense love and bond between two women (i.e., Persephone and Demeter) but also signifies the struggle between merger and individuation often perceived as being characteristic of lesbian relationships (i.e., Persephone's attempt to resolve the conflict of being separated from Demeter). After reviewing several of the classical developmental accounts of lesbianism, Deutsch (1995) is curious to know why there are so few narratives of young women having Oedipal desires for the mother. Deutsch (ibid., p. 30) rejects the pre-Oedipal dynamics emphasised in many of the classical accounts and instead highlights what she perceives to be the glaring omission in all of them: '… the recognition of the existence of the Oedipal mother who exists as the object of desire for some girls, just as she exists for most boys.' In a similar fashion, Elise (2020) proposes a new theory of female homoerotic desire. Her claim is that, although desire for the mother is a primary experience for both sexes, the mother never fully recognises the girl's same-sex desire for her. Instead of the little girl experiencing lack as a result of penis envy, Elise suggests there is a void resulting from the mother's lack of recognition of the daughter's Oedipal desire. Re-interpreting classical theory, Friedman and Downey (2002, p. 158) consider whether merger and fusion in lesbian relationships can be an enriching, rather than pathological, experience and represent positive aspects of lesbian relationships such as 'intimate connection, mutual engagement, mutual empowerment, empathy and relational authenticity.' O'Connor and Ryan (1993) take the

[15] In Greek mythology, Persephone is the daughter of Zeus and Demeter. She enjoys a close relationship with her mother, Demeter, until she is abducted and raped by Hades. Wanting to retain a relationship with her mother, a peaceful solution is found whereby Persephone spends time both in the underworld with Hades and above ground with her mother.

classical oral theorists to task. They argue that there is more to oral sexual activity than simply oral sadism, such as sucking and biting: oral sexual activity may also include kissing, nibbling and licking. In addition, O'Connor and Ryan do not consider oral sexual activity as an immature component of lesbian sexuality but rather as a healthy part of foreplay and as a legitimate form of sexual pleasure in its own right.

Revised Theory Four: Female Sexuality and Fluidity of Desire

Increasingly, psychodynamic thinking acknowledges that female sexuality and identity may be more fluid and contingent than men's[16] and may alter across the lifespan (Reed 2002). Diamond (2008, p. 3), a specialist researcher and academic in this area, defines sexual fluidity as a:

> situation-dependent flexibility in a women's sexual responsiveness [which] makes it possible for some women to experience desire for both men and women under certain circumstances, regardless of their overall sexual orientation… Women of all sexual orientations may experience variations in their erotic and affectional feelings as they encounter different situations, relationships and life stages.

Auchincloss and Samberg (2012, p. 101) provide some indications of how we might utilise the concept of sexual fluidity in order to understand lesbianism specifically:

> Some lesbians become aware of same-sex attractions in childhood and adolescence and remain lesbian in orientation throughout their lives. Others have satisfying heterosexual relationships in adolescence and early adulthood, developing same-sex interests and lesbian identity in mid- and later adulthood… Some women who become aware of their lesbianism and entered relationships with women in adolescence and young adulthood develop opposite-sex interests later in life and form heterosexual relationships.

Drawing on her clinical work, Golden (1987) supports Auchincloss and Samberg's observation about the diversity of lesbian desire. She distinguishes between primary lesbianism and elective lesbianism. The former alludes to women who experience their same-sex desires as innate, and the latter refers to women who feel they have self-consciously chosen their lesbianism. According to Golden, elective lesbians may vary substantially in how they perceive same-sex desires, some experiencing them as a fixed part of their sexual identity, while others feel them as more dynamic and mobile.

Describing therapy with several women, Kirkpatrick (2002) also teases out this variability in female sexual desire. Her clinical vignettes illustrate that women may experience same-sex and opposite-sex desire independently or simultaneously. Furthermore, sexual desire may attach to particular body shapes or personality styles: these types of attractions also shift over time. Magee

[16] There is evidence that fluidity can also play a significant role in men's sexuality (Savin Williams 2017).

and Miller (1997) echo Kilpatrick's formulations, suggesting that each woman has her own, individual erotic signature, which consists of sexual phantasies, behaviours and practices specific to her and which, like her handwriting, may change shape and form.

2.6 Bisexuality: Shifting Psychodynamic Perspectives

Despite its centrality in classical theory (see section 2.1 above), bisexuality received minimal theoretical development in the decades after Freud and is generally considered under theorised compared to gay male sexuality and lesbianism (Rapoport 2019). As a result of this theoretical neglect, Auchincloss and Samberg (2012, p. 26) point out that bisexuality has become a term 'lacking conceptual clarity'. Smith (2002) identifies at least four ways bisexuality is theorised in psychodynamic thought, including: (1) the existence of maternal and paternal identifications in all individuals; (2) the idea that every sexual object is essentially bisexual; (3) the presence of masculine and feminine traits in all of us; and, finally, (4) actual bisexual (sexual) behaviours. This section will briefly outline some of the key shifts in psychodynamic thinking about bisexuality since Freud.

Several post-Freudian theorists supported Freud's conjectures about bisexuality. Rejecting monosexuality as unnatural, Stekel (1922) agreed with Freud that bisexuality was a universal phenomenon in all human beings. In contrast to Freud, Stekel mostly defined bisexuality as a combination of opposite-sex and same-sex desires (i.e., bisexuality as sexual orientation) rather than as a combination of masculine and feminine identifications (i.e., psychic bisexuality). Stekel, however, viewed same-sex desire as more neurotic than opposite-sex desire. In line with Freudian theory, Winnicott (1971) reformulated the idea of psychic bisexuality, arguing that human beings had both male and female elements. Developmentally, female elements emerged earlier during the phase when the infant was undifferentiated from the mother. Male elements developed when the infant established the capacity for concern and began the process of separation from the mother.

Other post-Freudian theorists vehemently repudiated the idea of bisexuality and posited that there was only a primary, biological heterosexuality (Rado 1940, 1949). In Rado's theory, same-sex desire in adulthood represented a phobic avoidance of opposite-sex desires and was precipitated by inadequate early parenting. Rado argued that all gay men unconsciously retained opposite-sex desires and imitated male-female gender roles in order to create an illusion of heterosexuality. Rather than allow for the possibility of bisexuality, Bieber et al's (1962) research, which involved the study of 106 gay men and 100 non-gay men in psychodynamic treatment, corroborated Rado's proposition of a primary, biological heterosexuality. Any deviation from heterosexuality was labelled 'a pathologic, biosocial, psychosexual adaptation' (ibid., p 220).

More recently, contemporary theorists have attempted to tighten up the definition of bisexuality. Maintaining a distinction between gender identity and sexual orientation, Blechner (2015), for example, argues that the term 'bisexuality' should be reserved solely for describing sexual

attraction to both sexes, while the term 'bigenderism' should be used to refer to individuals who combine male and female identities/identifications. Bisexuality and bigenderism should not be conflated: some people who identify as bigender do not necessarily identify as bisexual. The concept of bigenderism has potential to enrich clinical practice as it opens up the possibility that all clients, regardless of sexual orientation, may express male and female identifications and self-representations during their analysis. Layton (2000) also addressed definitions by arguing that psychodynamic theory is unable to fully conceptualise bisexuality, because it has become too dependent on dualities (e.g., activity and passivity, heterosexuality and homosexuality, masculinity and femininity). Such dualities, via splitting, are defined by what the other is not: someone is heterosexual because they are not homosexual, or someone is feminine because they are not masculine. Layton proposes that, because bisexuality is more ambiguous and does not lend itself easily to dichotomous thinking, theorists have struggled to define its meaning(s) in a thoughtful and nuanced way. Instead of the term bisexuality, Young-Bruehl (2001) proposes that we embrace the concept of multisexuality. According to Young-Bruehl, bisexuality implies a middle point between two polarities whereas multisexuality implies a broad spectrum of sexual variability. Drawing on postmodern theory, Ryan (2002, no page number indicated) seems to agree with this line of reasoning, suggesting that if we challenge the hetero-homo binary, we might think more freely of 'sexualities, or of multisexualities, or multiple non-normative sexualities, with emphases on the supposed pluripotentiality, mutability and fluidity of sexuality.'

Other theorists have offered different conceptualisations of bisexuality. Since the young girl remains emotionally and relationally tied to the mother when she enters the Oedipal phase (and does not automatically switch her attention to the father), Chodorow (1978) proposes that the young girl must initially experience a bisexual Oedipal configuration. This means the young girl may oscillate between same-sex and opposite-sex attractions and develop the capacity for sexual fluidity in her sexual object choices. Reinvigorating the concept of psychic bisexuality, Elise (1998) defines it as an individual's simultaneous ability to *penetrate* and be *penetrated by* the lover's body and mind. In other words, Elise (ibid.) suggests that psychic bisexuality symbolises an unconscious wish *to be* and *to have* both sexes. Ferraro (2003) identifies a link between psychic bisexuality and creativity, conjecturing that our creative capacities rely on a healthy, psychic balance of masculine and feminine elements. Impasses in the creative process result from a temporary disharmony in the bisexual functioning of the mind. David (2018) posits an unconscious bisexualisation process, whereby individuals of either sex can integrate the masculine and the feminine components of sexuality so successfully that they are able to identify with and share the psychosexual experience of someone of the opposite sex.

2.7 Lacan, Jung and the Enigmas of Sexuality

This section examines Lacanian and Jungian thinking on sexuality and sexual development as well as newer perspectives on concepts such as psychosexuality and perversion.

Lacanian Perspectives

Lacan's model of the mind is more structural than developmental (Evans 1996; Homer 2005; Bailly 2009, 2018). Lacan describes three 'registers' that structure the psyche and organise human experience: the Imaginary,[17] the Symbolic[18] and the Real.[19] The Symbolic register is of particular interest to us because Lacan perceives the Symbolic as the register of language. For Lacan, language precedes the subject and forms not only our human identity but, crucially, our sexual subjectivity (Wolff-Bernstein 2012). With his emphasis on language, it is hardly surprising that Lacan's account of human sexuality accentuates the linguistic and symbolic aspects over the biological. While Lacan does not outline a theory of same-sex desire per se, he does explain how our sexual desires are formed and shaped.

Unlike Freud, Lacan postulates that our sexual identity is not determined by identification but by our relationship to the Phallus. In Lacan's theory, the Phallus is not the male genital organ in its anatomical sense (i.e., the penis) but rather the Phallus signifies the unspecified object of the mother's desire (Evans 1996; Homer 2005; Bailly 2009, 2018). The Phallus represents a lack for both boys and girls. From an early age, the child recognises that he or she and the mother are marked by this lack. The child seeks to become the Phallus for the mother but soon accepts that he or she does not have the Phallus and can never be the primary object of the mother's desire (Evans 1996; Homer 2005; Bailly 2009, 2018). The Phallus, then, acts as a linguistic signifier for the child's sense of incompleteness (Horrocks 1997).

Interestingly, as Bailly (2018) and Leader (2010) point out, the initial relationship between child and mother in Lacan's model is triangular rather than dyadic. There are three elements present: the child, the mother and the object of the mother's desire (the Phallus). Bailly (2018, p. 98) notes that the three elements are asymmetrical because 'two are objects in relation to the other and are also subjects, whereas the Phallus is only an object.' This triadic relationship (child-mother-Phallus) only becomes an Oedipal structure when Lacan introduces the Name-of-the-Father or 'the quaternary function' (Bailly 2018, p. 101). The Name-of-the-Father does not refer to the actual person of the father but to a symbolic process. Another linguistic signifier, the Name-of-the-Father acts as a metaphor for authority and prohibition. The Name-of-the-Father impels the child to relinquish the phantasy that he or she can be the object of the mother's desire (Bailly 2009, 2018). The child gradually acknowledges that there is a hypothetical object who has or is the Phallus and fulfils the mother's desires. The Name-of-the-Father ushers in the Oedipus complex and the child becomes symbolically, rather than literally, castrated (Bailly 2009, 2018). The child is forced to recognise that the mother's desire pre-exists and is independent of him or her. As Flanders (2018, p. 66) summarises:

[17] The Imaginary is the realm of images and identifications. It is associated largely with the mirror stage, where the infant recognises his own image in mirror. The infant's identification with the mirror image, however, leads to an alienated sense of self or sense of fragmentation.
[18] The Symbolic is linked to language and contains all that is representable and communicable.
[19] The Real is the order that resists language and contains all that cannot be represented, symbolised or spoken. In a sense, we can think of the Real as being the unknowable.

> In the Lacanian narrative of child development, the individual is grounded as a subject by his or her submission to the Name-of-the-Father, the signifier presented by the mother to the child in a metaphoric process as a substitute for the Phallus, the imaginary object of her desire. [The Name-of-the-Father] separates the baby linguistically and socially from the mother.

Responding to the criticism that Lacan's theory of sexuality prioritises the role of the father, S. Bailly (2018, p. 95) offers a strong refutation:

> For Lacanians, the place of the mother in the development of the human subject is…central… She is the ineffable reality around which and in response to which the psyche of the *parl-être* – the being of speech – in fact the human being, is constituted.

Feminists have criticised Lacan's version of the Oedipus complex because Lacan's use of the concept of the Phallus privileges language associated with the male and therefore is profoundly sexist (Evans 1996). However, some feminists (Mitchell and Rose 1982; Dean and Lane 2001) argue that Lacan's distinction between the Phallus (symbolic) and the penis (anatomical) provides an alternative framework for conceptualising sexuality that divorces desire from the constraints of a biological or anatomical model. Lacan's proposition that sexual and gender identity is linguistically formed and symbolically constituted offers a non-essentialist psychodynamic theory for understanding sexual development.

Lacan's concept of jouissance is also useful when thinking about sexual desire. Although jouissance may be translated as 'enjoyment' or 'pleasure', Leader (2010) argues that, for Lacan, jouissance actually refers to any pleasure or sensation that is too much for one to bear. As Perelberg (2018) elaborates, jouissance does not simply mean 'pleasure', because it is linked to the death drive. Jouissance:

> arises from one's own body, especially the border zones – mouth, anus, genitals, eyes, ears, skin. Anxiety about jouissance is one of being overwhelmed by one's own drives… Jouissance designates an excess of pleasure, a satisfaction that is overwhelming, that brings suffering as a result of a prolonged state of internal excitation, in a mixture of the life and death drives. (Perelberg 2018, p. 29).

In his later work, Lacan offers an account of desire drawing on his concept of jouissance (Evans 1996; Homer 2005). Lacan defines a masculine form of desire based on what he terms phallic jouissance and a feminine form of desire based on an unspeakable 'Other' jouissance (Homer 2005). Phallic jouissance is not masculine in the sense that only men experience it. Phallic jouissance denotes an everyday type of sexual enjoyment that we all experience but which leaves us dissatisfied or wanting more. Similarly, the unspeakable 'Other' jouissance is not feminine because it is only experienced by women. The unspeakable 'Other' jouissance denotes a sexual

enjoyment that is indefinable or is experienced as a self-shattering, unspeakable ecstasy. Lacan's concept of an 'unspeakable 'Other' jouissance has been used by psychoanalysts and queer theorists alike to describe the elusive, queer, excessive and mysterious qualities of sexuality (Bond Stockton 2017; Geldhof and Verhaghe 2017).

Jungian and Post-Jungian Perspectives

Freud's seven-year (1906–1913) friendship and professional collaboration with Jung ended painfully because of theoretical differences between the two men. The main divergence of opinion between Freud and Jung was over whether the libido was equivalent to sexuality, as Freud conjectured, and whether sexuality was the driving force of the psyche. As Denman (2004) notes, Jung viewed libido as a much broader, general concept, representing a form of creative life energy, of which sexuality was only one element.

Although Jung did not theorise substantially about same-sex sexuality, he outlined some basic thoughts on the subject. On the whole, Jung considered same-sex desire to be an indicator of psychological immaturity (Hopcke 1988). Jung's main theory of same-sex desire drew on his concept of contrasexuality.[20] Gay male sexuality resulted from the gay man's overidentification with his anima; lesbianism resulted from the lesbian's overidentification with her animus. Jung also proposed that gay male sexuality developed as the result of: (1) an over-developed mother complex; (2) the projection of the anima onto the father, thus making the father a sexually desirable object; (3) the failure to balance the male and female elements making up the hermaphroditic archetype[21] of the self; and (4) the result of genetic or biological factors (Hopcke 1988). Jung wrote very little about lesbianism. According to Downing (1995, p. 266), Jung acknowledged 'a social function…binding women together for political (one presumes feminist) activity.' Furthermore, Jung accepted the possibility of intimate friendships between women based on tenderness and warmth but not on sexual desire (Downing 1995).

Jung's use of his theory of contrasexuality to explain same-sex desire has been much debated. One of the main criticisms of the theory comes from post-Jungians (Hillman 1985 and Gordon 1993 cited in Kast 2006) who report that, in clinical practice with male and female clients, one can observe both anima and animus figures. In other words, these archetypes are not as gender specific as Jung initially thought. In order for there to be successful individuation, Kast (2006) argues that men and women must do more than simply integrate their anima and animus as Jung originally proposed. Men and women also must work through and process the maternal and parental complexes which further shaped and coloured these archetypes during childhood and

[20] Contrasexuality is the idea that men have an unconscious feminine side (anima) and women have an unconscious masculine side (animus) and that psychological wholeness is achieved through the integration of an individual's contrasexual aspects (Samuels 1986).

[21] The hermaphroditic archetype is not to be conflated the androgyne archetype (described later). According to Garber (1995, p. 208), the hermaphrodite 'presents insignia of maleness and femaleness at once: hermaphroditic figures in classical statuary often display both feminine breasts and a penis. In contrast, the androgyne is usually characterised as indistinguishably masculine and feminine…you can't tell or almost can't tell whether they [androgynous persons] are male or female.'

adolescence. Drawing on a postmodern perspective, McKensie (2006, p. 407) argues that Jung's anima/animus theory is too heteronormative and 'a terrible fit for our time'.

Contemporary post-Jungians draw inspiration from other archetypes for understanding same-sex desire. One example is the androgyne archetype. Singer (1976) emphasises how the androgyne subtly balances masculine and feminine elements creating an impression of gender totality and sexual wholeness. McKensie (2006), however, considers Singer's model too simplistic and unable to fully account for the gender and sexual fluidity we see today. From a psychological point of view, Lingiardi (2002, p. 176) links the androgyne archetype with the idea of a primordial bisexuality while Hopcke (1991) views the androgyne, with its mix of masculine and feminine attributes, as allowing multi-gendered and sexual selves. Hopcke (ibid., p.188) identifies several cultural figures that may represent the androgyne archetype, including '…berdache and eunuch, shaman and pervert, Boy George and Tootsie, Yentl and Gertrude Stein.' Kulkarni (1997, p. 97) is critical of the androgyne archetype and rejects it on the grounds that it remains 'enmeshed in gendered language' and is a 'dualistic and symmetrical' concept.

Other archetypal figures may exemplify same-sex desire. In relation to gay male sexuality, Giaccardi (2015, 2020) brings our attention to the archetype of the double. The double can signify a soul-mate relationship between two men (e.g., Achilles and Patroclus) and represent the potential for love, intimacy and friendship between two males. Rather than sameness indicating pathology or narcissism, the double can be interpreted as an archetype of relatedness and mutuality. In relation to lesbianism, Downing (1995, p. 280) draws our attention to the goddess Artemis who signifies love between women, because she 'shuns the world of men' and has an intimate relationship with the female nymph, Kallisto. Downing (1995, p. 283) also claims Aphrodite not only as a model for lesbian desire but for sexuality in all its guises:

> Aphrodite is the goddess of *all* erotic love, all sensual pleasure, all delight in beauty, a goddess of sexuality…dedicated to mutual enjoyment…whether it be marital or adulterous, heterosexual or homosexual, between men and between women.

New Perspectives on Psychosexuality and Perversion

Laplanche (1995) and Stein (1998, 2008) offer new models for understanding psychosexuality. Laplanche (1995) postulates that an infant's unconscious is formed when it receives and represses 'enigmatic messages' from the mother. These enigmatic messages are unconsciously transmitted to the infant when the mother physically takes care of it: breastfeeding it, nursing it, stroking its skin, fussing over it and satisfying its bodily needs. Through these maternal gestures of care, the mother experiences intense bodily sensations and experiences unconscious 'sexual' phantasies towards the infant. The infant subliminally picks up the mother's phantasies and sensations and undergoes what Laplanche terms a primal seduction.[22] As the infant cannot

[22] Laplanche does not mean abuse or molestation. His conjecture is that all infants will experience this primal seduction as a result of ordinary, everyday maternal care.

decipher these seductive, 'adult' messages, an enigmatic or unknowable dimension of sexuality is elaborated within the infant's psyche and body. As Baraitser (2015b, p. 222) explains:

> The message between adult and child…comes too early for the child to decode. Sexual in its intent, the message is a form of seduction, and not simply a seduction fantasy on the part of the child.

Building on the idea of the enigmatic, Stein outlines two further dimensions of psychosexuality: the poignant and the excessive. Stein (2008, p. 48) suggests that sexuality becomes poignant when one's desire resonates with the desire of someone else or is intensified 'by conscious and unconscious fantasies about oneself and the other, and oneself in the mind of another.' Reminiscent of Lacan's concept of an unspeakable 'Other' jouissance, sexuality becomes excessive when it feels overwhelming, when boundaries are transgressed, when contradictory impulses compete, when there is too much excitement or too much stimulation or, in Stein's (2008, p. 63) own words, when:

> pleasure in pain, pain in pleasure, disgust and fascination, danger and safety, awe and terror intertwine, transform into each other or swallow each other.

Drawing on Laplanche and Stein, as well as on their joint theoretical model of self-development and affect regulation through attachment relationships, Target (2007, 2015) and Fonagy (2008, 2009) outline a new developmental theory of psychosexuality. In schematic terms, both theorists posit that caregivers may not positively affirm a child's active sexual behaviours, such as masturbation, nor adequately mirror the emotions associated with infantile sexual arousal. Rather than stay attuned to the child when it exhibits signs of sexual excitement, the caregiver may turn away or ignore what is going on. While it is accepted that the caregiver responds in this way out of an unconscious respect for the infant's boundaries, this parental non-mirroring of a child's sexual behaviours and feelings may mean that the child never fully symbolises or owns its sexuality. The child may experience sexuality as something inherently unstable or uncontained, leading the child to internalise an excited but alienated sense of its own sexuality.[23] Applying Target's and Fonagy's theory to same-sex desire, Hertzmann (2015) suggests that when the child's emerging same-sex sexual orientation is incongruent with that of the heterosexual parents, the parental response to the child's sexual excitement may be one of disapproval or confusion. If the child then internalises this response, he or she is likely to experience deep shame and internal conflict about their sexuality as they grow up. These theorists articulate a new understanding of sexual subjectivity. When clients, whether LGB or non-LGB, describe aspects of their sexuality that therapists cannot fully understand or imagine, these clients may be expressing enigmatic, poignant, excessive and/or previously unmirrored aspects of their sexuality.

[23] Target and Fonagy do not present this encounter between caregiver and child as pathological but rather as a normal process experienced by all caregivers and children to various degrees.

Other contemporary theorists have tried to rescue clinically useful insights from classical theories of perversion. Wood (2003, 2015), for example, has found value in Glasser's (1979) theory of the 'core complex'.[24] For Wood, the core complex alerts us to the possibility that for some clients, intimacy and relatedness may be experienced as claustrophobic or as dangerous. This fear of intimacy and closeness may be traced back to childhood where the caregiver may have excessively stimulated and seduced the child while, at the same time, neglecting the child's emotional needs. In adulthood, these individuals may oscillate between wanting intimacy and fear of it. In order to ward off fears of being overwhelmed or feelings of merger, these individuals may perhaps make use of sexualisation, dehumanisation or violence when they relate sexually with others. Clinicians may find an understanding of these core complex anxieties useful for understanding the emotional dynamics underpinning the sexuality of some clients in therapy. Harding (2001) also explores core complex anxieties in clinical work with couples. Rather than trying to determine if sex and sexuality are being used perversely in the relationship, an alternative approach may be to consider whether sex and sexuality are being used expressively (i.e., to enhance intimacy and connection) or defensively (i.e., to sexualise aggression). In a similar vein, Dimen (2001) rejects the concept of perversion because, for her, it is built on stigmatising and moral projections to do with a therapist's own 'preferences' or 'tastes'. According to Dimen (2001, p. 827), 'perversion may be defined…as the sex that you [the client] like, and I don't.'

2.8 The Science of Sexuality

Psychodynamic attitudes to scientific research on sexual orientation are mixed. While some psychodynamic therapists frame their understanding of sexual orientation within a wider scientific framework (Friedman and Downey 2002; Denman 2004), other therapists are more circumspect about the scientific data, arguing that such data does not add value to psychodynamic models of sexuality, which are more concerned with psychic reality (Magee and Miller 1997; Cohler and Galatzer-Levy 2000). In each of the sections below, I will consider the current research evidence as well as limitations from several types of scientific studies on sexual orientation. However, it is important to emphasise that inclusion of the scientific literature in this literature review is not intended to dilute the specificity of psychodynamic thinking about sexuality or to revert to a modernised version of a 19th century model based on heredity and social factors, but rather to locate psychodynamic theories about sexuality within a wider, biopsychosocial perspective.

Family Studies

Family studies measure whether traits run in families by comparing rates in families of probands (i.e., people who have the trait) with rates in families of controls (i.e., people who represent the base rate in the general population). In family studies of sexual orientation, the most common methodology involves recruiting gay and heterosexual probands, then interviewing them about

[24] Glasser described this complex as occurring universally in normal development. It begins with the child's wish to merge with an idealised, omnipotently gratifying mother as an early solution to its anxieties about separation and individuation. However, fusion with the mother brings with it the threat of being completely engulfed or annihilated.

their own and their siblings' sexual orientation, and finally, comparing the results (Dawood, Bailey and Martin 2009). Some studies additionally contact the proband's siblings to verify proband accounts. Several of these studies demonstrate that gay men are more likely to: (1) have more older brothers than heterosexual men (the so-called 'birth order effect'); and (2) have more brothers who are also gay (Pillard et al 1981; Pillard and Weinrich 1986; Blanchard and Zucker 1994; Blanchard et al 1995; Bogaert, 2003; Bogaert and Skorska 2011; Vanderlaan et al 2014). Similarly, some studies have indicated that, on average, lesbian women are more likely to have more lesbian sisters than heterosexual women (Bailey and Benishay 1993; Pattatucci and Hamer, 1995). *Limitations:* A proband's own assessment of a sibling's sexual orientation may not always be accurate. These studies cannot distinguish between genetic and environmental factors (Dawood, Bailey and Martin 2009).

Twin Studies

Twin studies examine the concordance rates of specific traits amongst monozygotic (MZ) and dizygotic (DZ) twins. In order to separate genetic and environmental determinants, the most common methodology compares the concordance rates of monozygotic (MZ) and dizygotic (DZ) twins *reared together.* As well as sharing the same DNA, it is assumed that the prenatal and early postnatal environments for the majority of twins *reared together* will be similar, though not necessarily experienced identically. If a higher concordance rate is recorded for MZ twins (who have greater genetic similarity than DZ twins), then this higher concordance rate is more likely to be attributable to genes and not the environment. As with family studies, probands with twins are recruited and interviewed about the sexual orientation of their twins. Studies conducted over the last 25 years demonstrate: (1) statistically significant concordance rates for sexual orientation in MZ twins; and (2) moderate heritability for gay male sexuality and lesbianism (Bailey, Dunne and Martin 2000; Bailey and Pillard 1995; Boomsma, Busjahn and Peltonen 2002; Dawood, Bailey and Martin 2009; Johnson et al 2009). *Limitations:* Samples tend to be small and self-selecting. Studies with the highest concordance rates of same-sex sexual orientation between twins tend to be observed in samples recruited through homophile publications rather than from national population registers, making the results potentially biased. There is also no firm evidence to support the 'equal environments assumption' informing most twin studies (Dawood, Bailey and Martin 2009).

Genetic Studies

Genetic studies aim to identify similarities in chromosomes across population groups with the same trait. Hamer et al's (1993) landmark study identified that 33 out of 40 pairs of gay brothers shared significant similarities in the genetic markers of a particular region of the X chromosome (Xq28). A subsequent study conducted by Hu et al (1995) replicated the Xq28 finding but with fewer significant results. Using a larger sample of 409 pairs of gay brothers, a study conducted by Sanders et al (2015) located two regions of linkage in the X chromosome, including the Xq28 region, thus reinforcing Hamer's earlier findings. Genome-wide association studies in very large

databases with detailed genetic and phenotypic data have also made it possible to re-examine the genetic basis for sexuality (Ganna et al 2019; Jordan 2020). Genome-wide association studies are a relatively new way to identify genes involved in human variation and in human disease. The method scans the whole genome for small variations, called single nucleotide polymorphisms (SNPs), that occur more frequently in people with a particular trait or condition than in people without it. Each study can look at hundreds or thousands of SNPs at the same time. The results can identify genes that may contribute to a person's risk of developing a certain disease. However, these methods have also been used to search for patterns of genes that are associated with same-sex behaviour. In these studies, same-sex behaviour is not considered in any way to be a disease but rather a component of human variation. A modest degree of heritability (30%) for same-sex behaviour has been confirmed and the genetic influence appears to involve many genes. It would seem that there is no single gene, or even small set of genes, that have a strong influence on non-heterosexuality (i.e., it is polygenic). *Limitations:* Many of these studies (Hamer et al 1993; Hu et al 1995; Sanders 2015) do not claim to find a 'gay gene'. These studies only provide strong associational evidence for the existence of genetic marker patterns for a subset of gay brothers (ASSAF 2015). Researchers are yet to find any significant genetic linkage for female sexual orientation (Bailey et al 2016).

Neuroanatomical Studies

Neuroanatomical studies assess whether differences in brain regions influence sexual orientation. LeVay's (1991) post-mortem study on four cell groups in the hypothalamus (i.e., INAH-1, INAH-2, INAH-3 and the INAH-4)[25] remains the most well-known in this area. LeVay's study found that the INAH-3[26] was three times smaller in gay men than heterosexual men and was similar in size to heterosexual women. The significance of LeVay's findings were used extensively to support the argument that sexual orientation was determined in the brain during prenatal development. *Limitations:* The sample size for LeVay's study was limited (19 gay men, 16 heterosexual men, six heterosexual women). All the gay men in the sample died of AIDS compared with only six of the heterosexual men and one of the heterosexual women. Minimal consideration was given to the possible effect of the drug treatment or the disease itself on the brain structure of the gay men. While the gay men in the sample were known to be gay based on records obtained at the time of their deaths, the remaining sample were only presumed to be heterosexual. However, it should be noted that recent studies continue to link structural and functional differences in the brain with sexual orientation (Swaab 2008; Savic, Garcia-Falgueras and Swaab 2010; Bao and Swaab 2011).

Socio-Behavioural Studies

Although there is evidence for greater fluidity in sexual orientation amongst women, socio-behavioural research indicates that significant proportions of the population, whether they identify

[25] INAH refers to the Interstitial Nucleus of the Anterior Hypothalamus.
[26] INAH-3 is sexually dimorphic (i.e., is two or three times larger in men than women).

as LGB or as non-LGB, do not experience 'choosing' their sexual orientation (Mclintock and Herdt 1996; Herek et al 2010, Savin-Williams and Vrangalova 2013). Both LGB and non-LGB individuals tend to report becoming aware of their sexual orientation at around the same age, typically around nine or ten years of age. This suggests that there is little difference in how LGB and non-LGB individuals subjectively experience the 'innateness' of their sexuality. In other words, sexual orientation does not appear to be a choice in any meaningful sense. *Limitations:* These studies are often criticised for suggesting that personal agency is not involved in the development of sexual identity or sexual orientation. We should not understand these studies as offering a completely deterministic account of human nature or as ignoring the role of human agency but rather we should understand these studies as suggesting that people make choices about who they want to be and how they want to live within the constraints of biology and environment which they can neither choose nor change.

Evolutionary Studies

As same-sex sexuality cannot lead to reproduction and is unlikely to be positively 'selected' on a genetic basis, most evolutionary theorists consider the existence of same-sex sexual orientation to be anomalous. However, some studies (Camperio-Ciani, Corna and Capiluppi 2004; King et al 2005; Lemmola and Camperio-Ciani, 2009) have found that female relatives of gay men experience increased fertility and have more children, on average, than women who do not have gay male relatives. This suggests an evolutionary compensation for same-sex sexual orientation. Gay family members may also contribute substantially to family bonding and provide additional support in rearing or upbringing children (Denman 2004). *Limitations:* These studies require wider replication amongst different population groups and with larger samples.

Environmental Studies

Reviewing a wide range of academic research on the role of upbringing and parenting on the development of same-sex sexual orientation, including Peplau and Garnets 2000; Rosario and Scrimshaw 2014, the ASAAF (2015, p. 44) report on sexual diversity concludes as follows:

> There is a lack of evidence to support the idea that the way parents bring up their children, or the relationships formed between children and parents, impact on sexual orientation. While family environment may shape other elements of sexuality and the way sexuality is expressed, and while construction of…sexual identities have social and cultural components, [sexual] orientation is not directly correlated to family upbringing.

Similarly, Bailey et al (2016. p 84) echo this conclusion:

> The hypothesis that pathological parent-child relationships cause homosexuality has generated little scientific research, and almost no recent research. We believe that this is primarily because the hypothesis has little scientific promise.

The Royal College of Psychiatrists (2010) are also critical of environmental and developmental accounts of sexual orientation:

> Despite almost a century of psychoanalytic and psychological speculation, there is no substantive evidence to support the suggestion that the nature of parenting or early childhood experiences play any role in the formation of a person's fundamental heterosexual or homosexual orientation. (RCP, cited in ASSAF 2015).

These environmental studies highlight the limitations of psychodynamic models of sexuality, which tend to posit that Oedipal and developmental factors are causative of same-sex sexuality.

2.9 The Psychosocial Dimensions of Sexuality

Referring to a 'suture' between the mind and the social world, Frosh and Baraitser (2008) highlight the value of a psychosocial approach for examining specific phenomenon, such as sexuality and gender. Psychosocial approaches include the simultaneous investigation of the psychological and social aspects of a problem. Psychodynamic psychotherapy is increasingly engaging with other disciplines, such as social constructionism, queer theory and bisexuality studies, in an attempt to articulate a psychosocial position and to revitalise its thinking on sexuality. The inclusion of psychosocial perspectives in this review is not intended to dilute the specificity of psychodynamic thinking about sexuality but rather to create an interdisciplinary dialogue and to recognise that the distinction between 'the psychological' and 'the social' is not a decisive one. People's sexuality is not only experienced on an individual and subjective (psychic) level but is mediated by the social, cultural and historical context.

Social Constructionism

Social constructionists argue that, while sexuality may have a biological basis, its meaning is shaped within the context of culture and varies over time (Beasley 2005). Historical and cross-cultural comparisons (Friedman 1986; Bailey et al 2016) confirm that same-sex sexual behaviours are perceived differently through the ages and across civilisations. Examples of this include the idealisation of adult gay male sexual practices in Ancient Greece, the discovery of Mesolithic cave art celebrating male-male sexual activity and the use of same-sex sexual acts as a meaningful component in tribal initiation rituals in New Guinea, to name a few.

One of the prominent thinkers associated with the social constructionist position is Foucault. Foucault (1976) argues that knowledge is socially produced through institutional discourses and in relation to sexuality, he (1976) argues that established institutions employ certain classifications and terminology to regulate and marginalise minority sexual interests. Established institutions (e.g., law, medicine, church) use categories and labels to legitimise and demarcate what is

'desirable' and what is 'undesirable'.[27] According to Foucault, these established institutions produce and repeat their own ideological and normative discourses about sex and sexual behaviour in order to control how sexuality is experienced, practiced and thought about in wider society. Rubin's theory (1984) of a 'sexual hierarchy' has also been influential. Rubin, a pre-queer theorist, argues that certain forms of sexuality are accepted by society – again through cultural discourse – while other forms are denigrated, leading to a distinction between 'sex negative' and 'sex positive' people. 'Sex negative' people include LGB individuals, sex workers, sadomasochists, people who cruise for sex, people who are polyamorous, use pornography and who have sex cross-generationally. 'Sex positive' people include those who are heterosexual, coupled, procreative, married, monogamous, do not use pornography and who have sex with people from the same generation.

Gagnon's and Simon's (1973*)* 'script theory' offers another influential social constructionist perspective. They use the metaphor of 'scripts' to describe an implicit set of socially and culturally determined messages or 'codes' about how we ought to practice our sexuality. They highlight three scripts in particular that may shape and inform how we experience our sexuality. These are: (1) 'cultural scripts' informed by the attitudes, norms and prejudices of established institutions such as the family, the media or the education system; (2) 'interpersonal scripts' informed by how we relate to ourselves and others within the 'rules' and constraints set upon us by these institutions; and (3) 'intrapsychic scripts' informed by the internal conflicts we experience as we interact and negotiate the implicit 'codes' laid down by these institutions. Using the script metaphor, we might understand LGB accounts of being rejected and excluded, for example, as being 'scripted' through LGB individuals' experiences of parental and familial disapproval (the cultural), their conflictual relationships with parents/family members that result from these experiences of disapproval/rejection (the interpersonal) and their private, subjective responses in relation to all of this (the intrapsychic).

A landmark, edited collection of papers (Domenici and Lesser 1995) brought together a number of mostly gay and lesbian analysts who drew on social constructionist thinking. As the editors (ibid., p.6) outlined in their introduction to this collection:

> The shared vision of each author [in this book] is one which respects diversity, does not privilege one form of sexuality over another, confronts the uses of categorisation, hierarchisation, and the use of 'abnormal' within psychoanalytic theory, is suspicious of the power plays which underlie essentialist assumptions, and views gay, lesbian and heterosexual identities as historical and cultural productions.

At the time of publication, this collection of papers was a radical departure. By embracing the proposition that sexuality was socially and culturally constructed or 'scripted', these therapists

[27] In some countries, for example, the law condemns same-sex sexual activity as 'criminal'. The medical profession has historically diagnosed same-sex sexuality as 'mental disorder'. Some religious teaching denounces same-sex sexual acts as 'sinful'.

could challenge long-standing prejudices within psychodynamic theory about what constituted 'natural' sexuality (historically heterosexuality) and what 'natural' sexuality involved (historically procreation). Borrowing insights from social constructionism has helped free psychodynamic theorising of sexuality from its 'normative theoretical straitjacket' (Schoenberg 1995, p. 220). Social constructionist thinking has better prepared psychodynamic therapists for clinical practice with non-heterosexual clients, as it opens up the possibility that sexual orientation is fluid, contingent and shifting rather than rigid and fixed.

Queer Theory

Emerging out of social constructionism and radical LGB political activism,[28] queer theory is notoriously difficult to define. Its 'definitional indeterminacy' (Jagose 1996, p. 1) is considered one of its core characteristics. Just as the word 'queer'[29] has multiple meanings and applications, so too does queer theory. Barker (2016) suggests that it is easier to think of queer *theories* (plural) rather than queer *theory* (singular). Queer theory is a discipline in flux and always shifting, embracing multiplicity and contradiction. This is perhaps why Giffney (2017) does not consider it to be a unified discourse. The word 'queer', with all its vagueness and ambiguity, implies that queer theory is a discipline that actively resists definition. It is, as Sullivan (2003, p. v) states, 'a discipline that refuses to be disciplined'. Nevertheless, Barker (2016, p. 31) attempts to define the core features of a 'queer' perspective as:

> resisting the categorisation of people; challenging the idea of essential identities; questioning binaries like gay/straight, male/female; demonstrating how things are contextual based on geography, history and culture etc; and examining the power relations underlying certain understandings, categories and identities.

The most prominent queer theorist is Butler (1990). One of her enduring concepts is that of 'performativity'. Butler (ibid.) argues that our sexuality and gender are acts (i.e., things we *do* or *perform* rather than what we *are*). We have learnt to make ourselves socially intelligible to others by appropriating, practising, rehearsing and performing specific behaviours, gestures and ways of being that are culturally imposed on us and mark us out as 'male', 'female', 'gay' or 'straight'.

Another influential theory of Butler's (ibid.) is that of the 'heterosexual matrix', which can be schematically understood as a series of heterosexual cultural norms that operate imperceptibly and 'naturally', ultimately imposing a compulsory heterosexuality on all of us. Any deviation from this heterosexual 'norm' is considered 'unnatural' or deviant. However, as Butler argues, there is no reason for assuming any fixed relationship between sexed bodies, gender identities and sexual

[28] Wholly repudiating the idea that there is any fixed essence to identity, queer theorists are often presented as holding an anti-identity perspective (Johnson 2015). Rather than seek greater rights and acceptance for 'queer' individuals and identities within existing social and political contexts and institutions (e.g., marriage, child adoption), queer theorists tend to reject identity politics and political assimilation and embrace radical, revolutionary political activism where the aim is to restructure society and resist all (heterosexual) norms (Jagose 1996; Sullivan 2003).

[29] Originally meaning 'strange' or 'odd', queer became a derogatory term to describe LGB people in the late nineteenth century. In the 1980s, the term was reclaimed by the LGB community as a positive form of self-identity. Queer can also be used as a verb – 'to queer something' – meaning to make something familiar less so.

desires. Under the heterosexual matrix, an individual who is biologically male is assumed to identify as a man, express himself as masculine and to experience sexual attraction to females (i.e., is heterosexual). Under a less heteronormative matrix, an individual who is biologically female might identify as genderqueer, express herself as androgynous and experience attraction to both genders (i.e., is bisexual).

Kosofsky Sedgwick (1990) is another leading queer theorist, who is best known for delineating a set of queer theoretical positions known collectively as 'epistemologies of the closet'. One of her main theoretical innovations was to distinguish between a 'minoritising' view of same-sex sexuality, which applies only to a small, distinct population who identify as exclusively 'gay' or 'lesbian', and a 'universalising' view, which is much broader and recognises sexuality as fluid and contingent, therefore making it a topic of interest to a wider range of people such as those who identify, for example, as 'primarily heterosexual', 'bisexual', 'questioning' or as 'sexually fluid'.

In recent years, both queer and psychodynamic theory have acknowledged their shared preoccupation with issues such as identity, desire and sexuality. In their pioneering book, Giffney and Watson (2017) stage an interdisciplinary 'encounter' between the two schools of thought. Several psychodynamic theorists (Frosh 2017; Rose 2017; Nobus 2017) writing in the book recognise the value of the two disciplines collaborating with one another. Each discipline enlivens and provokes the other, leading to new and unexpected insights about sexual subjectivity. However, there are theoretical tensions. While valuing queer theory as a set of ideas that can challenge therapist assumptions about sexuality and gender, Jungian theorist Kulkarni (2017) fears that the idea of 'sexual fluidity' has become reified in queer theory and risks becoming a rigid or fixed concept itself, the very opposite of what queer theory aims to achieve. By overemphasising the concept of 'sexual fluidity', Downing (2017) also argues that queer theory may undermine its own potential as a disruptive, destabilising discourse: sexual fluidity could become prescriptive or a new form of normativity. In a similar vein, Hinshelwood (2017) contends that the notion of fluidity threatens the human need for stability and coherence, particularly in relation to our identities and sense of ourselves. While acknowledging the 'very real epistemological differences' between queer theory and psychoanalysis, Baraitser (2019, p. 211) compellingly sums up the intimate connection between the two disciplines when she writes:

> Surely psychoanalysis is… 'a queer theory' or if not a queer theory, then at least queer in its own right, given that the Freud of *Three Essays on the Theory of Sexuality*…stakes the future of psychoanalysis on the premise that a wayward deviant sexuality is central to psychic life, and sexuality's aim is always already perverse.

Bisexuality Studies

Bisexuality studies is a branch of sexuality studies that is often overlooked and marginalised. Bisexual scholarship contests the dominant model in the West that sexuality is dichotomous and monosexual (i.e., people are either gay or straight) and aims to redress what has become known

as the *erasure* or *invisibility* of bisexuality (Alexander and Anderlini-D'Onofrio 2012; Eisner 2013; Barker 2016). Given that bisexuality disrupts binary models of sexuality and gender, bisexual scholarship is uniquely placed to contribute to queer, non-normative understandings of sexuality, yet many commentators (Barker 2016) have noted with disappointment that queer theory has not engaged as fully with bisexual scholarship as perhaps it should. One of the main challenges facing bisexuality scholarship is defining what bisexuality actually is or means. Is bisexuality, as Udis-Kessler (1992) suggests, a combination of two elements, opposite and same-sex attraction, existing in relative proportions to one another? Or is bisexuality, as Klein (1978) proposes, a third point or space on a continuum with opposite and same-sex attraction at either end? Another key question is whether bisexual identity and bisexual behaviour should be distinguished. Storr (1999) suggests that an individual may have desire for both men and women and may even have had sexual encounters with both genders in the past without actually identifying as bisexual. Bisexual scholarship and activism emerged mainly in response to the distorted, biphobic stereotypes most people have about bisexuality and bisexual people. As Guidry (1999, pp. 22-23) notes:

> Current clichéd views about bisexuals include that they are conflicted, are in denial of their 'real' homosexual identity, are indecisive, are ambivalent fence-sitters, are merely in a transitional phase, are confused, are promiscuous and sex-crazed, are attempting to be chic or trendy, have retarded sexual development, are shallow and lack the capacity for deep love, or are wanting the best of both worlds.

Bisexual scholarship aims to expand our understanding of bisexuality and to dispel the types of prejudices outlined in the quotation above. Blumstein and Schwartz (1977), for example, undertook interview-based research with people who had sexual histories involving both men and women. Their study showed that bisexuality was not monolithic, and that women and men experienced their bisexuality differently. On the whole, women found it easier than men to accept their bisexual identity and attractions. Whereas women viewed their bisexuality as a natural extension of their intimate female friendships, men perceived that their bisexuality undermined their masculinity or sense of maleness. Eadie (1993) suggests that gay and lesbian studies have excluded bisexuality intentionally, as an epistemological ploy to keep the homo-hetero distinction in place. Viewing bisexuality as a hybrid position, Eadie recognises that bisexuality has subversive potential to destabilise the homo-hetero taxonomy and undermine oppositional or binary thinking about sexuality. Both Däumer (1992) and Ault (1996) agree that bisexuality, on account of its ambiguity, challenges dichotomous and dualistic models of sexuality. Garber (1995) resists all attempts to define bisexuality, proposing that, by its very nature, bisexuality is multiple, elusive, in motion and heterogeneous. Pramaggiore (1996) describes bisexual theories as *epistemologies of the fence*,[30] repurposing the metaphors of the fence and fence-sitting to emphasise the in-betweenness of bisexuality.

[30] This is a nod to the queer theorist Kosofsky Sedgwick (1990) who described queer theories as *epistemologies of the closet*. The use of the term 'fence' refers to the oft-heard prejudice that bisexuals are fence-sitters and cannot decide what sexuality they really are.

Within psychodynamic psychotherapy, Rapoport (2019) has led the way in terms of integrating insights from bisexuality studies with psychodynamic theory. Re-examining bisexuality through Winnicottian, Lacanian and relational lenses, Rapoport, as both psychoanalyst and bisexual scholar, makes the case for plurality and multiplicity. She uses Winnicott's concept of a third space to envisage a place where sexuality can be experienced as something emergent, creative and playful and where there is an opportunity for sexual potentiality rather than sexual fixity. Drawing on Mitchell's concept of 'multiple self-organisations' and Bromberg's concept of 'multiple self-states', Rapoport explores the possibility of us all having multiple sexual selves, where we experience our sexuality as indeterminate, discontinuous and ambiguous rather than as rigid and immutable. From a Lacanian perspective, Rapoport presents bisexuality as a signifier for the uncertainty and unknowability inherent in sexuality.

2.10 Clinical Dimensions

This section addresses key debates relating to clinical practice with LGB clients.

Classical Cures and Conversions

Freud (1920) himself did not classify same-sex sexuality as an illness or an identity that could or should be changed. In a 1935 letter to a mother of a gay son (cited in Gay 2006), Freud outlined his position that analysis could only reduce her son's intrapsychic and interpersonal conflicts rather than modify his sexual orientation. However, the first few generations of psychodynamic therapists adopted a strikingly antipodal stance and approach. In clinical work with gay men, classical therapists extensively used a range of reparative techniques, often more than one at a time, to reverse same-sex sexual attraction. These techniques included: (1) actively prohibiting same-sex sexual activity and practices (Socarides 1968); (2) deliberately cultivating a positive transference or identification with the client in order to provide what was 'missing' developmentally from early childhood (i.e., a powerful father figure who could loosen the pre-Oedipal dependency on the mother) (Socarides 1968); (3) pressuring the client to date or have sexual intercourse with women (Ovesey 1969); (4) educating or 'retraining' the client to recognise the desirability of heterosexuality (Bieber 1965; Socarides 1968); (5) issuing ultimatums threatening to end the treatment if the client did not actively pursue efforts to become heterosexual (Ovesey 1969); and (6) teaching mind-control techniques so that the client could learn to curb his same-sex fantasies (Hatterer 1970). Until the early 1990s, most classical treatments of lesbians also assumed the desired outcome of psychotherapy was heterosexuality. Siegal (1988) claimed that over half of her lesbian clients (she reports 12 cases) became heterosexual during analytic treatment with her.

Running in parallel with these psychodynamic approaches were psychiatric and medical attempts to 'cure' same-sex sexual orientation. According to Dean and Lane (2001), psychiatric and medical 'cures' in the 1950s and 1960s involved: (1) hypnosis; (2) electroshock therapy; (3) castration; (4) use of noxious stimuli including emetics; (5) visual and auditory suggestion aimed

at reducing same-sex fantasies; (6) drugs; and less frequently, (7) lobotomy. However, as Drescher (2010) points out, the psychodynamic, psychiatric and medical professions gradually recognised that conversion therapies were largely unsuccessful. This realisation ushered in the de-pathologisation movement of the 1970s.

Currently, there is a broad consensus that there is little (if any) evidence to support claims that same-sex sexual orientation can be changed through reparative therapy (APA 2009). Multiple studies have demonstrated that such therapies cause long-term psychological harm, including depression, anxiety, suicidality, low self-esteem, self-hatred, sexual dysfunction, relationship conflicts and social withdrawal (Shidlo and Schroeder 2002; Haldeman 2002). Research studies that claim conversion therapies are efficacious have been heavily criticised for their significant methodological limitations (Cramer et al 2008; Serovich et al 2008; APA 2009; Beckstead 2012; Panozzo 2013). The methodological limitations of these studies include: (1) absence of randomised control designs; (2) failure to provide baselines; (3) lack of a multivariate measurement of sexual orientation (i.e., no differentiation made between sexual behaviour, sexual identity and sexual attraction); (4) lack of longitudinal design and follow-up; (5) restrictive samples consisting predominantly of white men over 18 years old, thus producing results with very little applicability to women, non-whites and adolescents; (6) sample attrition with high drop-out rates; (7) excessive use of retrospective pre-tests; and (8) overreliance on self-report measures especially in more recent studies.

Contemporary Approaches: Meanings, Not Causes

While we know that a minority of mental health professionals, including psychodynamic psychotherapists, still try to change the same-sex attraction of LGB clients (Bartlett, King and Smith 2009; Lingiardi, Nardelli and Tripodi 2015), the majority of psychodynamic therapists working today do not use reparative techniques. Increasingly, contemporary therapeutic approaches focus on the unique developmental experiences of LGB clients and the difficulties they face living in a heteronormative and often homophobic world. Roughton (2001) urges clinicians to address their unfamiliarity with the lives and norms of LGB clients. In particular, he criticises the psychodynamic tendency to focus on the causes that may underlie an individual's same-sex desires. Auchincloss and Vaughan (2001, p. 1179) echo Roughton's perspective and advocate a 'renewed capacity for analytic listening'. This new form of listening must abandon the search for causes and instead pay attention to LGB clients' personal experiences of being LGB (e.g., early feelings of difference or gender atypicality, experiences of internalised homophobia and conflicts linked to the 'coming out' process). Questioning whether we even need a psychodynamic theory of same-sex sexual orientation, Auchincloss and Vaughan propose that the psychodynamic methodology alone is insufficient for generating a theory, largely because conclusions drawn from psychodynamic treatments with LGB clients are based on unrepresentative clinical samples. Likewise, Drescher (1998, 2002, 2007) recommends that questions of aetiology, such as 'Why is this person gay?', are better reframed as questions about meaning, 'Why does this person feel differently from everybody else?'. However, while welcoming

this focus on meanings, Cohler and Galatzer-Levy (2013) caution that the meanings we attach to different aspects of LGB experience change over time. In particular, these authors refer to older LGB-identifying therapists who need to put their younger LGB clients' experiences into historical context in order to avoid an 'intergenerational dissonance' or the perpetuation of a 'master narrative' that is no longer relevant in all cases. The authors discuss a master narrative about adolescents 'coming out' to their parents. An older LGB therapist might assume that LGB adolescents in therapy fear a homophobic parental response. However, given the shifts in social and cultural attitudes in recent decades, not all LGB adolescents fear 'coming out' and many may already know that their parents will respond positively. In therapy with LGB youth, older LGB therapists may need to spend some time uncovering the family dynamics first rather than assuming the parental reaction to a child's 'coming out' will be rejection or lack of acceptance.[31]

Homophobia, Discrimination and Stigma in LGB Lives

Clinical guidelines (APA 2012; BACP 2017; BPS 2019) for effective work with LGB individuals advise therapists to develop an in-depth understanding of the unique developmental and personal challenges facing LGB individuals. Friedman and Downey (1995, 1999, 2002, 2008) write extensively about *internalised homophobia,*[32] the process whereby LGB individuals internalise the homophobic and hostile attitudes they encounter in wider society and culture. Internalised homophobia leads to a negative self-evaluation of what it means to be LGB and can significantly impair the psychological well-being of LGB individuals. Rohleder (2020), for example, highlights the pervasiveness of homophobia, by noting how, from the earliest age, children in the playground hear and use homophobic slurs, such as 'faggot', 'sissy' and 'dyke'. Throw-away phrases, such as 'That's so gay!', have become part of modern-day parlance without any real questioning of the homophobia underlying them. Studies have demonstrated that homophobic experiences are particularly damaging for young people in the process of discovering their sexual orientation or when they are thinking about 'coming out' (Denton 2012; Goldbach et al 2014).

Although tolerance and acceptance of LGB people has increased over time (see Cohler and Galatzer-Levy 2013, above), the 'coming out' process can still be fraught with emotional difficulties. As Friedman and Downey (2008) describe, some parents, close relatives or friends may still be homophobic and reject children or other loved ones who 'come out'. In many instances, the 'coming out' process is not restricted to LGB individuals but is rather a broader process involving the whole family (Pachankis and Goldfried 2013). Research has indicated that even supportive families require an adjustment period when a relative 'comes out' (APA 2012) Furthermore, as Galatzer-Levy and Cohler (2002) indicate, 'coming out' is not a one-off occurrence but rather an ongoing process throughout life. In a similar vein, Vaughan (1998)

[31] Although it is important to note that this more optimistic view of 'coming out' is, by no means, consistent across the board (Watson et al 2019), especially in other countries (Reyes et al 2015).

[32] Although I have included bisexuals as experiencing internalised homophobia, it is more accurate to say that bisexuals experience *internalised biphobia*. Eisner (2013, p. 320) defines *internalised biphobia* as 'the acceptance and internalisation by bisexuals of negative stereotypes about bisexual people and bisexuality itself and a belief in the superiority of both monosexual people and monosexuality. This is often done subconsciously, meaning that most bi people are unaware of their internalised biphobia.'

describes how LGB individuals revisit the 'coming out' process every time they change jobs or move homes. There are also dilemmas associated with 'coming out' within professional contexts. Pachankis and Goldfried (2013) discuss how workplace homophobia may adversely impact LGB career prospects in certain professions.

Research shows that LGB individuals are at a higher risk than heterosexual people of experiencing poor mental health outcomes, including depressive episodes and generalised anxiety disorders (Warner et al 2004; King et al 2008; Chakraborty et al 2011; Adams et al 2013; Elliott et al 2015; Semlyen et al 2016). This increased vulnerability to mental illness is strongly, but not universally, associated with internalised homophobia as well as actual experiences of homophobia, social stigma and discrimination (APA 2012). Family rejection or lack of family connectedness are also closely linked to negative mental health outcomes within LGB populations (Eisenberg and Resnick 2006; Corliss et al 2009; Ryan et al 2009; DiFulvio 2011; Blosnich and Bossarte 2012; Harper et al 2012; Reyes 2015; Watson et al 2019). Furthermore, gay and bisexual men are also more dissatisfied with their bodies and their physical health than heterosexual men (Tiggeman et al 2007; Peplau et al 2009; Nodin et al 2015) and there are higher rates of substance-use disorders amongst LGB adults (McCabe et al 2009).

In addition to experiences of homophobia and biphobia, LGB individuals face other forms of discrimination. As the APA (2012, p. 12-13) guidelines point out:

> Lesbians and bisexual women…must contend with the prejudice and discrimination posed by living in a world where sexism continues to exert pervasive influences… Similarly, gay and bisexual men are confronted…with the pressures associated with expectations for conformity to norms of masculinity in the broader society… Bisexual women and men can experience negativity and stigmatisation…from lesbian and gay individuals as well as from heterosexual individuals.

In order to fully understand the different and overlapping forms of oppression that impact LGB lives, the BACP guidelines (2016, p. 14) recommend that therapists adopt an intersectional approach:

> A person's experience of gender, sexuality and/or relationships – and the options that are available to them in how they express or label their gender, sexuality and/or relationships – will be intrinsically bound up with their race, class, disability, nationality, cultural background, faith, age, generation, geographic location, body shape and size, survivor status and many other dimensions.

LGB-Specific Relationship and Sexual Issues

Therapists are increasingly advised to familiarise themselves with different aspects of LGB relationships and sex lives (APA 2010; BACP 2017; BPS 2019). On the whole, research has

shown (Pachankis and Goldfried 2013) that LGB couples form relationships for the same reasons as their non-LGB counterparts and also experience similar levels of relationship satisfaction and stability. Furthermore, LGB couples share the same type of relationship difficulties as non-LGB couples, such as breakdowns in communication, dual career issues and sexual problems (see APA 2012). However, although LGB individuals and couples now adopt children and co-parent (Downey and Friedman 2008), they still face significant challenges in becoming parents, not least because of: (1) decisions around alternative insemination and surrogacy; (2) lack of acceptance and support from families and friends about their wishes to form a family; and (3) homophobic reactions from the wider community, including schoolteachers, paediatricians and other agencies (Downey and Friedman 2008; APA 2012). Despite contrary claims, research indicates that there is little difference in the psychological development and emotional well-being of children brought up by either one or more LGB parents and children brought up by heterosexual parents (Pachankis and Goldfried 2013; Richards and Barker 2013).

Lesbian relationships: Although not restricted to lesbian couples, loss of sexual desire and passion within lesbian relationships is often reported in the clinical literature (Reed 2002; Downey and Friedman 2008). It is not known why this phenomenon is reported so commonly amongst lesbian couples, nor is it clear whether it is the lesbian client or the lesbian couple who report having little sex or whether this is the therapists' interpretation of the clinical material being brought to the analysis. A recent research study (Cohen and Byers 2014) contradicted the perceived wisdom that lesbians have less sex. The study showed that lesbians have sex at least once a week or more and participate in both non-genital and genital sexual activities. In addition to penetration, research indicates that lesbian couples engage in a diverse range of non-penetrative sexual activity, including the use of sex toys, cunnilingus, scissoring, anilingus, vaginal massage and fingering (Richards and Barker 2013; Clarke et al 2016). Issues of merger and over-closeness are also often reported to occur in lesbian relationships (Krestan and Bepko 1980; Bepko and Johnson 2000; Reed 2002; Downey and Friedman 2008). Although lesbian merger and fusion may sometimes be interpreted negatively as representing a lack of individual differentiation or lack of emotional self-sufficiency (Nichols 2004), other commentators view lesbian fusion and merger as demonstrating women's capacity for emotional connection and interpersonal relatedness (Green et al 1996; Burch 1997).

Gay male relationships: Research shows that gay and bisexual men are more likely than lesbians and heterosexuals to pursue non-monogamous and polyamorous relationships (APA 2012). Gay men often form stable life-long relationships with one partner, while in some cases also accepting a degree of extradyadic sex (Denman 2004). Studies indicate that gay men in open relationships are equally as satisfied as their monogamous counterparts (LaSala 2008). Like lesbians, gay men engage in numerous sexual practices including activities as varied as mutual masturbation, oral sex, use of sex toys, anal sex, cruising, cottaging, attending bath houses and cybersex (Denman 2004; Richards and Barker 2016). However, the sexual lives of gay men are often erroneously assumed to revolve exclusively round anal intercourse. A study by Coxon and McManus (2000) revealed that most gay and bisexual men (around 60%) engage in anal intercourse only once or

twice a month and that a third of gay and bisexual men do not engage in anal sex at all. Another study (McBride and Fortenberry 2010) found that heterosexual partners engage in anal sex as commonly as gay and bisexual men. When gay men experience intimacy issues in their relationships, evidence suggests that this can be closely related to one or both partner's unresolved internalised homophobia (Meyer and Dean 1998; Lynch 2015).

Bisexual relationships: Although bisexuals are more likely to view polyamory as a relationship ideal, many bisexuals still pursue and are in monogamous relationships (APA 2012). One complication facing bisexuals in relationships is when the other partner is monosexual and/or is opposed to nonmonogamy (Pachankis and Goldfried 2013).

Transference and Countertransference Dynamics with LGB Clients

Before the 1980s, therapists paid very little attention to the impact of their own emotional responses to LGB clients in therapeutic work (Kwawer 1980). Increasingly, however, therapists are more willing to discuss and write about their reactions when working with the LGB client group. Given the wide range of therapist-client combinations (such as lesbian client with a gay therapist or bisexual male client with a heterosexual female therapist), it is only possible to highlight the more common LGB transference and countertransference dynamics reported in the literature. However, there are two difficulties in reviewing these accounts: (1) the single case approach of psychodynamic reporting, which means generalisability cannot be assumed; and (2) the extent to which transference and countertransference dynamics with LGB clients differ from those with non-LGB clients.

Having reviewed the existing literature and conducted research with lesbian and heterosexual female therapists, Igartua and Des Rosiers (2004) describe some of the ways in which lesbian clients' transferences are heavily shaped by their *perception* of their therapists' sexual orientation. Female therapists perceived as lesbian report experiencing more idealised transferences from their lesbian clients (ibid., 2004). In this dynamic, the lesbian client, particularly if younger and in the early stages of lesbian identity formation, may strongly identify with the therapist and perceive her as a role model. Idealised transferences of this nature are often accompanied by an equally intense denigration or devaluation of the therapist. Such transferences may lead the lesbian client to seek fusion with the idealised mother-therapist or produce phantasies of the therapist as omnipotent. Idealised transferences frequently contain erotic overtones and the lesbian client often simultaneously identifies with and desires the therapist.

Female therapists *perceived* as heterosexual report experiencing more negative transferences from their lesbian clients (Igartua and Des Rosiers 2004). In this configuration, the therapist may represent a rejecting or disapproving parent or authority figure. Some lesbian clients may come to therapy with the expectation of censure and denunciation in relation to their lesbian desires, having perhaps experienced, and then internalised, such reactions from their mothers during childhood and adolescence. In these cases, the therapist may become a repository for the lesbian

client's displaced anger, rage and resentment stemming from these earlier experiences of rejection.

Both lesbian and heterosexual female therapists commonly observe positive maternal transferences when working with lesbian clients. Igartua and Des Rosiers (2004) report that some lesbian clients may perceive the female therapist as a mother figure, someone who can provide the nurturing and acceptance that was possibly missing from their upbringing when their own mothers may have rejected them because of their lesbianism. The therapy may act as a type of corrective emotional experience. These maternal transferences may also be erotic, reactivating repressed pre-Oedipal or Oedipal sexual desires for the mother.

Male therapists (whether gay themselves or perceived to be gay) report that their gay male clients often experience intense paternal transferences towards them (Isay 1989). As gay men often report being rejected by their fathers in childhood and adolescence, gay clients may view the male therapist as a potential father figure who can offer them understanding and acceptance. Paternal transferences often include erotic components where the male therapist becomes the primary love object for the gay client (Lewes 1998). In the erotic transference with gay clients, Corbett (1993) describes how he learns over time to tolerate and work with his clients' sexual fantasies towards him as well as his own corresponding anxieties and fears about this experience. Gay clients often experience paternal transferences with female therapists too (Isay 1991).

Therapists experience a diverse range of countertransference reactions in their clinical work with LGB clients. Frommer (1994) and Flowers (2007) recognise that attempts to adopt a neutral therapeutic stance are often undermined by therapists' unconscious or unanalysed homophobia and heterosexism. Drescher (1998) discusses the range of countertransference reactions straight male therapists often experience in relation to gay clients, including sexual attraction, shame, disgust and confusion. Several therapists (Isay 1986, 1989, 1991; Lewes 1988, Corbett 1993) have written about the difficulties straight male therapists have in understanding and working with gay clients with strong cross-gender identifications. Isay (1991) also describes the intense countertransference feelings of anger and rejection aroused in the LGB therapist when a LGB client inadvertently discovers that the therapist is gay and responds homophobically. While the homophobic reaction is often linked to the LGB client's unresolved internalised homophobia, it can be traumatising for the LGB therapist to be subjected to homophobic attitudes or abuse during the analysis. When the lesbian therapist and lesbian client share experiences in common (e.g., discrimination, stigma), Igartua and Des Rosiers (2004) describe how, in the countertransference, some lesbian therapists may overidentify with their lesbian clients. Heterosexual female therapists can often overlook their emerging erotic countertransference with their lesbian clients because of unresolved or unanalysed anxieties around their own same-sex desires (Igartua and Des Rosiers 2004).

LGB Therapists' Self-Disclosure (of Sexual Orientation)

Another key clinical consideration is whether LGB therapists should self-disclose their sexual orientation to their LGB clients. As with any other form of therapist self-disclosure,[33] there are risks. Self-disclosure may lead to a shift in therapeutic focus away from the client towards the therapist (Kronner 2013) or could be harmful if client boundaries are already weak or compromised in some way (Porter, Hulbert-Williams and Chadwick 2015). When the LGB therapist and the LGB client hold similar outlooks or share experiences in common, Kronner (2013) suggests that self-disclosure may lead to the therapist's overidentification with the client. However, the main objection to self-disclosure (of sexual orientation) is that it may impede the development and elaboration of the transference relationship (Isay 1991).

Several authors, however, highlight the therapeutic benefits of LGB therapists self-disclosing their sexual orientation to LGB clients. As psychodynamic psychotherapy has a reputation for pathologising and attempting to 'cure' same-sex desire, LGB therapist self-disclosure may reassure LGB clients that the therapist is not going to set out to change their sexual orientation. Drescher (2004) views LGB therapist self-disclosure (of sexual orientation) as an effective technique for building trust and enhancing therapist credibility. Looking across the therapy literature, Danzer (2019) itemises several other therapeutic benefits of LGB therapists self-disclosing their sexual orientation: role-modelling, increases in therapist empathy and reciprocal spontaneity or openness between therapist and client. However, therapeutic benefits may derive from other forms of therapist self-disclosure and not just self-disclosure of sexual orientation.

As Guthrie (2006) reports, LGB therapists often disclose their sexual orientation to LGB clients indirectly through how they advertise their services (e.g., on LGB-friendly websites), what they wear (e.g., pro-gay insignia), the way they speak or even the ways in which they decorate their consulting rooms (e.g., the choice of artwork and the books on display). Other ways of indirectly self-disclosing may happen 'through slips, errors and other non-verbal phenomena outside the therapist's conscious awareness' (Kronner 2013, p. 85). If LGB clients accurately 'pick up' the LGB therapist's sexual orientation and ask for confirmation, Guthrie (2006) advises that it would be anti-therapeutic to deny it. In these circumstances, Danzer (2019, p. 73) outlines the negative impacts of *non-disclosure:*

> [Non-disclosure] may implicitly send homophobic messages to clients…be rooted in or lead to client perception of therapist shame…may exacerbate LGBTQ therapist fears/anticipation of client judgement, homophobic comments, and the extent of internalised homophobia projected onto the client… as well as feelings of stress… misleading clients… and loneliness, isolation and inauthenticity.

[33] Such as a therapist's religious beliefs, marital status or political affiliation.

Empirical research has indicated that moderate amounts of LGB therapist self-disclosure of sexual orientation may be advantageous to treatments with LGB clients. Kronner (2013) conducted a study with eight LGB therapist-client pairs. He found that LGB clients who perceived higher levels of therapist self-disclosure reported higher levels of connection with the therapist. A study by Borden et al (2010) demonstrated that LGB clients viewed therapists as more expert and trustworthy when they disclosed both professional and personal background information about themselves. Perhaps the most balanced advice comes from Guthrie (2006), who recommends a case-by-case approach. He advises LGB therapists to closely examine their own countertransference reactions to LGB clients before deciding to disclose and also warns about the dangers of premature self-disclosure. Knox and Hill (2003) provide some research-based guidelines, advising that self-disclosure is justifiable so long as it is used infrequently and judiciously. Careful attention must be paid to the timing and content of the disclosure.

2.11 Training and Institutional Issues

In as early as 1921, Freud disagreed with proposals to exclude LGB individuals from undertaking psychodynamic training (Lewes 2009). Nevertheless, there has been a long history of LGB individuals being barred from training at psychodynamic organisations. A handful of authors have contributed to the literature relating to historical anti-LGB prejudice and bias within psychodynamic training organisations (Ellis 1994; Blechner 1993; O'Connor and Ryan 1993; Drescher 1995; Russell and Greenhouse 1997; Magee and Miller 1997; Friedman and Downey 1998; Roughton 2002; Friedman and Downey 2002). Key themes repeated across these accounts include: (1) explicit homophobic and prejudicial attitudes amongst senior psychodynamic therapists; (2) systematic exclusion of LGB candidates from training; (3) intrusive and inappropriate interviewing of LGB training candidates; (4) pressure on LGB trainees to 'pass' as heterosexual when accepted for training; (5) the invisibility of openly LGB therapists in senior, decision-making roles within psychodynamic organisations; (6) LGB trainee experiences of homophobia during their training, supervision and personal therapy; (7) persistent deference towards 'pathologising' theorists and texts on clinical courses; (8) institutional reluctance to teach diversity and difference; and (9) institutional unwillingness to consider evidence and data from other disciplines and the sciences.

2.12 A Biopsychosocial Model?

This literature review aimed to locate psychodynamic theory on same-sex sexual orientation within a wider, biopsychosocial perspective. A biopsychosocial perspective is generally understood as a multi-dimensional model for conceptualising health and illness that acknowledges a combination of biological, psychological and social determinants. While Engel (1977, 1980) is widely credited as originating the biopsychosocial model, Rossi (1994) was the first to apply such a model to the study of sexuality. Within psychodynamic psychotherapy, only a handful of theorists have adopted or attempted to articulate a multi-factorial, biopsychosocial model of sexuality (Friedman and Downey 2002; Denman 2004). Some queer theorists (Barker 2016, p. 116) have also embraced biopsychosocial approaches, recognising that 'our biological,

psychological and social worlds [are] overlapping, intrinsically linked and impossible to tease apart…all elements impact on each other in a complex web or network'.

Lehmiller (2014, p. 22) summarises the biopsychosocial model succinctly when he writes:

> Sexual behaviour is a consequence of multiple disparate forces acting upon a person. Some of these forces are internal and specific to the individual, whereas others are broad, external factors that affect anyone in a given culture or society. Moreover, some of these factors are certainly more important than others in helping us understand human sexuality, and the relative importance of these factors can vary considerably across individuals and across the lifespan. However, the biopsychosocial perspective acknowledges this complexity and allows us to look at sexuality as a product of the whole person, with the mind and body being fundamentally and intimately connected.

2.13 Summary

This chapter has summarised the extensive psychodynamic and non-psychodynamic literature on same-sex sexual orientation and has deepened my understanding of my research questions. As well as clarifying how UK psychodynamic therapists understand and conceptualise same-sex sexual orientation both theoretically and clinically, this research may also identify to what extent UK psychodynamic therapists draw on a biopsychosocial model to inform their theoretical views and clinical practice with LGB clients. The next chapter addresses the research process and outlines my methodology and methods.

3 Methodology and Methods

The previous chapter discussed psychodynamic and related literature on same-sex sexual orientation. This chapter is concerned with the methodology and methods[34] informing my research study. I begin by revisiting the research questions. I then outline my philosophical assumptions and how these inform my subsequent choice of methods using the 'Research Onion' model proposed by Saunders, Lewis and Thornhill (2012). The chapter moves on to provide a step-by-step account of the research design, including instrument construction, piloting, sampling, participant recruitment, data collection and analysis, issues of validity and reliability and ethics. The limitations of my methodology and methods are reviewed in the discussion chapter (chapter six, see below).

3.1 Review of Research Questions

The final versions of the main research questions are:

1. How do UK psychodynamic psychotherapists understand and conceptualise same-sex sexual orientation both theoretically and clinically?

2. In what ways has psychodynamic training on sexual orientation shaped the views and practice of UK psychodynamic psychotherapists working with LGB clients?

The research questions did not emerge fully formed but were refined and modified during the pre-empirical stages of the study (Punch 2014; Barker, Pistrang and Elliott 2016). When I started the PhD, I had identified the broad research topic, but the research questions only took shape after further immersion in the literature, discussion with my supervisors and wider consultation with psychodynamic colleagues on the BPC Task Group on Gender, Sexuality and Relationship Diversity (referred to as the 'Task Group' from now on). Mapped against Bryman's (2012, p. 90) criteria for evaluating research questions, I aimed to develop questions that were 'clear', 'researchable', 'connected with established theory and research' (chapter two, see above), 'linked to each other' and 'neither too broad nor too narrow' to prevent me from making an original contribution to knowledge.

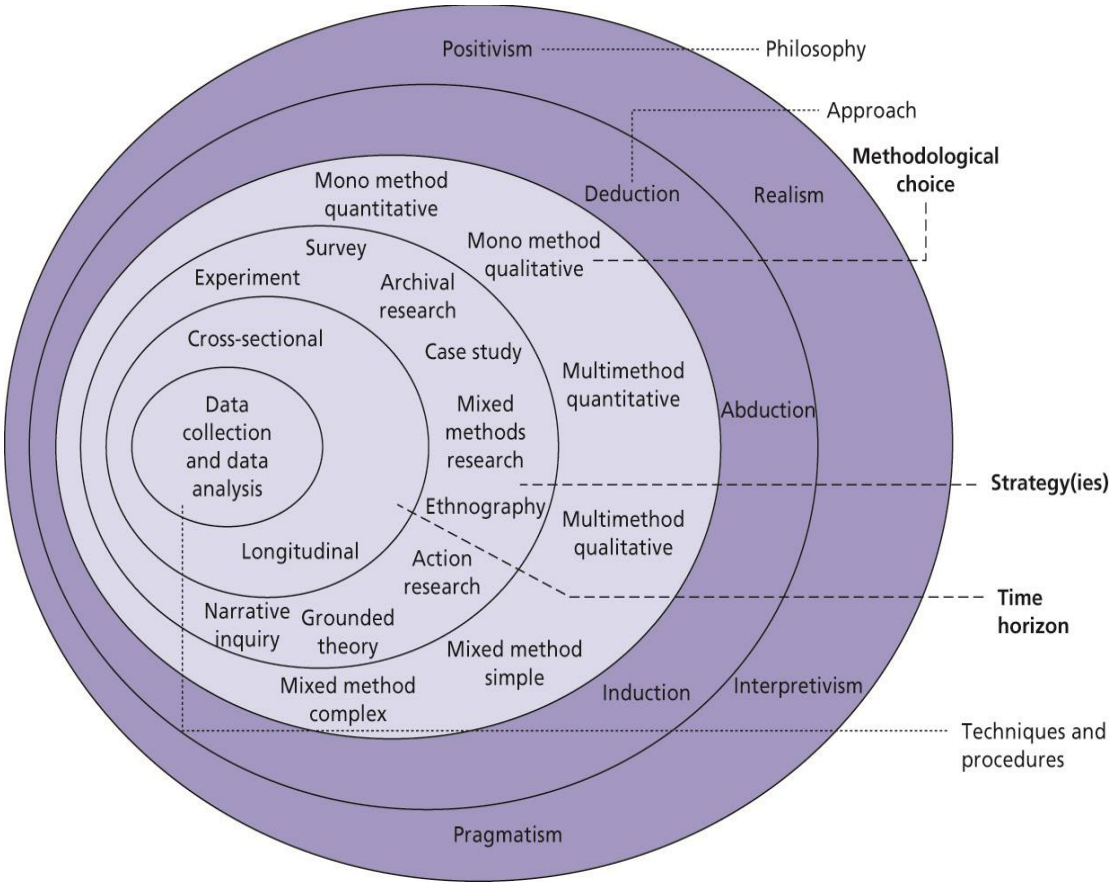
3.2 The 'Research Onion' Methodology Model

In order to answer my research questions, I formulated an appropriate and rigorous methodology using the 'Research Onion' model. Developed by Saunders, Lewis and Thornhill (2012), the 'Research Onion' model (see Figure 3-1) compares the research process to the layers of an onion

[34] The terms 'methodology' and 'methods' are often used interchangeably. However, I understand the terms to refer to different aspects of the research process. Research methodology informs and shapes research methods. Methodology refers to the study of methods and deals with the philosophical principles underlying the research process. Methods refer to the specific techniques and processes for data collection employed under those philosophical assumptions.

and provides a useful metaphor for thinking about research design. The researcher starts with the outermost layer of the onion, the research philosophy, and 'peels back' each subsequent layer until the onion's core is reached, the data collection and data analysis. The choice of research philosophy, in the outermost layer, guides and informs all ensuing research decisions, the innermost layers

Figure 3-1: A visual representation of the 'Research Onion' model



Source: Saunders, Lewis and Thornhill, 2012.

First Layer of the Onion: Research Philosophy

Research philosophy describes how knowledge is constructed, replicated and validated. In order to select the most appropriate research philosophy for my study, I familiarised myself fully with the research methodology literature (Bryman 2012; Flick 2014; Gray 2014; Punch 2014; Barker, Pistrang and Elliott 2016; Yin 2016), critically interrogating my own assumptions about the nature of reality, 'ontology', what it is to know, 'epistemology', and how my own values, 'axiology', influence how I think about and interact with the world. As Mertens (2010, p. 9) advises:

> If researchers do not acknowledge (or know) the philosophical assumptions that underlie their works, this does not mean that they have no philosophical assumptions. It merely means that they are operating with unexamined assumptions.

This process of philosophical reflection was fundamental for setting the groundwork of my study.

Ultimately, it was the philosophy of pragmatism[35] that resonated with me most deeply and was selected as the philosophy for my study. Broadly conceived, the pragmatist posits that knowledge is 'both constructed and based on the reality of the world we experience and live in' (Johnson and Onwuegbuzie 2004, p. 18). Pragmatism defines the world as existing independently and as being mediated and interpreted by social beings. This perspective suggests that there is not one single approach to understanding the world or our interactions within it. Pragmatism aims to avoid the either/or thinking associated with purely positivist[36] and purely interpretivist[37] philosophical viewpoints. In rejecting these two purist positions, pragmatism refutes the 'incompatibility thesis'[38] (Howe 1988) and instead offers a flexible research paradigm, situated in the middle ground, capable of drawing on what is valuable from both the positivist and interpretivist traditions (Armitage 2007; Yin 2016; Shannon-Baker 2016). Rather than forcing researchers to wear 'a theoretical and methodological straitjacket' (Ritchie et al 2014, p. 9), pragmatism allows researchers to embrace both quantitative and qualitative methods, which can be viewed as 'different but complementary forms of empirical inquiry' (Punch 2014, p. 304).

Second Layer of the Onion: Research Approach

A pragmatic philosophy meant that my research study did not apply an exclusively theory-led deductive or data-led inductive approach. While deductive and inductive research approaches may appear distinct and irreconcilable, they are often compatible and used simultaneously. Bryman (2012) suggests that deduction and induction are not mutually exclusive and more appropriately may be considered as preferences rather than as settled distinctions. The divide between deduction and inductive is not decisive:

> Any experienced researcher knows that the actual process of moving between theory and data never operates in one direction. Outside of introductory textbooks, the only time we pretend that research can be either purely inductive or deductive is when we write up our work for publication. (Morgan 2007, p. 70)

As Johnson and Onwuegbuzie (2004, p. 17) elaborate:

> [The] logic of enquiry [underpinning a pragmatic research philosophy] includes the use of induction (or discovery of patterns), deduction (testing of theories and hypotheses) and abduction (uncovering and relying on the best set of explanations for understanding one's

[35] Pragmatism originally emerged at the start of the twentieth century and is typically associated with Charles Sanders Peirce, William James and John Dewey. Although the influence of pragmatism declined considerably between the 1930s and 1970s, both Punch (2014) and Gray (2014) point to a recent revival in its popularity.
[36] A positivist proposes that reality is something external and objective and focuses on causality. A researcher working in the positivist tradition aims to be independent and detached from the data and uses highly structured and (largely) quantitative methods.
[37] An interpretivist proposes that reality is socially constructed and subjective and considers social phenomena as contingent and multiple. A researcher working in the interpretivist tradition acknowledges that meanings are not fixed, and that the researcher cannot be separated from what is being researched. An interpretivist conducts in-depth and (mostly) qualitative studies.
[38] This is the idea that the use of both quantitative and qualitative methods is incompatible at either the level of practice or that of epistemology.

results).

In other words, deductive and inductive approaches, when combined, augment one another, producing more nuanced and complex data on the questions being researched.

Third Layer of the Onion: Methodological Choice

Pragmatism legitimised the merging of methods in my study. I found Johnson, Onwuegbuzie and Turner's (2007, p. 129) definition of mixed methods research the most compelling:

> Mixed methods research is an intellectual and practical synthesis based on qualitative and quantitative research… It…offers a powerful third paradigm choice that often will provide the most informative, complete, balanced, and useful research results. Mixed methods research is the research paradigm that…partners with the philosophy of pragmatism.

Greene, Caracelli and Graham (1989) identify five broad rationales for conducting mixed methods research: (1) triangulation, allowing findings to be corroborated and verified from multiple perspectives; (2) complementarity, using one research method to elaborate, clarify and illustrate findings generated by the other method; (3) development, using one method to inform the development and design of the other method, so that omissions or gaps in knowledge can be addressed; (4) initiation, identifying inconsistencies, contradictions or new perspectives that may lead to the re-framing of the research questions; and (5) expansion, broadening the range of inquiry, to obtain a richer, fuller account of the phenomena being studied. Mixed methods enhance research findings by combining the strengths of both methods while simultaneously counterbalancing their weaknesses.

Fourth Layer of the Onion: Research Strategy

A survey[39] seemed the most appropriate and convenient strategy for gathering data on my research questions. My survey strategy consists of two phases: (1) an online, self-completion attitudes questionnaire distributed to all registrants of the BPC (approximately 1403 psychodynamic practitioners in 2015–16); and (2) semi-structured interviews undertaken with a mainly purposive sample of BPC registrants.[40]

The questionnaire was intended to 'set the scene': that is, identify and describe the existing range of theoretical, clinical and professional perspectives of UK psychodynamic therapists and, where relevant, examine any associations between therapists' personal and professional attributes and

[39] The term 'survey' refers specifically to a research strategy or design for gathering data that could involve a wide variety of data collection methods including questionnaires, interviews or focus groups. Contrary to common usage, survey strategy does not refer solely to quantitative or deductive research. Furthermore, the terms 'survey' and 'questionnaire' should not be used interchangeably as is sometimes the case. The term 'questionnaire' refers to a specific research instrument or data collection method used within a survey research strategy or design.
[40] The BPC collaboration is discussed in more detail in section 3.16 under the sub-heading 'partnership working'.

their viewpoints on specific issues, such as conversion therapy. The questionnaire provided the context for the interviews and generated additional questions for clarification within the interview study. The final questionnaire and interview topic guide can be found in Appendix B (see below) and Appendix C (see below) respectively.

Fifth Layer of the Onion: Time Frames

Due to the constraints of time and resources available in a PhD study, I selected a cross-sectional time frame. I collected data from my research population, the BPC membership, at specific points in time. The data collection period for the questionnaire was between September 2015 and December 2015. The interviews were conducted between July 2017 and May 2018.

Sixth Layer of the Onion: Data Collection and Data Analysis

From sections 3.4 to 3.16, I provide a detailed, step-by-step account of the research design and delivery, including the data collection and data analysis procedures. However, in order to shape and inform my own study design, I first had to establish the empirical context and review the few empirical attitudes studies that already existed in my area of interest.

3.3 Establishing the Empirical Context

Overall, I identified 11 relevant clinical attitudes studies. I have summarised the results of these studies in Appendix D (see below). Interestingly, these 11 studies were either conducted in the UK (n=4), the USA (n=5) or Italy (n=2). I did not identify any other relevant attitudes research from any other countries. As the professional, social, cultural, political and religious contexts are very different to our own here in the UK, the findings from the USA and Italian studies are not directly transferable to the UK setting. However, these studies were useful comparators and inspired questionnaire items and interview questions within my own study. Looking across the 11 research studies**,** I identified several limitations:

1. The majority of the studies (n=8) are mono method, typically involving a self-completion questionnaire of some description. Questionnaire data alone, if predominantly quantitative, are not sufficient for providing an in-depth understanding of the issues under investigation. Qualitative data are also needed to present a fuller picture.

2. The three studies using mixed methods (i.e., a combination of self-completion questionnaires plus interviews) have limitations in terms of the reporting. Ciclitira and Foster (2012) do not report their questionnaire results. Bartlett, King, and Phillips (2001) report their questionnaire findings separately to their interview findings, so results are not synthesised in the same paper. Ellis (1994) integrates findings from both her questionnaire and interviews but does not employ appropriate conventions for reporting

empirical results, for example no use of IMRaD or systematic discussion of the sample and methods.

3. With the exception of four studies (Garnets et al 1991; MacIntosh 1994; Bartlett, King, and Phillips 2001; Bartlett Smith and King 2009) where the questionnaire response rates are unusually high (50%–75%), most other studies using questionnaires achieve moderate (25%–50%) to average (25% or less) response rates. Two studies have very low response rates: 9.11% (Friedman and Lilling 1996) and 11% (Lingiardi, Nardelli and Tripodi 2015).

4. Several of the questionnaire studies use convenience sampling frames (Lingiardi, Nardelli and Tripodi 2015), so some units of the population are more likely to have been selected than others. Other studies (Kilgore et al 2005) have clear sampling biases, excluding, for instance, practitioners without doctorates, meaning some members of a population have no chance of being selected for inclusion in the sample. Many of these studies are, therefore, not representative or lack generalisability to the wider professional population they seek to investigate.

5. Several of the studies focus on conversion therapy (Bartlett, Smith, and King 2009; Lingiardi, Nardelli and Tripodi 2015) and do not address broader theoretical and clinical issues that may be of interest when working with LGB clients, such as the role of internalised homophobia or transference and countertransference issues.

6. Most studies prioritise clinical practice with gay men and lesbians (Friedman and Lilling 1996; Jordan and Deluty 1995) and exclude consideration of bisexual clients.

7. Ellis' study (1994) is the only one to explicitly address the training and institutional context. This is an essential area of focus because trainees first encounter and internalise theoretical, clinical and professional attitudes, whether positive or negative, toward same-sex sexual orientation within their training organisations.

8. Some studies (Bartlett, Smith and King 2009) do not focus on psychodynamic therapists but rather gather data from a wide range of mental health professionals, including psychologists, psychiatrists and behavioural therapists.

The current study seeks to redress some of these limitations by:

1. Adopting a mixed methods approach, including a self-completion questionnaire plus semi-structured interviews, to triangulate and synthesise data.

2. Encouraging greater response rates to the questionnaire through targeted marketing and promotion (see section 3.7).

3. Addressing broader therapeutic issues than just conversion therapy, for example LGB therapists' self-disclosure of their sexual orientation to LGB clients, internalised homophobia, and LGB-specific transference and countertransference dynamics.

4. Exploring attitudes towards bisexual clients in addition to gay and lesbian clients.

5. Incorporating questions relating to the training and organisational context alongside questions of theory and technique.

6. Restricting the research focus to psychodynamic psychotherapists in order to specifically elucidate the views and practices of therapists working within the theoretical framework of psychodynamic psychotherapy, which may not be used by a broader range of mental health professionals.

3.4 Questionnaire: Pre-Pilot Development and Testing

In the pre-pilot stage, I identified the questions for inclusion in my questionnaire. Questions were initially informed by a rapid review of the literature and close examination of similar research studies (see section 3.3). I compiled a long list of questions and probable answers, grouped into key topic areas and arranged into a logical order. In line with Gillham (2000), this long list included: (1) questions of *fact*; (2) questions about *opinions, beliefs, judgements;* and (3) questions about *behaviours* (what people do). The questions about *opinions, belief and judgements* were the most challenging to design because many respondents may lack comprehensive models for thinking about same-sex sexual orientation. I was aware of Sandler's (1983) distinction between therapists' *private theories* (what they personally feel and think about a particular clinical issue and what their clinical experience has led them to believe in practice) and *official theories* (what they have been taught to think about a particular clinical issue during training). Furthermore, the sensitivity in the profession around same-sex sexual orientation made wording questions as neutrally as possible a considerable task. It was a challenge to create questions that did not predispose respondents towards socially desirable answers. BPC task group members reviewed the first full draft of the questionnaire. I present their feedback below.

Questionnaire Instructions

Task group members suggested that, in the questionnaire instructions, I should explicitly allay any potential anxieties respondents might have in relation to confidentiality.

> In the introduction…perhaps we need some way of strengthening the confidentiality information, provided it's true that the completed questionnaire is not linked to any other membership information and there is no way of identifying individual respondents.

Question and Answer Selection

Task group members offered suggestions about how specific questions might be reformulated to allow more granularity, nuance and richness of response.

> We might get more information if these questions were combined into a series of statements for which people would be asked about their extent of agreement or disagreement.

Several response options were considered unsuitable for capturing the complexity of psychodynamic thinking on same-sex sexual orientation.

> The answer to this question is 'yes' or 'no'…whereas perhaps we want respondents to prioritise these options by ranking in order of importance or indicating how useful each of these options are.

Some question responses required open-text boxes to allow for more in-depth answers.

> If we could change 'Other' to 'Why do you say that?', this might give more information we can work with later.

Additional response options, such as 'don't know' or 'not applicable', were requested for specific questions to avoid respondents feeling coerced into having to guess an answer.

> I was forced to answer question X… There should be a 'don't know' option… I wondered if there could also be a 'don't know' box for question Y.

Question Routing

Some task group members identified problems with the routing and flow of the questionnaire. This raised the issue of question sequencing. More signposting or skip logic might be needed so that respondents could bypass non-relevant question items.

> If the respondent…has not treated anyone homosexual, then it should indicate on the questionnaire that they don't have to answer questions X to Y.

Questions Related to Training Organisation

Some members viewed questions related to training organisation as potentially divisive, possibly deterring BPC members from completing the questionnaire.

> I suspect people would find it difficult to volunteer negative information about their training

organisation.

Other members felt strongly that questions about their training organisation were central to the research and should be included.

> Speaking personally, I would like to know where my own training organisation fits into the overall pattern of responses.

Task group members offered several solutions to this dilemma.

> Perhaps in smaller training organisations, it may be thought to make people too identifiable, especially with the demographic categories asked for. In that case, I think it is better to reduce the demographic information (e.g., age) rather than the training organisation information.

Coverage of Transgender Issues

Another concern was around whether the questionnaire should address transgender issues. Some task group members felt that including transgender would distract from the main research focus: same-sex sexual orientation.

> Transgender is more about gender identity whereas LGB is more about sexual orientation, and for various reasons, it is important to remain aware of this distinction.

Other members felt there was scope to address LGBT as an interconnected area and that it was appropriate for transgender to be included in the study.

> I agree with including transgender for important reasons - moral, legal, equality, inclusiveness, professional … The T in LGBT too easily gets lost or cast out if it's not attached to LGB.

3.5 Questionnaire: Pilot Testing

Based on the task group members' feedback, I produced a revised questionnaire to pilot test with 17 BPC registrants who had not previously been involved with the questionnaire development. These volunteer pilot testers were recruited via an open email sent to all BPC registrants. Pilot testers were asked to complete the revised questionnaire and fill out a detailed feedback form (found in Appendix E, see below). This pilot study was valuable because it gave an indication of the questionnaire's overall utility and functionality. The pilot testing helped to: (1) identify how long on average respondents took to complete the questionnaire; (2) clarify questionnaire instructions; (3) tease out any ambiguity in question phrasing; (4) establish whether any key topics had been omitted; and (5) highlight any flaws in layout, design and usability. The pilot feedback follows.

Questionnaire Length

Fifteen pilot testers (88%) reported that the questionnaire length was appropriate, taking approximately 20 minutes on average to complete. The remaining two (12%) respondents struggled with the questionnaire. One respondent explained that they had made two attempts but had needed more time to think about how to answer the questions. The other respondent rejected the questionnaire outright and refused to engage with it, stating that they were 'personally…out of sympathy with the approach'. By this, the respondent meant that a questionnaire was unsuitable for gathering data on an issue as complex as sexual orientation.

Incompatibility with Clinical Experience

Pilot testers expressed concern that certain response options did not always reflect or resonate with their own personal and clinical experiences of working with LGB clients.

> I think there is wide variance in sexuality, and I do not easily define…others in the specific categories of L, G, B or H... There is a premise running throughout…that LGB patients are potentially a homogenous group when this is not my clinical or life experience.

Some pilot testers considered sexual orientation to be fluid and thought the predominant use of tick-box questions inadequate for capturing the multidimensionality of sexual orientation.

> There is something about the degree of categorisation which goes against both my view of sexuality and psychoanalysis. I was thinking about a female patient who I have seen for a long time… I have no idea how she would currently define her sexual orientation and I would have no interest in defining it myself.

At this point in the research process, my own thoughts on same-sex sexual orientation were underdeveloped. I was not familiar with concepts such as 'sexual fluidity' or with disciplines such as queer theory, which consider sexuality very differently to psychoanalysis. Although I identify as a gay man, pilot feedback helped me recognise how embedded my own thinking was in a dichotomous framework and how this limited the ways some questionnaire items were worded.

Need for Open-Ended Responses

Several pilot participants requested additional opportunities for more open-ended responses so they could reflect more thoughtfully on specific issues or offer qualifications to their answers.

> I think obliging people to think about their own attitudes and state them would be preferable to someone else's range of options.

Social Desirability

A handful of pilot testers highlighted that respondents may answer some questions less honestly in order to present a more favourable impression.

> To a degree once you move away from factual responses e.g., numbers of patients, then there can…be a pressure to answer in a politically correct fashion. I hope we are insightful and brave enough to struggle with this.

Use of Language

Some questions were criticised for using prejudicial language. Feedback on language illustrated the difficulties of designing a completely non-biased questionnaire.

> I found the language in the questionnaire problematic at times… I think the moves to modernise the profession are really important and that we should get these things right and not compound problems by inappropriate use of language.

Researcher's Assumptions

It was not uncommon for pilot testers to draw attention to researcher bias, which they thought was evident in the wording, tone and ordering of some of the questions and response options.

> I think the questions start from false assumptions about sexuality and do not start with a neutral stance of enquiry.

In the earlier stages of the PhD, I had a personal bias towards expecting proof of homophobia within the psychodynamic profession and at the time of pilot testing, I was over reliant on out-dated or more classically oriented psychodynamic literature. I had not yet sufficiently taken into account the extent to which contemporary psychodynamic thinking had started to critique the pathological theories of the past. This bias was often reflected in my question response options.

> The response set to this question [i.e., theories of sexual orientation] is not presented in a neutral way… It could be read as four pathological items followed by three non-pathological ones.

The next respondent's comments were particularly insightful and shocked me with their incisiveness about my own unconscious assumptions. This type of feedback was incredibly useful as it demonstrated how difficult it can be to achieve neutrality and not let one's own experiences and unconscious prejudices bias the research process.

> I cannot think of another psychotherapy questionnaire that would put 'sexual abuse' first as a reason for people seeking therapy… I think there is an (unconscious) insinuation that this reason would apply more to LGB patients. Also, the two main reasons people seek therapy (depression and anxiety) are completely missing. I would try to imagine a listing that is more consistent with the evidence for reasons people seek therapy in general.

Some pilot testers commented that I had not made a clear enough distinction between the different LGB populations.

> There were a number of implicit assumptions… These include the underlying belief that there is a meaningful category of patients/candidates/therapists called 'LGB' who can be thought about and discussed together.

> No conclusions based on my answers will be remotely valid unless a distinction is made between gays and lesbians or…more accurately, men and women. Differences between gay and lesbian patients might be as much to do with gender as sexual orientation.

Faulty Question Construction

Pilot testers noted several examples of faulty question construction.

> I found myself veering between two thoughts: am I being asked if I think homosexuality is a perversion…or am I being asked if, in my experience with LGB patients, I have found the concept of perversion relevant and useful? These are very different questions.

A handful of respondents found the response options for specific questions to be imprecise or contradictory, potentially producing misleading and inaccurate answers.

> In question X, I wanted to answer that 'in all cases', I would use the same approach with LGB and non-LGB patients, but I feared this would be misconstrued as not understanding or taking account of the obvious socio-economic and historical tensions in relation to homosexuality (as also with differing cultural and ethnic backgrounds).

Omitted Questions

Pilot testers suggested that some important topics were missing from the questionnaire, including questions on the specific experiences of being a LGB therapist in the profession.

> [We need] something about the respondent, as therapist, who is LGB, feeling comfortable to be out and open about their sexuality within their training organisation.

Some pilot testers thought the questionnaire needed to address the role of training organisations in tackling issues of discrimination and prejudice.

> We need a question on the way psychoanalytic organisations have failed LGB patients, candidates and members and what steps need to be taken to remedy this situation.

Demographic Questions

One respondent held a very strong opinion about the wording of the demographic questions. Again, my own limited knowledge about the complexity of gender identity had been exposed.

> Good practice would normally mean that this question [asking for the respondent's gender] would give options of 'female', 'male' and 'other' (with a request to give more information for the latter choice). To include 'transgender' in the list is to imply that being transgender means that you are not actually male or female, which some would find offensive. Also, the options should be in alphabetical order and not privilege 'male' as first choice, especially in a profession where the majority are not male. I would then add a subsequent question asking: is your gender identity different to that assigned at birth?

After careful consideration of the pilot feedback, I made further modifications[41] to the questionnaire. The final questions were inputted into *Survey Monkey.*[42]

3.6 Questionnaire: Validity and Reliability

Confirmation of validity is an important factor in any questionnaire because it measures 'the degree to which data…are accurate and credible' (Bryman 2012, p. 717). However, as Bell (2010, pp. 119-120) points out, 'measuring the extent of validity can become extremely involved and there are many variations and subdivisions.' In line with my pragmatic approach, I accepted Punch's (2014, p. 240) recommendation that 'there is no fool proof procedure to establish validity and the validation methods used should depend on the situation.' Furthermore, the pre-piloting work with task group members (n=10) and the piloting work with the BPC volunteers (n=17) considerably enhanced the content[43] and instrument validity[44] of my questionnaire. As Galasinski and Kozlowska (2010, p. 272) comment:

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[41] Not all feedback could be accommodated. I increased the number of open-ended questions but did not remove all categorical questions. Open-ended questions might produce more intricate data, but they would be harder to analyse: a balance was needed. I continued to ask questions about LGB clients as a whole rather than ask individual questions about gay men, lesbians and bisexuals separately, otherwise the questionnaire would have become unwieldy. The questionnaire retained its focus solely on LGB clients and did not additionally address transgender. In the end, respondents were asked to identify their training organisation, but this was not compulsory.

[42] *Survey Monkey* is an online questionnaire development software application. It is a fairly user-friendly platform, which is easy for respondents to navigate and automatically collates data as responses are received. *Survey Monkey* helped improve the visual and functional design of the questionnaire by allowing me to include: (1) a 'progress bar' so respondents could see how far along in the questionnaire they were and how far they had left to go; (2) a mechanism allowing respondents to go back and edit answers; (3) a 'Save and Return' function allowing respondents to save their answers and to come back to the questionnaire at a later time; and (4) a 'Skip Logic' function allowing respondents to bypass non-relevant questions.

[43] The extent to which the questionnaire items were appropriate and complete.

[44] The extent to which the questionnaire items measured what they were intended to measure.

> What are in effect technical issues (i.e., validity) can be dealt with by careful attention to design, measurement and pilot work. Thus, item wording can be clearer, the process of completion simplified, and the response options can be better matched to the way people think about the topic at hand.

Pre-pilot and pilot work also enhanced the questionnaire's reliability. Reliability refers to the 'consistency, dependability and replicability of the results obtained from a piece of research' (Zohrabi 2013, p. 259). Several factors may undermine the reliability of a questionnaire. More systematic factors include the instrument itself (e.g., How well-worded were the questions?). Less systematic factors include participant variability (e.g., What was the respondent's mood when completing the questionnaire?) and environmental variability (e.g., Was the questionnaire completed in the morning and at home or in the evening after a busy day at the clinic?).

Due to professional and personal demands, pilot testers were unable to commit to a test-retest experiment in order to examine the possible influence of these factors. As a partial solution, I consulted the task group members once more and asked them to comment on any questions that they felt were more likely to yield variations in response depending on the participant and environmental factors outlined above. Some questionnaire items were further simplified.

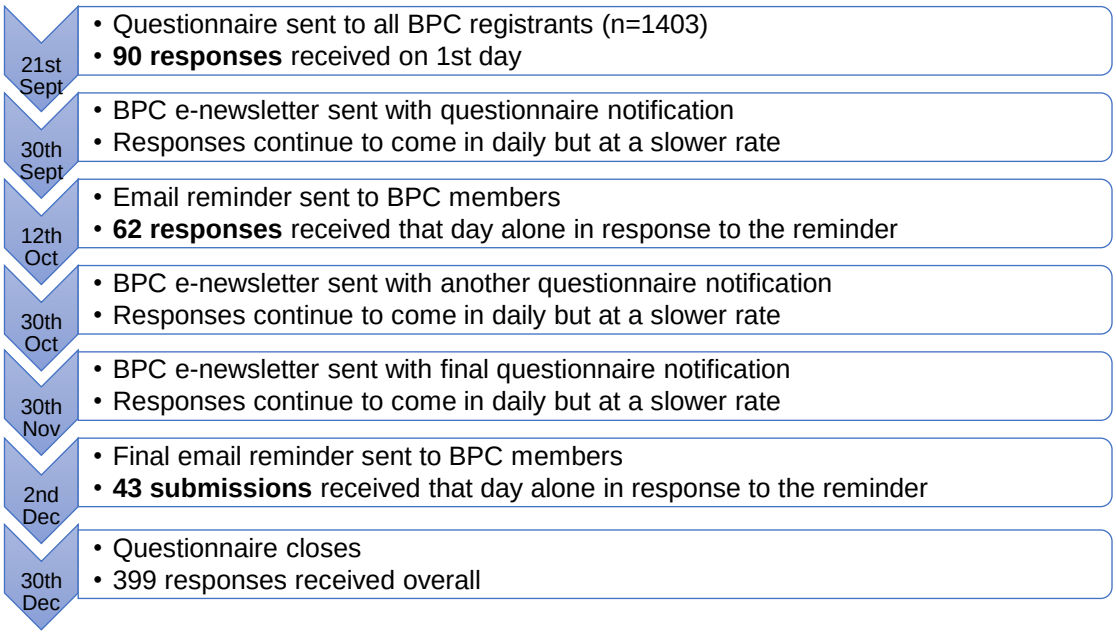
In order to increase confidence in the reliability of my questionnaire, I decided to carry out a reliability analysis on a couple of question subsets within the questionnaire. Cronbach's Alpha was 0.891 for the subset of questions exploring respondents' views on the BPC's role in developing a more inclusive psychodynamic psychotherapy profession. This represented good internal consistency. Cronbach's Alpha was 0.676 for the subset of questions exploring respondents' views on a range of theoretical statements. This represented moderate internal consistency (i.e., less reliable).

3.7 Questionnaire: Dissemination and Marketing

The questionnaire was launched on 21st September 2015 with a closing date of 30th December 2015. The BPC led on all marketing and promotional activities (see Figure 3-2, below, for promotional timeline). Targeted email communications were particularly effective for boosting response rates. Very limited use was made of social media. In addition, the BPC publicised the questionnaire in its monthly e-newsletter and quarterly magazine, *New Associations.*[45]

[45] The 17th edition of *New Associations* (March 2015) was dedicated to the issue of same-sex sexual orientation and promoted the work of the BPC Sexual and Gender Diversity Task Group. A feature appeared promoting the upcoming questionnaire.

Figure 3-2: Questionnaire promotional timeline



3.8 Questionnaire: Data Analysis

Data analysis consisted of several phases. In the first phase, I created a data analysis plan (Simpson 2015) (Appendix F, see below). The plan provided a template for how I might analyse the questionnaire data and present the results in the best way, for example by using pie graphs, bar graphs or tables. The data plan also outlined how I would test for associations between respondents' personal and professional attributes and their views on specific questionnaire items, such as LGB therapists' self-disclosure of their sexual orientation to LGB clients. Since most of my data was categorical, I needed to recode the existing data into binaries, create cross tabulations and test for associations using chi-squared (χ^2) tests. χ^2 is a common statistical test to assess whether variables in a cross tabulation are related to one another, and in particular, whether a set of observed frequencies deviate significantly from a set of expected frequencies (Greasley 2008; Berman-Brown and Saunders 2008).[46]

In the second phase, I downloaded the data from *Survey Monkey* into Microsoft Excel and created a codebook to simplify and standardise the data for analytical purposes (Pallant 2013). Then I re-coded the data in Excel using the codebook. This involved re-defining each of the questionnaire variables by assigning a number to each response (e.g., replacing 'female' by 1, 'male' by 2 and

[46] As Clark and Foster (2015) outline, χ^2 tests must fulfil four basic assumptions in order to be useful: (1) variables must be nominal or ordinal and the data must be represented as counts or frequencies; (2) each count must be independent and contribute no more than once to the overall count; (3) none of the expected frequencies in the table cells can be less than five; and (4) the sample size must be at least 20. χ^2 tests are underpinned by a null and an alternative hypothesis. A null hypothesis states that there is no significant relationship or difference between the two (or more) variables being examined. The alternative hypothesis states that there is a significant relationship or difference between two (or more) variables being examined. When conducting χ^2 tests, conventional wisdom is that we may accept a small *p*-value (typically ≤ 0.05) as indicating a strong association between the variables being tested, meaning the null hypothesis is rejected and the alternative hypothesis is accepted. A large *p*-value (≥ 0.05), on the other hand, indicates weak association between the variables being tested, meaning the null hypothesis is accepted, and the alternative hypothesis is rejected.

so on). You can find the codebook in Appendix G (see below).

In the third phase, I became fully acquainted with the Statistical Package for Social Sciences (SPSS) (Gray and Kinnear 2012; Pallant 2013; Davis 2013). I then uploaded the re-coded Excel worksheet to SPSS and screened the data for errors (Pallant 2013). I used the SPSS 'Descriptive Statistics' function to check that categorical variables were not out of range for possible scores. The number of valid and missing cases was also checked.

In the fourth and final phase of the data analysis, qualitative data from open-ended questions were entered into separate Excel worksheets (18 in total). The data for each worksheet were read, re-read and summarised. Patterns of responses were identified and grouped together into themes. Appendix H (see below) provides a sample from one of the qualitative worksheets.

3.9 Interviews: Pre-Pilot Development

The focus of the pre-pilot phase was to draft an effective interview topic guide or 'protocol'. I was guided by the Interview Protocol Refinement (IPR) Framework (Castillo-Montoya 2016).

Phase One: Interview and Research Question Alignment

The alignment involved generating an initial set of interview questions, more than were actually needed, and then mapping these interview questions against the research questions. This ensured that the interview questions were relevant and aligned to the study's overall aims.

Phase Two: Creating an Inquiry-Based Conversation

I created an inquiry-based conversation by constructing a topic guide that balanced inquiry with conversation. As Table 3-1 (below) shows, I achieved this by using a variety of question types: (1) introductory questions to warm up interviewees; (2) transition questions to gently ease interviewees in; (3) substantive questions likely to answer the research questions; and (4) closing questions providing an opportunity for closure.

Table 3-1: Question types used in final topic guide

Question Type	Examples from final topic guide
Opening questions	• Can you briefly tell me your reasons for choosing to take part in this interview?
Transition questions	• Would you say you have an interest in the area of same-sex sexualities? If so, how did this interest develop?
Substantive questions	• Could you describe which theories, psychoanalytic and non-psychoanalytic, you find useful for understanding and explaining same-sex sexualities?
Closing questions	• Is there anything else you think relevant or important to discuss that we haven't covered so far?

While unanticipated or unplanned questions naturally emerge during the course of an interview, it is good practice to think in advance about some possible prompts to encourage participants to open up and expand on their answers in more detail (as Table 3-2, below, illustrates).

Table 3-2: Follow-up questions/prompts in final topic guide

Question 4	**Could you describe your clinical work with clients with same-sex sexual orientation(s)?** • Could you outline any technical considerations, such as use of countertransference or self-disclosure, you think are useful when exploring same-sex sexualities in the clinical setting? • Are there any clinical issues that are unique or specific to the LGB community, for example stigma or internalised homophobia? • What similarities and/or differences do you see in your clinical work between lesbians, gay men and bisexual clients? • Could we think a bit about how your clinical work with LGB clients compares with your clinical work with non-LGB clients?

Phase Three: Topic Guide Review

After reviewing my initial topic guide, both my supervisors felt it contained too many questions, many of which repeated the questionnaire items. Furthermore, the initial questions were too specific, not offering sufficient flexibility for participants to speak freely and for new or unexpected topical trajectories to develop. My supervisors encouraged me to imagine a series of open-ended questions. I had to learn to trust my interview participants to interpret the questions in their own unique ways and to offer them the necessary breathing space to do so. A less structured topic guide would facilitate this process of reflection. The final topic guide (Appendix C, see below) is considerably more flexible in design, consisting of eight core questions using a combination of question types and prompts. Questions were mostly open-ended in order to: (1) yield spontaneous, rich, first-person descriptions; (2) encourage participants to describe what was of interest to them; and (3) capture the diversity of participants' perspectives.

Phase Four: Pilot Testing

I pilot tested the topic guide with a small sample of individuals. In this phase, the researcher 'conducts interviews simulating rapport, process, consent, space, recording, and timing in order to "try out" the research instrument' (Baker 1994, cited in Castillo-Montoya 2016, p. 827). I describe the pilot testing process in detail in the next section.

3.10 Interviews: Pilot Testing

I piloted my topic guide with four BPC members, three of whom I already knew as valued colleagues and whose feedback and judgement I trusted. The other participant was unknown to me but had been recommended as someone with an interest in my research topic. I conducted the pilot interviews between July and October 2017.

Interview Preliminaries

At the start of the interview, I provided pilot participants with a Participant Information Sheet (Appendix I, see below) and a Consent Form (Appendix J, see below). I explained both documents to the pilot participants before asking them to sign and date them. Pilot participants were also asked if they would complete an optional Demographics Form (Appendix K, see below). I then conducted the main interview asking for permission to record. After conducting the interview, pilot participants were sent a feedback form (Appendix L, see below) to complete. All feedback received was used to refine the topic guide.

Using a five-point scale from 'strongly agree' to 'strongly disagree', the first part of the feedback form asked pilot testers to rate their level of agreement with a series of statements about how the interview preliminaries had been handled. The statements addressed: (1) how clearly I had introduced myself and my background; (2) how clearly I had explained the overall research project and its aims; (3) how explicit I had been in relation to ethical issues such as consent, anonymity, confidentiality, the right to withdraw from the interview and permission to record the interview; and (4) how responsive I had been to their questions or concerns before starting the interview. All pilot participants (n=4) either strongly agreed or agreed that these elements had been handled well.

One pilot participant found my approach reassuring.

> I think the introduction was very clear and well done, on paper and in discussion. I felt well informed and prepared for the interview.

Another pilot participant offered constructive advice about how the interview preliminaries could be improved.

> It would be helpful if the interviewer said quite firmly at the start that he expected silences or thinking time and that the interviewee could take as much time as necessary. Therapists are used to this, but it is a little different when you know that a recorder is running in the background.

Question Construction

In the second part of the feedback form, pilot participants were asked to consider the wording and phrasing of the interview questions. Pilot participants suggested some minor changes in order to reduce non-neutrality and to allow more scope for deeper engagement and contemplation.

> I found that the most productive questions were the ones that invited reflection and development e.g., 'Could we think a bit about how your clinical work with LGB clients differs from work with non-LGB clients?'

> Some of the questions confronted me (in a helpful way) with areas of my own thinking that need more attention and/or development, but the researcher was open in listening and encouraging my responses.

Interviewer Conduct

In the third part of the feedback form, pilot participants were asked to give feedback on how well I had conducted the actual interview. Overall, feedback was positive.

> The researcher presented himself calmly and professionally, establishing and maintaining a straightforward mode of communication, which supported me in reflecting on and answering the questions. He seemed neutral but interested and thoughtful as he listened… I did not feel rushed or pressurised in any way. The researcher was calm throughout the interview, moving us gently along but not giving me any sense of limited time, so I felt able to reflect at my own pace.

One interviewee felt I had facilitated the interview sensitively and had created a containing space for quiet reflection.

> I really feel the interview was managed extremely well and do not have any significant criticisms or suggested changes to make. I enjoyed the experience and appreciate the opportunity to reflect on these themes, with the researcher's helpful facilitation.

My conduct appears to have made the interviewees feel supported and at ease.

> I feel the researcher was neutral in his questioning and equally in his reception of my answers. He maintained a quiet but thoughtful attitude, which I found supportive and facilitating.

One pilot participant commented favourably on how well I had presented my own expert position as a researcher while appreciating the interviewee's expert position as a psychodynamic clinician.

> The interviewer spoke to me on a level, appearing neither superior nor subservient. This facilitated openness so that the conversation flowed. He didn't try to score points; he behaved as if he acknowledged that I knew my job but that he also was confident in his job as a researcher.

While I appear to have behaved professionally during the interview, I was not entirely successful in being neutral and detached in all participants' eyes.

> I was aware that the interviewer did not have an entirely neutral standpoint. I believe this was partly due to knowing him.

The issue of personal disclosure had to be considered. One pilot participant (the one I did not know previously) requested further background information about the research and my personal motivation for conducting it. In the spirit of honesty, I disclosed my sexual orientation.

> There was a degree of non-neutrality...by stating at the outset that he was gay…although I am not suggesting this was not right to do. However, on the other hand, I did feel in his demeanour and personal responses, the interviewer was able to maintain neutrality.

Although the self-disclosure of my own sexual orientation did not appear to have an adverse effect on the interview, it raised an important question about whether personal disclosure was appropriate when conducting the main interviews or whether a case-by-case approach might be needed.

Other Lessons Learned

Piloting highlighted the value of building rapport. As rapport with each interviewee was established, it was noticeable how they became more relaxed and reassured. I achieved rapport by: (1) providing appropriate verbal and non-verbal feedback; (2) maintaining eye contact; (3) listening actively and empathically to what the interviewee was sharing; (4) not interrupting; (5) staying in the background as much as possible; (6) maintaining a relaxed posture; (7) nodding at suitable points; and (8) making non-evaluative but encouraging noises (e.g., ‘mmh’, ‘ah-ha’). Another lesson I learned from the piloting work was the importance of improvisation. Improvisation involved me letting the interviewee digress a little, varying the phrasing and order of questions and being able to explore unexpected lines of enquiry that spontaneously cropped up. Throughout the pilot interviews, there were countless ‘on-the-spot’ moments, where modifying the interview structure to respond to a specific individual’s interests generated richer data than if I had kept rigidly to my topic guide.

3.11 Interviews: Sampling and Recruitment

For the main interviews, participants were primarily recruited via a purposive sampling technique with a minor component of snowballing. Purposive sampling can be defined as:

> The selection of participants or sources of data to be used in a study, based on their anticipated richness and relevance to the study’s research questions including sources whose data are presumed to challenge and not just support a researcher’s thinking. (Yin 2016, p. 339).

In other words, purposive sampling aimed to achieve a broad but not necessarily representative range of perspectives. Using Flick’s approach (2014), I aimed to recruit: (1) critical cases, experts on issues of sexuality and gender; (2) sensitive cases, individuals who identified as LGB or had a personal and often political interest in the subject area; (3) deviant cases, individuals known to

hold extreme or very individualised views; (4) typical cases, individuals who might be considered an 'average' BPC registrant, someone interested in the research area but not a specialist; and (5) maximal variation cases, participants with different genders, sexual orientations, ethnicities, ages and theoretical affiliations from across all 14 BPC membership organisations. In addition, due to the research focus on institutional attitudes and practices, I also aimed to recruit: (1) senior therapists who might be currently involved in candidate selection, training analyses, supervision or teaching; (2) individuals who had recently qualified or were at an early stage of their career; and (3) individuals who had qualified decades ago and were retired or close to retirement.

Several of the critical, sensitive and deviant cases I interviewed were already known to me through: (1) my various teaching roles; (2) my involvement with the BPC Task Group; (3) hearing these individuals speak at conferences; and (4) reading influential papers these individuals had written on the subject area. I used the BPC register to recruit more generalist participants.[47] As the BPC register includes details of BPC registrants who are training analysts or supervisors, I was also able to use the register to identify the senior therapists I wished to interview. Additional participants were identified through snowballing techniques.[48] I followed-up therapist names recommended to me by other interviewees and my primary supervisor.

I sent email invitations to all potential participants and immediately followed-up affirmative responses (36 in total including pilots) to arrange a mutually convenient location and time for the interview. Participants were not recruited all at once: recruitment continued until the point of saturation, that is when no new data was being obtained. No repeat interviews were conducted. Only the researcher and the interviewee were present at the interviews. Interviews varied in duration and took place across a range of settings. In the interview results chapter (chapter 5, see below) and in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong, Sainsbury and Craig 2007) (see Appendix M, below), I fully describe the sample's characteristics, the non-participation rate, the interview settings, the interview duration(s) and my previous professional relationships with the participants.

3.12 Interviews: Field Notes

Although they do not form part of my overall analysis, it was helpful to take field notes particularly when an interview had been difficult or emotionally charged. One participant, for example, became visibly distressed while recounting an abusive experience she had endured as a young lesbian who had just 'come out'. While she was fine for the recording to continue, it felt important to note the emotional hue the interview had taken and how this had affected me, because I became more empathic towards the interviewee. In another instance, a senior psychotherapy figure behaved rather dominatingly, constantly posturing and asserting their position of power throughout the interview. In this case, I noted my feelings of vulnerability and my difficulties in

[47] The BPC register contains the names of over 1450 psychoanalytic and psychodynamic psychotherapists and counsellors, including psychoanalysts, Jungian analysts, and child psychotherapists who are registrants of the BPC.
[48] Snowball sampling involves primary data sources nominating another potential primary data source to be used in the research.

maintaining control of the interview. Other interviewees, while very accommodating and open with me, made what I considered to be homophobic, biphobic or transphobic comments. This made me feel both very uncomfortable and angry. In some interviews, maintaining rapport was, as Bryman (2012, p. 218) notes, 'a delicate balancing act'. These field notes were invaluable for reminding me that it is virtually impossible for the researcher to remain detached during fieldwork.

3.13 Interviews: Recording and Transcription

All 36 interviews were digitally recorded. I used two devices, one intended solely for back-up. Both devices were made by the market leader, Sony, in order to ensure high-quality recordings. No recordings failed during the data collection period and all recordings were clear with very little to no background noise. All 36 interview recordings, the four pilot interviews and the 32 main interviews, were uploaded to *Trint*, an online transcription platform with strong provision for maintaining confidentiality and the security of data. *Trint* uses automated speech-to-text technology to convert audio files into text, producing time-coded transcripts with an accuracy rate of around 50%. I individually transcribed 26 of the interviews and received support from a family member with the remaining ten. I double-checked all 36 transcripts for accuracy. Active involvement in the transcription phase helped increase my familiarity with the data.

My own transcription technique evolved over time, starting with a more naturalised approach (Oliver, Serovich and Mason 2005; Davidson 2009; Mero-Jaffe 2011). Naturalised transcription requires as much detail as possible. As well as the actual content of what is said, naturalised transcription includes all repetitions, pauses, hesitations, overlapping speech, grammatical errors, false starts, slang, involuntary vocalisations (e.g., laughing, sighing), verbal tics (e.g., 'uh-uh', 'mmh', 'you know, sort of', 'I mean') and non-verbal communications (e.g., pointing, fidgeting, nodding). However, when I offered participants the opportunity to review these naturalised transcripts, I became aware that many found them difficult to read. I began to produce more denaturalised or 'intelligent' transcripts to avoid undermining the trust between the interview participants and me. As Oliver, Serovich and Mason (2005, p. 13) advise:

> For participants engaging in member checking, naturalised transcription could be seen as disrespectful if the participant would have written the words differently or perceived their grammar more accurately than portrayed in the naturalised text.

Denaturalised transcription aims to produce a more sanitised and edited version of the interview, focusing on the informational content and substance of what is said. Denaturalised transcripts flow more freely with the messiness of speech removed and with grammar and punctuation added to make them more intelligible. This decision was later justified when I decided to undertake a Framework Analysis (FA) of my interview data (see section 3.14). Since FA is primarily interested in the content of what is said rather than how it is said, the conventions of naturalised transcription were not required (Gale et al 2013).

3.14 Interviews: Data Analysis

I conducted a Framework Analysis (FA) on my interview data. FA is an increasingly common approach to qualitative data analysis in the social sciences (Richie and Spencer 1994; Swallow, Newton and Van Lottum 2003; Srivastava and Thomson 2009; Furber 2010; Smith and Firth 2011; Gale et al 2013; Parkinson et al 2015). FA is compatible with my pragmatic methodology because it does not align with specific epistemological, philosophical or theoretical perspectives (Gale 2013 et al) and can be adapted for use in inductive or deductive analysis or both. It is a rigorous and practical analytical method with clear procedures to follow (Ritchie and Spencer 1994). FA involves summarising data in a grid that has rows for cases (people interviewed) and columns for themes. Each cell in the grid may be considered the intersection of a case and theme. When data is entered into the cell, a summary of the source content relevant to that case is created. Other features of FA include: (1) the reduction of large volumes of data into more manageable units through summarisation and synthesis; (2) the facilitation of analysis by case and by theme; (3) the retention of links to the original source material, making for easy retrieval of data; and (4) the systematic management of data. There are five phases of analysis to follow.

Phase One: Familiarisation

This involved immersing myself in the data: listening to the audio recordings; reading and re-reading the transcripts; reviewing the field notes; noting initial impressions; and listing key ideas and recurrent themes. Due to the sheer volume of data collected (over 100,000 words across 533 pages of transcript), it was not essential to review all the data in depth at this stage (Srivastava and Thomson 2009) but rather to achieve a reasonable overview.

Phase Two: Identifying an Analytical Framework

This stage involved reading the transcripts more carefully and coding them manually on paper, that is 'chunking up' the transcript into manageable units of meaning. The codes applied to the interview transcripts were 'semantic' rather than 'latent' (Braun and Clarke 2013, p. 207). Codes were constructed at face value; I did not 'dig deeper' for meanings beneath the surface. The data analysis would concentrate on the content of what was said rather than how it was said. In order to facilitate the coding, all transcripts had adequate line spacing and large, right-hand margins. Interesting passages of text were underlined; general impressions were jotted down. Initial codes were then applied to specific lines or chunks of text, with notes in the margins. Codes appeared to focus mainly on: (1) participants' descriptions of their clinical behaviours, practices and techniques when working with LGB clients; (2) participants' theoretical models, concepts and frameworks for thinking about same-sex sexual orientation; (3) participants' relationships with their clients, colleagues, trainees and training organisations; and (4) participants' own professional and private values in relation to the research topic.

Although I approached the data analysis with some *a priori* ideas, for example existing theories identified from the literature review and specific areas of interest arising from the questionnaire results, I tried to maintain an open mind to allow less familiar or unanticipated codes to be identified. The process of coding was not straightforward, and as Braun and Clarke (2013, p. 207) point out, 'coding is not an exclusive process'. Some passages of data were rich enough for multiple codes to be applied or for codes to overlap. Since FA aims to reduce data, multiple coding was applied sparingly and only if it was likely to be valuable in the subsequent analysis (Parkinson et al 2015). An anonymous coded transcript is provided in Appendix N (see below).

Coding the first 15 transcripts generated an unwieldy number of codes (200+). While this alarmed me at first, I was aware that a proliferation of codes was to be expected at this early stage. Looking across the 200+ codes, I tried to identify what they had in common so they could be grouped into higher-order categories. Codes were merged, renamed or deleted. The newly formed categories became my working analytical framework, which was then applied to the remaining 21 transcripts.

The working analytical framework continued to be refined until no new codes were generated. The final analytical framework consisted of 130 codes clustered into to ten overarching themes, which are outlined in Appendix O (see below). I agree with Braun and Clarke (2013) that themes do not just emerge fully formed from the data. As Srivastava and Thomson (2009, p. 76) describe:

> Devising and refining a thematic framework is not an automatic or mechanical process but involves both logical and intuitive thinking. It involves making judgements about meaning, about the relevance and importance of issues, and about implicit connections between ideas.

I took responsibility for coding all 36 transcripts, discussing and reviewing the process regularly in supervision. Three transcripts were sent to a colleague, Dr Karen Ciclitira.[49] She independently reviewed the transcripts in order to confirm or identify gaps in the analytical framework. The transcripts she received were completely anonymised and blank, that is none of my coding work was shared with her. Dr Ciclitira's codes are presented in Appendix P (see below). On the whole, they aligned very closely to my own themes, building my confidence in the analysis.

Phase Three: Indexing

The indexing process involved systematically applying the final analytical framework to each transcript. I used the qualitative data analysis software, NVivo,[50] for the indexing process.

[49] Dr Ciclitira is Associate Professor in Psychology at Middlesex University London. She has conducted her own research exploring issues of diversity within psychotherapy training organisations. She is a Member of the BPF Racism and Equality Committee and the BPC Task Group on Gender and Sexual Diversity.

[50] I used Bazeley and Jackson's (2013) NVivo step-by-step manual to familiarise myself fully with the software.

Phase Four: Charting

Once indexed, the data were summarised into thematic charts mirroring the categories and subcategories of the analytic framework. The purpose of charting was to condense the original data even further and to visualise the dataset as a whole. As Gale et al (2013, p. 5) emphasise, charting requires 'an analytic sensibility' and 'the ability to strike a balance between reducing the data on one hand and retaining the original meanings and "feel" of the interviewees' words on the other.'

Phase Five: Mapping and Interpretation

The final stage involved interpreting the data. I read across rows in the thematic charts to understand how different themes related to each other for a particular participant (within-case analysis). I read down columns to view everything about a theme (thematic analysis). I compared the perspectives of different participants on a specific theme (between-case analysis). For interpretative purposes, I drew on Miles and Huberman's recommendations for generating meaning from qualitative data (Miles and Huberman 1994). Simultaneously and iteratively, I utilised several of their suggested tactics, including noting patterns or themes, clustering cases, and making contrasts and comparisons. This approach helped identify connections, associations and interrelationships across the data. Miles and Huberman's guidelines for testing and corroborating qualitative data (Miles and Huberman 1994) were also useful. In particular, I employed the following tactics: checking the meaning of outliers, identifying extreme cases, following up surprises, looking for negative instances and checking out rival explanations. This approach helped tease out contradictions, inconsistencies and ambivalences across the data.

3.15 Interviews: Quality Assurance

Quantitative and qualitative methods differ substantially from one another, so the measures used to establish validity and reliability in quantitative work are not appropriate for evaluating qualitative work. Alternative frameworks for establishing rigour in qualitative methods have been proposed in the research methodology literature (Guba and Lincoln 1994; Yardley 2000, 2008).[51] Ultimately, however, it was Elliott, Fischer and Rennie's (1999) guidelines on qualitative research that I found most practical. My qualitative interview work was mapped against their seven criteria:

1. *Owning one's perspective*. This involves qualitative researchers specifying their theoretical orientations and personal biases, and acknowledging how their values, interests and assumptions influence the research process. In section 3.2, I outlined my philosophical and methodological orientations. Later, in section 3.16, I discuss the role of

[51] Guba and Lincoln's (1994) criteria for quality assuring qualitative research are based on the concepts of trustworthiness and authenticity. Trustworthiness in qualitive findings can be mapped across four domains: (1) credibility; (2) transferability; (3) confirmability; and (4) dependability. Authenticity, on the other hand, refers to the extent to which qualitative researchers fairly and fully present a range of different participant perspectives. Yardley's (2000, 2008) four principles for evaluating qualitative research include: (1) sensitivity to context; (2) commitment and rigour; (3) transparency and coherence; and (4) importance and impact.

researcher reflexivity.

2. *Situating the sample.* This involves qualitative researchers describing the interview participants and their characteristics so that readers can assess how widely applicable or relevant the findings are. In chapter five (section 5.1), I provide a detailed account of the interview sample, including personal demographics and professional characteristics. I also provide a detailed account of the interview setting(s).

3. *Grounding in examples.* This involves qualitative researchers providing sufficient examples of the data to illustrate both the analytic categories used in the study and the commentary developed in the light of them. In chapter 5 (sections 5.2 to 5.11), I present my qualitative analysis and commentary, supported with extensive extracts taken from the transcripts of the research participants. The use of extensive quotations allows the reader to assess for themselves the fit between the data and my commentary.

4. *Providing credibility checks*. This involves qualitative researchers checking with others to assess the credibility of their categories, themes or accounts. In section 3.14, I discussed how another experienced researcher, Dr Karen Ciclitira, independently reviewed and coded some interview transcripts to confirm or identify gaps in my analytical framework. Furthermore, in line with the COREQ framework, all 36 interviewees were offered the opportunity to review and validate their transcripts, of which 31 responded. Furthermore, supervision acted as a further layer of credibility checking. Task group members also reviewed and commented on summaries of my emerging results.

5. *Coherence.* This involves qualitative researchers representing their interpretations of the data in a way that achieves coherence and integration while retaining nuance and complexity. Interpretations should be presented in the form of a data-based narrative, framework or underlying structure. In chapter 5 (see below), I present my data as ten overarching themes or data-based 'stories', extensively weaving interview data into my narrative. These ten overarching themes or 'stories' are underpinned by an analytical framework (Appendix O, see below) which adds structure and coherence to the analysis.

6. *Accomplishing general vs. specific research tasks.* This involves qualitative researchers indicating whether their analysis aims to provide a general or specific understanding of the phenomena being studied and whether the sample achieves this. As I outlined in section 3.11, the interviews aimed to provide a broad, general and descriptive understanding of my research topic. I have been clear about my sampling strategy and have described the appropriateness of my sample for obtaining this generalist viewpoint.

7. *Resonating with the reader.* This involves qualitative researchers producing a thorough report of their findings from which readers can 'make sense' of the phenomena being described. Through the various credibility checks (see point 4 above), I was able to

ensure that my themes 'resonated' with and were intelligible to the target audience for my research, that is psychodynamic psychotherapists.

3.16 Ethical Considerations

Robust ethical standards are achieved by 'conducting research in a responsible and morally defensible way' (Gray 2014, p. 93). For my study, there were four main ethical considerations: (1) informed consent; (2) confidentiality; (3) partnership working; and (4) researcher reflexivity. My research study was awarded ethics approval from the UCL Research Ethics Committee (REC) in February 2015 (questionnaire) and February 2017 (interviews).

Questionnaire: Anonymity and Consent

Respondents were guaranteed anonymity with specific assurances provided in the questionnaire's instructions. No identifying data were collected other than what the respondent was prepared to state in the professional characteristics and personal demographic sections of the questionnaire. Demographic data were used to identify the overall profile of the participants but could not be traced to individuals. No contact details were requested from any respondents.

Interviews: Anonymity and Consent

Interviewees were asked to complete a Consent Form, which included a guarantee of confidentiality of data and anonymity if direct quotes were used in the final thesis. The consent form made clear that the interview was going to be digitally recorded and transcribed. Interviewees were also provided with Participant Information Sheets to ensure that they were aware in advance of the interview process, research topic and of the issues likely to be raised. Interviewees were told in writing and in person that they could withdraw from the interview process at any time. In section 3.13, I provided an example of one interviewee becoming visibly upset during the fieldwork. I asked this interviewee whether she wanted me to stop the interview recording, but she was happy to continue. If she had indicated that she was unhappy to continue, I would have ended the interview and given her the option of continuing the interview at another time or of withdrawing from the interview process entirely. As the majority of participants discussed real-life clinical cases to illustrate their points, they were given the opportunity later to review and validate their interview transcripts. This option reassured interviewees that client confidentiality would not be compromised in any way and they could further disguise clinical material if necessary.

Partnership Working

The BPC supported my study. A Partnership Agreement was developed between the BPC and me (Appendix Q, see below). This agreement clearly set out our distinct roles and responsibilities and outlined some general partnership principles. The Partnership Agreement stipulated that BPC

staff and members of the task group would only be involved in the promotion of the research. There would be no BPC involvement in the data analysis process: this was to ensure that research results were independent from the organisation and not subject to any organisational or political interference. While BPC members advised on questionnaire development and reviewed emerging findings, the final interpretation and analysis of the results was conducted by the researcher alone. A clause was added to the Partnership Agreement stating that all intellectual property rights relating to the study belonged to me and that I could publish and build on the results as I wished in any future research work.

Researcher Reflexivity

Another important ethical consideration was around how one's own subjectivity as a researcher potentially biases the research process. Researcher reflexivity was a key consideration throughout the entire research project. As Braun and Clarke (2013, p. 35) define it:

> Reflexivity has many meanings, but here [in research contexts] it is concerned with a critical reflection on the research, both as process and as practice, on one's own role as researcher and on one's relation to knowledge. Reflexive research is that which acknowledges the role of the researcher in the production of knowledge, and in which the researcher reflects on their various positionings and the ways these might have shaped the collection and analysis of their data.

On one level, the influence of researcher subjectivity is completely unavoidable, particularly when conducting qualitative interviews. As Yin (2016, p.146) reminds us:

> Qualitative interviews are interpersonal or social encounters that occur in natural settings. Under these conditions, you will inevitably bring a point of view to all your conversations.

The researcher is implicated in the construction of knowledge and is an active participant in all stages of the research process. However, in order to counteract this potential limitation, Gibbs (2007, p. 92) recommends that:

> researchers…should be explicit about their preconceptions, power relations in the field, the nature of researcher/respondent interaction, how their interpretations and understanding may have changed and more generally their epistemology.

In the discussion chapter, I will reflect in detail on how my own positionality and subjectivity may have shaped the research process.

3.17 Summary

This chapter has outlined the research methodology and methods. Using the 'Research Onion' model, the chapter has covered the research design, the development of the research instruments, the data collection and analysis procedures, the sampling strategies, the procedures for measuring validity, reliability and rigour, and the ethical principles underpinning the study. The following two chapters present the results from the questionnaire and interviews.

4 Questionnaire Results

This chapter presents the questionnaire results. The main discussion of the data is reserved for chapter six (see below). As well as presenting descriptive statistics and results from chi-squared (χ^2) tests of contingency tables, quotations from open-ended questions are used extensively in the chapter to illustrate key themes. This approach to reporting qualitative data aligns with Côté and Turgeon's (2005, p. 74) guidelines: '…several participants [should] be quoted…a reasonable number of short, clear quotations make the results easier to understand and more credible'. In line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong, Sainsbury and Craig 2007), I enhance the transparency of my qualitative findings by clearly acknowledging each respondent being quoted (e.g., *Respondent 119*) and by providing basic demographic data about them. However, I do not provide respondents' professional characteristics in order to protect identities. The full quantitative dataset is presented in Appendix R (see below).

4.1 Response Rate

Questionnaires were sent to 1403 BPC registrants, 399 registrants returned responses, of which 287 were valid – a 20% response rate. Of the 287 valid responses, 267 were 90% or more complete[52] and 20 around 60% complete. The remaining 112 respondents had not answered beyond the first six questions on professional characteristics[53] and so did not provide any data on the substantive questionnaire items. These 112 responses were excluded from the main analysis.

4.2 Personal Demographics of Respondents

Table 4-1 shows the gender of the questionnaire respondents.

Table 4-1: Gender of respondents

	Total Frequency (n=275)	%
Female	195	70.9
Male	79	28.7
Other	1	0.4

Missing (n=12)

Two comments were included in the open-text box:

> I'm just glad you offered the option of other [gender]. ***Respondent 238: Gender not specified, 30–39, Heterosexual***

> I am cis female but I don't especially believe in the gender binary. ***Respondent 001: 'Other' Gender, 50–59, 'Other' Sexual Orientation.***

[52] There were a few skipped questionnaire items resulting in some missing data.
[53] Even then, these 112 respondents varied considerably in how many of these opening six questions they completed: one question completed (n=34); two questions completed (n=1); three questions completed (n=1); four questions completed (n=3); five questions completed (n=15); six questions completed (n=58).

Table 4-2 presents the sexual orientation of the respondents. If the LGB categories (n=39, 14.3%) are combined with the 'Other'/'None of these options' categories (n=22, 8.1%), then just over a fifth (n=61, 22.4%) of respondents identify as non-heterosexual or, at least, not fully heterosexual.

Table 4-2: Sexual orientation of respondents

	Total Frequency (n=272)	%
Heterosexual	211	77.6
Gay	16	5.9
Lesbian	12	4.4
Bisexual	11	4.0
Other	10	3.7
None of these options	12	4.4

Missing (n=15)

Respondents identifying as 'Other' described themselves variously as being 'queer', 'undefined', 'primarily heterosexual' and 'heterosexual within a broadly bisexual orientation'. Some respondents provided fuller descriptions of their sexual orientation, considering it to be something fluid and contingent, which varied over time.

> Technically, I am a lesbian. I have lived with a woman for 28 years and am civilly partnered. I had lots of sexual relationships with men before this and in my mind could imagine a relationship with a man in the future if anything were to happen to my relationship. However, I would not designate myself bisexual either. In my dreams I am not stuck in binary choices and I don't have to limit possibilities in real life either. ***Respondent 240: Female, 60–69, 'Other' Sexual Orientation***

> I would have thought that one of Freud's great achievements was to question the validity of these categories at a psychological level. Each of us has a sexuality that is our own and is deeply personal and moulded by a multiplicity of factors. ***Respondent 175: Male, 50–59, 'Other' Sexual Orientation***

Table 4-3 shows the age[54] of the respondents. Just over four-fifths of the respondents (n=211, 81.2%) were aged over 50. No respondents were under the age of 30.

Table 4-3: Age group of respondents

	Total Frequency (n=272)	%
30-39	15	5.5
40-49	36	13.2
50-59	77	28.3
60-69	108	39.7
70+	36	13.2

Missing (n=15)

[54] I had thought grouping ages into categories would make analysis easier but recognise, in hindsight, that continuous data would have been useful for calculating measures of central tendency such as the mean, median and mode.

4.3 Professional Characteristics of Respondents

As briefly mentioned in section 4.1, 112 respondents provided data on their professional characteristics before abandoning the questionnaire. In section B of Appendix R (see below), I include an analysis of these 112 partial responders for those readers who may be interested. Research shows that partial- or non-response analyses are infrequently reported in questionnaire research (Werner, Praxedes and Kim 2007). Partial- or non-responses are important considerations as both can increase the sampling variance (because the sample size is reduced) or contribute to bias, especially when the partial or non-responders differ in characteristics from the respondents included in the final analysis. There were some minor differences between the final sample (n=287) and the partial responders (n=112) but these were not significant.

In terms of training status, the majority of respondents (n=242, 88.3%) in my final sample were fully qualified and just over one-tenth (n=32, 11.7%) were in training. Table 4-4 shows the clinical settings where respondents worked.

Table 4-4: Respondents by workplace setting

	Total Frequency (n=284)	%
Private	258	90.8
NHS	104	36.6
Other Settings	88	31.0

Missing (n=3). Frequencies exceed 284 and percentages add to more than 100% because respondents could tick multiple options (i.e., % are overlapping).

Table 4-5 shows the most frequently identified therapeutic modalities across the sample. Forty-nine respondents (17.1%) reported working across multiple therapeutic modalities.

Table 4-5: Respondents by therapeutic modality

	Total Frequency (n=286)	%
Psychoanalytic Therapist[55]	155	54.0
Psychodynamic Therapist[56]	96	33.4
Psychoanalyst	48	16.7
Jungian Analyst	42	14.6
Other[57] Therapist	11	3.8
Did not state	3	1.0

Missing (n=1). Frequencies exceed 286 and percentages add to more than 100% because respondents could tick multiple options (i.e., % are overlapping).

Table 4-6 shows how respondents self-identified theoretically. Over two-fifths of respondents (n=124, 43.4%) reported having multiple theoretical affiliations.

[55] Full breakdown: Psychoanalytic Psychotherapist (n=139, 48.4%); Psychoanalytic Couples Therapist (n=16, 5.6%).
[56] Full breakdown: Psychodynamic Psychotherapist (n=67; 23.3%); Medical Psychodynamic Psychotherapist (n=12, 4.2%); Psychodynamic Counsellor (n=9, 3.1%); Psychodynamic Practitioner in Mental Health and/or Forensic Settings (n=4, 1.4%); Psychodynamic Couples Psychotherapist (n=2, 0.7%); Psychodynamic Psychotherapist in time-limited work with adolescents (n=2, 0.7%).
[57] Under 'Other', respondents included their work with children and adolescents as well specialist skills (e.g., Dream Matrix Facilitator; Dynamic Interpersonal Therapy (DIT) practitioner; and Rehabilitation Counsellor).

Table 4-6: Respondents by theoretical affiliation

	Total Frequency (n=286)	%
Kleinian/Contemporary Kleinian/Bionian	132	46.0
British Independent	125	43.6
Post-Classical[58]	84	29.2
Freudian/Contemporary Freudian	71	24.7
Jungian/Post-Jungian	56	19.5
Attachment-led	38	13.2
Non-aligned	29	10.1
Pluralistic	28	9.8
Other theoretical affiliation[59]	8	2.7

Missing (n=1). Frequencies exceed 286 and percentages add to more than 100% because respondents could tick multiple options (i.e., % are overlapping)

Table 4-7 provides a breakdown of respondents by training organisation. Forty-five respondents (15.7%) were members of multiple training organisations.

Table 4-7: Respondents by training organisation

	Total Frequency (n=286)	%
British Psychotherapy Foundation (BPF)	113	39.4
Foundation for Psychotherapy and Counselling (FPC)	57	19.9
Tavistock Society of Psychotherapists	37	12.9
British Psychoanalytical Society (BPAS)	36	12.5
Regional (outside of London) training organisations[60]	28	9.7
Solely Jungian-based training organisations[61]	25	8.7
Other training organisations[62]	26	9.0
British Society of Couple Psychotherapists & Counsellors	15	5.2

Missing (n=1). Frequencies exceed 286 and percentages add to more than 100% because respondents could tick multiple options (i.e., % are overlapping).

4.4 Number of LGB Clients Treated by Respondents

Respondents were asked about their LGB clinical caseloads.[63] As Table 4-8 shows, over two-thirds (67.5%) of respondents were currently treating between one and five LGB clients. Over a quarter of respondents (28.7%) were not currently treating any LGB clients.

Table 4-8: Number of LGB clients currently being treated by respondents

	Total Frequency (n=286)	%
0	82	28.7
1-5	193	67.5
6-10	10	3.5
10+	1	0.3

Missing (n=1)

[58] Post-classical includes relational, intersubjective, interpersonal, existential and self-psychological.
[59] Under 'Other', respondents included: mentalisation-based approaches; group analysis; social systems theory; Dynamic Interpersonal Therapy (DIT); schema therapy; and Lacanian psychoanalysis.
[60] Full breakdown: Severnside Institute for Psychotherapy (n=13, 4.5%); Scottish Association of Psychoanalytical Psychotherapists (n=7, 2.4%); North of England Association of Psychoanalytic Psychotherapists (n=4, 1.4%); Northern Ireland Association for the Study of Psychoanalysis (n=2, 0.7%); Wessex Counselling (n=2, 0.7%).
[61] Full breakdown: Society of Analytical Psychology (n=20, 7.0%); Association of Jungian Analysts (n=5, 1.7%).
[62] Full breakdown: Association of Psychodynamic Practice and Counselling in Organisational Settings (n=4, 1.4%); Association of Psychodynamic Counsellors (n=3, 1.0%); Association of Medical Psychodynamic Psychotherapists (n=2, 0.7%); Forensic Psychotherapy Society (n=2, 0.7%); Would rather not state (n=4, 1.4%); 'Other' (n=11, 3.8%).
[63] In hindsight, continuous data should have been collected in order to calculate measures of central tendency, such as the mean, median and mode.

Reflecting across their careers, Table 4-9 indicates that just over four-fifths (82.9%) of respondents had treated between one and 25 LGB clients. Around 15% had treated more than 25 LGB clients. Only four respondents (1.4%) indicated that they had never treated LGB clients.

Table 4-9 Number of LGB clients treated by respondents over career

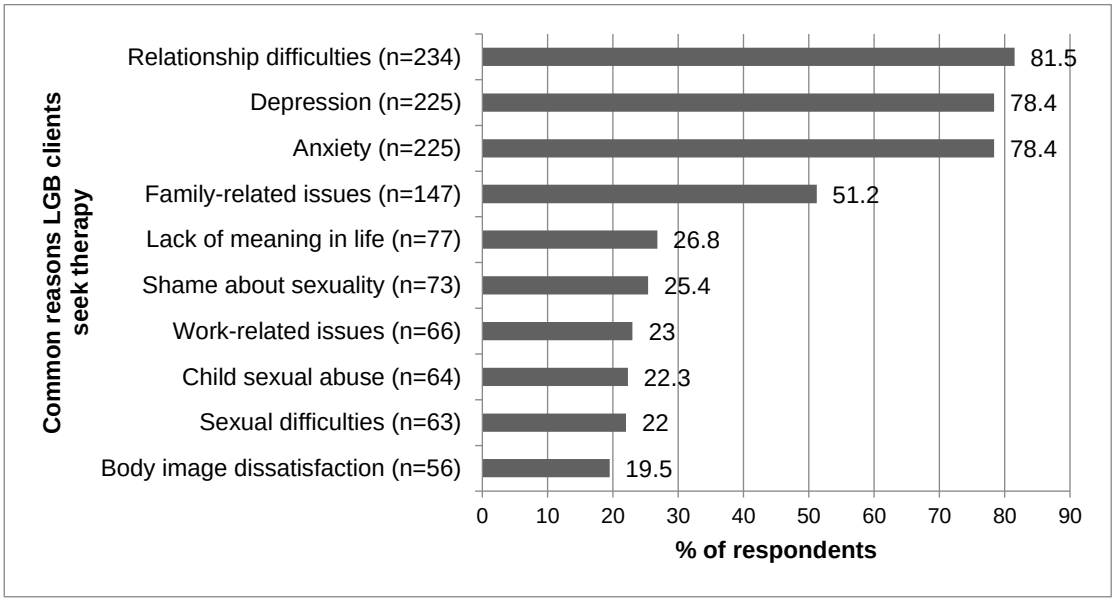
	Total Frequency (n=287)	%
0	4	1.4
1-25	238	82.9
25+	45	15.7

Missing (n=0)

4.5 Issues Brought to Therapy by LGB Clients

As Figure 4-1 illustrates, respondents cited relationship difficulties, anxiety, depression and family-related issues as the most common reasons LGB clients gave for seeking therapy.[64]

Figure 4-1: Most common reasons LGB clients seek therapy



Missing (n=0). Frequencies exceed 287 and percentages add to more than 100% because respondents could tick multiple options (i.e., % are overlapping).

In an open-ended follow-up question, respondents were asked whether they thought there were any reasons LGB clients might be more likely to give for seeking therapy compared with non-LGB clients. Of those responding (n=216), just over half (n=114, 53.8%) stated that there was no important difference between the two groups of clients.

> In 40 years of clinical practice, in and out of the NHS, the majority of LGB people I have seen have come for the standard range of psychological and psychiatric difficulties. ***Respondent 284: Male, 60–69, Heterosexual***

[64] From a list of 27 options, respondents were asked to identify a maximum of ten reasons LGB clients most commonly gave for seeking therapy.

The remaining respondents (n=102, 47.2%) answering the follow-up question discerned and reported differences in the nature and content of the problems their LGB clients brought to therapy compared to their non-LGB clients. These respondents reported that LGB clients were more likely to experience specific relationship issues, including: (1) difficulties in making and maintaining a long-term commitment to a partner; (2) issues with intimacy and trust; (3) relationship insecurity due to ageing or a LGB culture perceived to value youth and potency; (4) problems in managing open or non-monogamous relationships; (5) issues with differentiation or fusion with partners; (6) the impact of being HIV positive on a relationship; and (7) sexual difficulties and sexual addiction. Looking beyond relationship issues, respondents also identified other, less frequent reasons LGB clients were more likely to give for seeking therapy compared to non-LGB clients, including: (1) fertility, parenthood, adoption or wishing to start a family; (2) homophobic bullying; (3) sexual abuse; (4) intersectional issues e.g., being gay and black; (5) self-harming and suicidal tendencies; (6) substance abuse or addiction; (7) matters of religion, faith and spirituality; (8) ageing; and (9) gender identity issues.

Several respondents noted that LGB clients were more vulnerable to depression and generalised anxiety as a consequence of their experiences of discrimination and anti-LGB prejudice.

> LGB people experience a lingering feeling of being odd, out-of-step, not normal or mainstream, which in turn generates anxiety, depression, lack of meaning etc. ***Respondent 233: Male, 60–69, Heterosexual***

Other respondents thought that growing up in a predominately heteronormative culture intensified emotional and life problems for LGB clients.

> Feelings of isolation are more acute with LGB patients. This comes from not being able to be who they truly are in some social situations including places of work… LGB patients are more likely to feel they exist on the edge of society rather than in the midst. This often reflects how they felt as children growing up in their families of origin. ***Respondent 002: Female, 60–69, Heterosexual***

> There is some evidence of higher than average feelings of shame and self-disgust. I think issues of discrimination and socially mediated shame may be more prominent in LGB clients I have seen compared to non-LGB. ***Respondent 013: Male, 40–49, Gay***

Many respondents noted that disapproval of same-sex sexual orientation, whether parental, familial, cultural or religious, contributed to shame and alienation amongst LGB clients.

> There are many aspects that affect the work with LGB patients... There is the family aspect, as some LGB people are disengaged from their families and lack the benefit of their support. Of course, there is still stigma, especially in some professions and in cultural and religious groups. ***Respondent 119: Female, 40–49, Heterosexual***

> The process of discovering their identity, especially in relation to religion or family acceptance, contributes to a somewhat ruptured sense of themselves. They [LGB clients] seem to carry a sense of secrecy, shame, confusion and inadequacy that is very strong comparing to my non-LGB patients. ***Respondent 096: Female, 30–39, Lesbian***

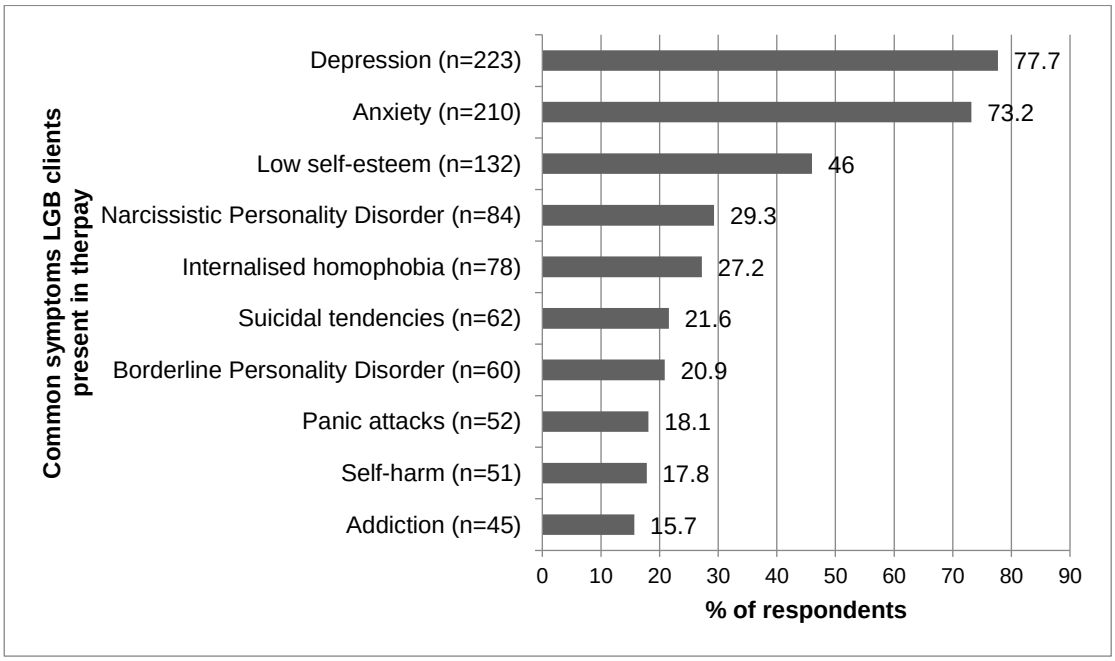
As a consequence of familial or societal disapproval and rejection, LGB clients often needed therapeutic support to learn how to better accept themselves.

> I think there is no doubt that to be accepted for whoever one is [is] essential to life as well as the therapeutic process and this is central to offering treatment to LGB patients. ***Respondent 100: Female, 60–69, Heterosexual***

> Sexual identity is at the heart of the individual and an orientation which has been subject to vilification can leave the individual with many internal conflicts. It is not uncommon for some LGB patients to feel on very bad terms with themselves, and this can lead them to seek therapeutic help. ***Respondent 148: Male, 50–59, Gay***

As Figure 4-2, shows, respondents cited depression and anxiety as the most common mental or physical issues LGB clients present in therapy.[65]

Figure 4-2: Most common mental or physical health issues LGB clients present in therapy



Missing (n=0). Frequencies exceed 287 and percentages add to more than 100% because respondents could tick multiple options (i.e., % are overlapping).

[65] From a list of 27 options, respondents were asked to identify a maximum of ten mental and/or physical health issues LGB clients most commonly presented in therapy.

In an open-ended follow-up question, respondents were asked whether they thought there were any mental and/or physical health issues LGB clients were more likely to present in therapy compared with non-LGB clients.

Of those responding (n=187) to this question, almost three-quarters (n=131, 70.0%) stated that there were no important differences between the two groups. A typical response was:

> I would not want to cluster them [LGB clients] into a unique set of any ten options for the reason that in my view 'they' are no different from heterosexuals insofar as what troubles them. ***Respondent 278: Male, 70+, Heterosexual***

Where respondents discerned and reported differences in the mental and/or physical health issues LGB clients brought to therapy compared to non-LGB clients, internalised homophobia was commonly mentioned.

> Stigma and homophobia, internalised and external, are the most frequent and distressing issues [reported by LGB clients]. ***Respondent 117: Female, 50–59, Bisexual***

> Many patients have harsh super ego issues, but I find this a particular issue for LGB patients. There is a link to internalised homophobia and shame. ***Respondent 215: Female, 60–69, Heterosexual***

As Table 4-10 shows, over half the respondents reported that their LGB clients only occasionally brought problems to therapy linked with their sexual orientation.

Table 4-10: Views on the centrality of sexual orientation when working with LGB clients

	Total Frequency (n=277)	%
Always	6	2.2
Frequently	75	27.1
Occasionally	143	51.6
Seldom	46	16.6
Never	7	2.5

Missing (n=10)

In the qualitative responses, several respondents expressed the view that sexual orientation was just one component of a client's presentation, whether LGB or non-LGB. In therapy, a client's sexual orientation should be considered in relation to their whole person and not in isolation.

> The patient's sexual orientation is usually not the issue, more the nature of their intimate relationships and that is the same for heterosexuals. ***Respondent 125: Female, 60–69, Heterosexual***

It seems to me that a gay client may be uninterested in issues related to sexual orientation specifically but come to therapy for the same spectrum of reasons as everyone else. ***Respondent 273: Male, 50–59, Heterosexual***

4.6 Duration of Treatment with LGB Clients

Respondents were asked to compare their LGB and non-LGB clients and report any differences in terms of treatment duration. As Table 4-11 shows, the majority of respondents (87.8%) considered the average duration of treatment with LGB clients to be much the same as with non-LGB clients.

Table 4-11: Average duration of treatment with LGB clients (compared with non-LGB clients)

	Total Frequency (n=278)	%
Much the same	244	87.8
Tends to be shorter	20	7.2
Tends to be longer	14	5.0

Missing (n=9)

When respondents (n=20) indicated that the average duration of treatment with LGB clients was shorter, they attributed this to several factors. Their qualitative responses included: (1) difficulties for the client in forming and sustaining long-term, meaningful relationships with others including with the therapist; (2) inability to contain anxiety or the intensity of feelings evoked in the analytic process; (3) unrealistic client expectations about what therapy could achieve; (4) treatment was only sought to address a one-off issue which was then quickly resolved; and (5) some LGB clients were treated within the NHS so only time-limited work was possible in any case.

When respondents (n=14) indicated that the average duration of treatment with LGB clients was longer, they attributed this to pathological attachments and/or disturbed early relationships.

> Issues of disturbed attachments in childhood, along with lack of trust, fear of disapproval and rejection strongly influence the length of time it can take to build the foundations of a therapeutic relationship [with LGB clients]. This is sensitive work that moves slowly on the path towards self-acceptance. ***Respondent 002: Female, 60–69, Heterosexual***

> I think it tends to be longer because there are more layers of early experience [with LGB clients] which need to be uncovered and thought about. I think it also takes time to break habitual patterns of repetition brought about by confusing early internal object relationships. ***Respondent 163: Male, 60–69, Heterosexual***

A few respondents suggested that treatments with LGB clients were longer because LGB clients were more receptive to self-exploration and wanted to engage with therapy at a greater depth.

> I've found that often LGB people are able to better identify what is troubling them compared to non-LGB clients. I think this is something to do with how much a person has to look inward when they question and recognise their sexuality to be anything 'other' than heterosexual. They have started the process of getting to know themselves better which often puts them slightly ahead. ***Respondent 001: 'Other' Gender, 50–59, 'Other' Sexual Orientation***

4.7 Professional Satisfaction Levels in Work with LGB Clients

Table 4-12 indicates that the great majority of respondents (90.8%) experienced the same levels of professional satisfaction in their therapeutic work with LGB clients as with non-LGB clients.

Table 4-12: Level of professional satisfaction when working with LGB clients (compared with non-LGB clients)

	Total Frequency (n=282)	%
The same	256	90.8
Less satisfied	18	6.4
More satisfied	8	2.8

Missing (n=5)

Several respondents reported that their clinical outlook on diversity had deepened as a result of working with LGB clients, leading them to feel more satisfied in their work with this client group.

> Work with LGB clients helps to develop and extend the knowledge and understanding of psychoanalytic work in diverse communities. ***Respondent 051: Male, 40–49, Heterosexual***

> It enriches my thinking about the variety of human beings there are in the world and the need for difference to be valued and accepted. ***Respondent 002, Female; 60–69, Heterosexual***

A few respondents found the work more satisfying because they had enjoyed a positive therapeutic experience with their LGB clients.

> I have registered a higher level of attachment, perhaps due to the relief in finding a place where they can be accepted as they are, hence it has been a stronger therapeutic alliance. ***Respondent 055: Female, 30–39, Heterosexual***

Some respondents reported a tendency for LGB clients to be defensive or less open to the analytic process. These therapists were less satisfied in their clinical work with this client group.

> Those [LGB] patients presented with more rigid defences and made less use of psychotherapy. ***Respondent 058: Female, 30–39, Heterosexual***

> There is often resistance to making changes for themselves which might alter how they feel. This has nothing to do with changing sexual orientation, but in their ability to accept themselves and to feel accepted. ***Respondent 030: Female, 50–59, Heterosexual***

A handful of respondents noted that their own unresolved conflicts about sex and sexuality might partially contribute to their difficulties in enjoying clinical work with LGB clients.

> I feel that I should have worked through more thoroughly my own conflicts about sexuality. I think that I am probably rather less well equipped to work with LGB patients as a result of not having done so. ***Respondent 173: Male, 50–59, Heterosexual***

> I find feelings around anal sex create ambivalence in me. I am aware that gay men need to express themselves in this way, but it doesn't feel quite right... I am aware of this prejudice and work with it rather than project it. ***Respondent 285: Male, 60–69, Heterosexual***

Some respondents blamed a lack of theoretical tools for thinking about same-sex sexual orientation, making them feel less prepared for the work and hence more dissatisfied.

> I am less satisfied with the work…the complexity of this area theoretically… Me and my patients seem to lack an adequate, integrated, developed 'image' of a happy, healthy homosexual adult life. ***Respondent 228: Female, 60–69, 'Other' Sexual Orientation***

> I suspect the whole body of work on sexual development needs an entire rethink if we are to move away from the concept of homosexuality as a perversion. This, I believe, would be extremely healthy for our theoretical framework. ***Respondent 159: Female, 60–69, Heterosexual***

4.8 Perceived Therapeutic Benefits Experienced by LGB Clients

Table 4-13 and Table 4-14 show that almost three-quarters of respondents thought most or all of their LGB clients experienced a reduction in symptoms or improvements in day-to-day functioning.

Table 4-13: LGB clients perceived to experience a reduction in symptoms

	Total Frequency (n=281)	%
All	46	16.4
Most	160	56.9
Some	65	23.1
Few	9	3.2
None	1	0.4

Missing (n=6)

Table 4-14: LGB clients perceived to experience improvements in day-to-day functioning

	Total Frequency (n=278)	%
All	47	16.9
Most	157	56.5
Some	63	22.7
Few	10	3.6
None	1	0.4

Missing (n=9)

4.9 Therapists' Theories of Sexual Orientation

Respondents were asked to indicate their level of agreement with a series of theoretical statements about sexual orientation.[66] Table 4-15 presents the full set of results.

Table 4-15: Level of agreement with theoretical statements about sexual orientation

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Sexual orientation is shaped by …					
An inborn or genetic component (n=280)	**8** 2.9%	**42** 15.0%	**172** 61.4%	**45** 16.1%	**13** 4.6%
Disturbed attachment relationships (n=281)	**30** 10.7%	**144** 51.2%	**88** 31.3%	**15** 5.3%	**4** 1.4%
Unresolved Oedipal conflicts (n=282)	**18** 6.4%	**117** 41.5%	**102** 36.2%	**33** 11.7%	**12** 4.3%
Early trauma (n=281)	**24** 8.5%	**133** 47.3%	**98** 34.9%	**22** 7.8%	**4** 1.4%
Multiple determinants (n=283)	**100** 35.3%	**141** 49.8%	**30** 10.6%	**5** 1.8%	**7** 2.5%
A mixture of nature and nurture (n=284)	**57** 20.1%	**149** 52.5%	**53** 18.7%	**17** 6.0%	**8** 2.8%

On the whole, respondents (n=172, 61.4%) were undecided about the first statement on whether an inborn or genetic component played a part in shaping someone's (same sex) sexual orientation. The next three statements in the table refer to the role of environmental factors in influencing someone's (same sex) sexual orientation. While over half the respondents agreed or strongly agreed with the statements about disturbed attachment relationships (n=174, 61.9%) and early trauma (n=157, 55.8%), just under half (n=135, 47.9%) agreed or strongly agreed with the statement about unresolved Oedipal conflicts. Almost three-quarters of respondents (n=204, 72%) either agreed or strongly agreed that same-sex sexual orientation is shaped by a combination of unresolved Oedipal conflicts or disturbed attachments or early trauma.[67] While the majority of respondents (n=241, 85.1%) either agreed or strongly agreed with the statement that

[66] In hindsight, there was a significant limitation in how this question was posed that had not been picked up during the piloting. The question does not explicitly ask about same-sex sexual orientation, but rather sexual orientation more generally, so it is difficult to determine whether respondents had same-sex sexual orientation in mind when answering the question. Given the general focus of the questionnaire, the likelihood is that most respondents answered in relation to same-sex sexual orientation, but I cannot be sure. As knowledge of the subject area deepened, I recognised that the question might also have benefitted from including an option stating that 'sexual orientation is shaped by cultural and social factors' (i.e., the social constructionist perspective).

[67] A 'select if' command was executed within SPSS to attain this result.

(same sex) sexual orientation had multiple determinants, almost three-quarters of respondents (n=206, 72.6%) agreed or strongly agreed that a combination of nature and nurture might play a role.

Chi-squared (χ^2) tests indicated no significant associations between respondents' personal attributes (i.e., gender, sexual orientation, age) and professional characteristics (i.e., therapeutic modality, theoretical affiliation) and their perspectives on each of the six theoretical statements above.[68] All comparisons fell short of the level of significance at 0.05. A full breakdown of the χ^2 results for this question is provided in Appendix R (see below).

Qualitative responses indicate that several therapists were aware of not having a fully coherent theoretical model of same-sex sexual orientation.

> I am aware that I don't have a particular theoretical or developmental stance that I take with LGB patients and while that's good in that it means I take each person as a unique individual and we try to understand them in many ways, I also feel it would be helpful to have a better understanding more generally. ***Respondent 229: Female, 50–59, Heterosexual***

> It [the questionnaire] provokes me to wonder what assumptions, perhaps unconscious, I am working under about the origins of sexual orientation. ***Respondent 268: Female, 70+, Heterosexual***

One clinician reported how their theoretical model had shifted over time.

> I was curious about the factors contributing to the emergence of different sexual orientations and would have argued strongly [in the past] for sexual orientation to be the outcome of non-genetic factors (i.e., of primary relationships, Oedipal constellations etc.). Now, I would adopt a much more agnostic position. ***Respondent 046: Male, 50–59, Heterosexual***

Some therapists tried to work with and tolerate multiple theories, ultimately allowing patients' own 'theories' about their sexual orientation to guide the work.

> I think different influences are relevant for individuals. For some, being LGB has been genetic. For others, it has been generated by developmental trauma. For others it may

[68] All responses and categories of respondent were reduced to two categories each. Thus, all comparisons had two degrees of freedom. The five-point Likert scale options were recoded as 'agree' and 'disagree'. The 'agree' category combined the previous categories of 'strongly agree' and 'agree'. The 'disagree' category combined the previous categories of 'neither agree nor disagree', 'disagree' and 'strongly disagree'. 'Neither agree nor disagree' was assigned to 'disagree' to ensure the χ^2 test's requirements were met (i.e., expected frequencies in the cells should not be less than 5). Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Therapeutic modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.

be some kind of mix which is never entirely clear. I am comfortable working with all of these and am most interested in patients' perspectives on themselves and the influences which they think are, or are not, relevant. ***Respondent 192: Female, 50–59, Heterosexual***

4.10 Therapists' Attitudes to Conversion Therapy

Table 4-16 shows that three quarters of respondents (n=209, 74.6%) either disagreed or strongly disagreed with the statement that 'sexual orientation can be changed or redirected through therapeutic means'. A quarter of respondents (n=63, 22.5%) were undecided about the statement while a small minority (n=8, 2.9%) agreed with it.[69]

Table 4-16: Views on whether sexual orientation can be changed or redirected through therapeutic means

	Total Frequency (n=280)	%
Strongly disagree	121	43.2
Disagree	88	31.4
Neither agree nor disagree	63	22.5
Agree	8	2.9

Missing (n=7). No respondent ticked 'strongly agree'

Table 4-17 shows the approach respondents would take if LGB clients specifically requested therapeutic help to change their sexual orientation. Only one respondent (0.4%) reported that they would actually treat LGB clients to change their sexual orientation.

Table 4-17: Views on LGB clients' requests to change sexual orientation

	Total Frequency (n=281)	%
Explore underlying reasons for wanting to change	235	83.6
Other approach taken with client	27	9.6
Assist client to accept their sexual orientation	16	5.7
Refer client to another colleague with experience of helping clients accept their sexual orientation	2	0.7
Treat client to change sexual orientation	1	0.4

Missing (n=6)

Rather than try to change LGB clients' sexual orientation, the majority of respondents reported that they would assist LGB clients to improve their sense of themselves by providing a thoughtful and respectful space for exploration.

> I would try to form an overall picture of their psychic functioning that would include…the psychic meanings bound up in their sexual orientation and what they…imagine they will gain in changing it. I would hope that psychic change produced in analysis would bring

[69] In hindsight, this is also a difficult question as sexual orientation does sometimes change during therapy, but that does not mean the therapy was intended to make that change or was focused on it.

> about greater self-knowledge and an easier relationship with [the] self. ***Respondent 234: Female, 50–59, Heterosexual***

> The sense that one's…sexual preference is wrong or needs changing is an issue of personal and social acceptance. It is deeply distressing and warrants exploration in an accepting therapeutic environment where any confusion or dystonic feelings can be explored without fear of further judgement. ***Respondent 238: Gender not specified, 30–39, Heterosexual***

Other respondents indicated that they would be clear with LGB clients that they did not offer conversion therapy or consider same-sex sexual orientation to be an indicator of pathology.

> On the one occasion this was requested, my position was that there was nothing amiss with the patient's sexual orientation/preferences but that I understood that there were cultural issues that added particular pressures. I was very willing to work with the person to explore their ambivalence about their sexual identity…but that I would not…work towards re-direction. ***Respondent 074: Female, 50–59, 'Other' Sexual Orientation***

> I would explain that I did not see their sexuality as an illness to change or alter but could work with them if they were depressed or wanted to explore enriching their lives. ***Respondent 107: Male, Age not specified, Heterosexual***

A few respondents used initial consultations with LGB clients to explore their motives for wanting to change sexual orientation before deciding whether therapy was a suitable option for them.

> I offer a number of consultations to explore with the patient what is troubling them…whilst also exploring the nature of the developing relationship with me with a view to us deciding whether ongoing sessions and a commitment to therapy is desired by the patient. ***Respondent 178: Female, 50–59, Heterosexual***

A few respondents observed that a client's sexual orientation sometimes changed during therapy, not as a result of any therapeutic attempts to modify it but rather because therapy might have emboldened clients to examine unexplored parts of their sexuality.

> I doubt very much if someone can change their orientation, but I have seen people become more heterosexually or homosexually orientated from what initially was described as a bisexual position but would hesitate to draw broader conclusions from a small number of examples. In those people, changing sexuality was not the aim of the work. ***Respondent 274: Female, 50–59, Heterosexual***

Sexual fluidity might account for changes in some clients' sexual orientation.

A few people do change their sexual choice in therapy either from hetero to homosexual or, more rarely, from homosexual to hetero or bi. I think that gender is a huge issue here. In general, there is much more fluidity in the sexual choices of women than in men. I think the history, experiences and sexual fluidity of women within the LGB spectrum are very different from those who are male and has to be thought about differently. ***Respondent 240: Female, 60–69, 'Other' Sexual Orientation***

4.11 Therapists' Views on Self-Disclosure (of Sexual Orientation)

Table 4-18 shows respondents' views on whether it is appropriate practice for LGB therapists to self-disclose their sexual orientation to LGB clients.

Table 4-18: Views on LGB therapist self-disclosure (of sexual orientation)

	Total Frequency (n=280)	%
No	181	64.6
Don't know	72	25.7
Yes	27	9.6

Missing (n=7)

Chi-squared (χ^2) tests (see Table 4-19) indicated a significant association between respondents' sexual orientation and whether it was appropriate for LGB clinicians to self-disclose their sexual orientation to their LGB clients, χ^2 (Df1, n=280) = 10.909, p = .001.

Table 4-19: Associations between respondents' attributes and views on LGB therapist self-disclosure (χ^2 analysis)

	χ^2	P value
Gender	3.158	.076
Sexual orientation	10.909	.001
Age	1.984	.159
Therapeutic modality	1.100	.294
Theoretical affiliation	2.360	.124

Question responses were recoded as 'Yes' and 'No'. The category of 'Don't know' was assigned to the 'No' category. Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Therapeutic modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' (that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.

Cross tabulation of the data relating to sexual orientation (see Table 4-20) shows that only 6.8% of heterosexual therapists compared to 21.3% of non-heterosexual therapists thought it was appropriate for LGB therapists to self-disclose their sexual orientation.

Table 4-20: Views on LGB therapist self-disclosure and respondents' sexual orientation (cross tabulation)

	Not heterosexual (n=61)	%	Heterosexual (n=206)	%
Yes (appropriate to self-disclose)	13	21.3	14	6.80
No (inappropriate to self-disclose	48	78.6	192	93.2

Missing (n=20). Question responses were recoded as 'Yes' and 'No'. The category of 'Don't know' was assigned to the 'No' category. Sexual orientation was recoded into two categories: 'heterosexual' and 'not heterosexual'.

Qualitative responses showed that many respondents adhered to the classical technique of analytic neutrality and were opposed to self-disclosure of any sort, including sexual orientation.

> [The] therapist needs to be more of a blank canvas for proper psychoanalytic work. Sensitivity and understanding about LGB issues are important. ***Respondent 236: Male, 60–69, Bisexual***

> Therapist abstinence is as applicable to sexuality as it is any other aspect of the therapist. ***Respondent 161: Female, 40–49, Heterosexual***

Classically minded practitioners perceived self-disclosure of any sort as biasing the therapeutic relationship. Typical responses from these therapists emphasised the distorting influence self-disclosure would have on transference aspects of the work.

> I would question and be cautious about any personal disclosure to any patient, as it compromises the analytic work. ***Respondent 071: Male, 50–59, Heterosexual***

> I would not expect any therapist working psychoanalytically to self-disclose in any way, regardless of their sexual orientation, as self-disclosure apart from any other objection impedes working with phantasy and transference. ***Respondent 079: Female, 60–69, Heterosexual***

Another concern was that self-disclosure of any type could undermine exploration of the negative transference.

> I think the patient needs to be free to think of the therapist in all sorts of ways and for things not to be foreclosed. It is an intrusion into the patient and self-indulgent to disclose such things. Probably a way of avoiding the negative transference and being too pally and nice. ***Respondent 134: Female, 60–69, Heterosexual***

> I believe that it is helpful for the therapist to exhibit a neutral perspective so that the patient will not feel coerced, manipulated or encouraged to please the therapist. ***Respondent 209: Female, 60–69, Heterosexual***

Some therapists thought self-disclosure might result in boundary violations, diminishing therapist credibility and leading to a shift of focus from the client to the therapist.

> None of the analyst's personal issues, and in particular the issue of sexuality and its complexities, should get mixed up with the patient's anxieties. ***Respondent 065: Male, 60–69, Heterosexual***

> The therapist, regardless of sexual orientation, should not disclose their preferences, as the focus is the patient, not the therapist. ***Respondent 061: Female, 50–59, Heterosexual***

Those respondents who thought LGB therapists' self-disclosure of their sexual orientation to LGB clients was appropriate emphasised the potential benefits. Self-disclosure could help create an atmosphere of trust and respect, where the historical damage caused by pathologisation of same-sex sexual orientation could be openly addressed.

> If it is important to the patient at the start of therapy to know the therapist's sexuality, then it's OK because at the moment there could well be distrust of psychoanalysis among LGB people. ***Respondent 034: Male, 70+, Heterosexual***

> In certain situations, I would not see it as inappropriate to disclose information about myself to any patient regardless of their sexual orientation if that disclosure was helpful for moving the therapy forward. ***Respondent 011: Male, 40–49, Gay***

LGB therapists' self-disclosure of their sexual orientation could help foster self-acceptance, validate LGB experience and reduce LGB clients' sense of isolation and shame.

> I can see why LGB therapists may choose to disclose in this way e.g., to model self-acceptance. ***Respondent 148: Male, 50–59, Gay***

> I have found traumatised minorities can feel relief at finding a therapist who has shared something. ***Respondent 069: Female, 60–69, Heterosexual***

It was not infrequent for respondents to recommend a case-by-case approach. Respondents felt the risks and rewards of self-disclosure would need to be carefully weighed up. Self-disclosure is context-sensitive: the moment-to-moment needs of the individual client should be considered along with the therapist's professional values and ethical stance.

> Self-disclosure is a tactic or a spontaneous occurrence that needs to be considered very carefully, whatever the context: this is not specific to LGB or any other category, so as a rule 'no', but there are exceptions as with anything else. ***Respondent 283: Male, 60–69, Heterosexual***

> Yes [self-disclosure is appropriate] but in a way which is worked through in the therapist's mind and puts their patient's needs first i.e., bears in mind the burden on one's patients of self-disclosure. It is not right with every patient and needs great care and thought. ***Respondent 117: Female, 50–59, Bisexual***

Some respondents noted that a therapist's sexual orientation, as well as any other personal fact, may already be known or assumed by the client. Information about the therapist could be gleaned from online profiles, what they wear and how the consulting room is decorated.

> Inevitably we all give off signals which categorise us…size of house, accent etc… I don't think the therapist should deny their sexual orientation and as is the same for any therapist the patient will probably come to know us as facts of our lives seep through. ***Respondent 116: Female, 50–59, Heterosexual***

The referral system or how therapists advertised their services, such as via Pink Therapy,[70] may also reveal a therapist's same-sex sexual orientation.

> Some patients will find me through LGB referral systems where my sexual orientation is stated. ***Respondent 005: Male, 50–59, Gay***

> I appreciate that there are other settings where it [self-disclosure] may be thought about quite differently e.g., Pink Therapy. ***Respondent 013: Female, 60–69, Heterosexual***

The advent of the internet means that different aspects of therapist identity are increasingly visible to clients. Therapists are no longer truly anonymous individuals.

> I do not disclose information about myself, though patients are free to find out whatever they find out about me…for example, from Googling me. ***Respondent 239: Male, 60–69, Heterosexual***

Due to the relatively small size of the LGB community and the limited opportunities for LGB dating and socialising, LGB therapists' sexual orientation may inadvertently be revealed through chance encounters with LGB clients outside the therapy, for instance at specific social occasions such as Pride events and at LGB-friendly venues, such as LGB bars.

> Belonging to the same minority group as a patient could raise issues of possible contact outside the consulting room which would need careful thought. ***Respondent 005: Male, 50–59, Gay***

[70] Pink Therapy is the UK's largest independent therapy organisation working with gender, sexuality and relationship diverse clients. See here.

A minority of therapists suggested that although they did not intentionally disclose their sexual orientation to clients, it may be unconsciously communicated through the unfolding, dynamic relationship between the therapist and the client.

> I think it's often known at some level. A friend of mine seeing a gay analyst would mention that when they talked about sexuality, it often didn't seem to feel right and felt odd. A gay colleague talked about not feeling their heterosexual analyst could really engage with them around gay sexuality. ***Respondent 285: Male, 60–69, Heterosexual***

> I recognise that we all make implicit disclosures all the time, and that these should be reflected on. ***Respondent 204: No demographics specified***

If a therapist's sexual orientation is discovered unintentionally, some interviewees suggested that it would undermine the treatment if this fact was then denied.

> If it [the therapist's sexual orientation] is generally known, and the patient knows it, it could be anti-therapeutic to deny it. This would be a matter of clinical judgement. ***Respondent 249: Female, 60–69, Heterosexual***

4.12 Therapists' Views on LGB Clients' Choice of Therapist

Table 4-21 shows respondents' views on whether LGB clients have the right to request access to LGB therapists.

Table 4-21: Views on LGB clients' rights to access LGB therapists

	Total Frequency (n=277)	%
Don't know	105	37.9
Yes	90	32.5
No	75	27.1
Prefer not to say	7	2.5

Missing (n=10)

As Table 4-22 shows, chi-squared (χ^2) tests found a significant association between respondents' gender and whether LGB clients have a right to request access to LGB therapists, χ^2 (Df1, n=277) = 3.910, p =.048.

Cross tabulation of the data relating to gender (see Table 4-23) shows that 43.0% of male therapists thought that LGB clients have the right to access LGB therapists compared to 30.4% of female therapists.

Table 4-22: Associations between respondents' attributes and views on LGB clients' rights to access LGB therapists (χ^2 analysis)

	χ^2	P value
Gender	3.910	.048
Sexual orientation	.031	.859
Age	.141	.708
Therapeutic modality	1.247	.264
Theoretical affiliation	3.445	.063

Question responses were recoded as 'Yes' and 'No'. The categories of 'Don't know' and 'Prefer not to say' were assigned to the 'No' category. Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Therapeutic modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.

Table 4-23: Views on LGB clients' rights to access LGB therapists and respondents' gender (cross tabulation)

	Female (n=181)	%	Male (n=79)	%
Yes, LGB clients have a right to access LGB therapists	55	30.4	34	43.0
No, LGB clients do not have a right to access LGB therapists	126	69.6	45	57.0

Missing (n=27). Question categories were recoded as 'Yes' and 'No'. The categories of 'Don't know' and 'Prefer not to say' were assigned to the 'No' category. Gender was recoded into two categories: 'female' and 'male'.

Those respondents in favour of LGB clients having the right to access to LGB therapists acknowledged that LGB clients may understandably be distrustful of psychotherapy. LGB clients may not want to risk undertaking treatment with a heterosexual therapist who they fear could be prejudiced against them.

> I think that in some cases trust can only be built in an environment which is or at least assumed to be safe from assumptions of pathology. Previous experiences of having their orientation pathologised could well prevent LGB patients from seeking help. ***Respondent 163: Male, 60–69, Heterosexual***

> I do accept that being part of a minority group is likely to have meant that the individual will have experienced prejudice possibly in a number of ways and would not risk psychotherapy with a therapist or analyst without knowing that at least in theory they would be understood and accepted. ***Respondent 139: Female, 60–69, Heterosexual***

Some therapists thought that the question was about preferences rather than rights. These respondents were comfortable with exploring client preferences for a particular type of therapist, but this was not the same as saying that LGB clients had a right to a particular type of therapist.

> I don't think patients should have a right to a particular demographic in the therapist, although preferences could be considered carefully in a collaborative and exploratory way. ***Respondent 204: No demographics specified***

On a practical note, some work settings (e.g., NHS) may not have the necessary resources to accommodate such requests from LGB clients.

> In an ideal world [LGB clients should have access to LGB therapists] but not in this publicly funded department where we do not have any gay therapists. ***Respondent 216: Male, 50–59, Heterosexual***

> It may depend on the context. In the NHS, for example, it would not be feasible, nor fair and respectful of therapists, to categorise practitioners on the basis of their sexuality. ***Respondent 281: Male, 60–69, Heterosexual***

Several respondents emphasised that it was not always necessary for therapists to have lived experience of being LGB in order to work effectively with LGB clients. For these therapists, sameness or similarity in terms of personal characteristics may not lead to better understanding or improved therapeutic outcomes.

> Why should any patients have a 'right' to a particular kind of therapist? This is to suggest that because you have no direct personal experience of something you can't work with that patient. By the same logic…LGB therapists should not work with straight patients, a childless therapist should not work with mothers or fathers... Therapy would turn into a pressure-group phenomenon rather than a way of thinking about the human psyche as a whole. ***Respondent 234: Female, 50–59, Heterosexual***

> There is an implication that shared experience and similarity to the patient is what is important rather than training and experience. ***Respondent 088: Female, 60–69, Heterosexual***

The issue of rights led to wider points being made about working with difference more generally. Some respondents questioned whether clients had the right to access therapists based on other identity characteristics such as race and gender.

> Does any minority group have a 'right' to seek a psychotherapist belonging to their own minority group? ***Respondent 201: No demographics specified***

> A 'right' sounds moralistic. Black people do not necessarily only or always benefit from a same race therapist… Women who have been abused by men can also sometimes benefit from therapy with men. ***Respondent 051: Male, 40–49, Heterosexual***

4.13 Transference and Countertransference with LGB Clients

In an open-ended question, respondents were asked if they experienced differences in the transference and countertransference when working with LGB clients compared with non-LGB clients. Of the 241 respondents answering this question, almost half (n=120, 49.7%) stated that there was little or no difference to report. Typical responses included:

> It is no more different than working with the complexity of transference identifications with non-LGB patients. ***Respondent 026: Male, 40–49, Gay***

Of those respondents reporting little or no difference, several of them indicated that differences in transference and countertransference dynamics were usually unique to the individual client rather than anything to do with sexual orientation.

> At times the transference and countertransference might be different but that applies to each individual patient and is not specific to LGB. ***Respondent 078: Female, 50–59, Heterosexual***

Respondents who discerned a difference in the transference and countertransference with LGB clients compared with non-LGB clients reported experiencing specific transferences as more intense or immediate. Some therapists reported the heightened quality in the erotic or sexualised transference with LGB clients.

> I have found the transference to be more sexualised with LGB clients. I am aware of a more powerful sexual/erotic transference and countertransference. ***Respondent 241: Female, 50–59, Heterosexual***

> A few of my lesbian patients have developed strong erotic transferences to me. While straight women have also at times developed such a transference, in a couple of my lesbian patients this has been accompanied by a strong wish for me also to be lesbian, and in one instance, the patient became convinced that I was. ***Respondent 213: Female, 60–69, Heterosexual***

One female, heterosexual respondent described her feelings of rejection in the erotic transference with her gay male clients.

> The transference, in my experience, has been impeded by being the 'undesired, unimportant object' (a woman) in the eyes of a gay man – making the transference veiled and lost. ***Respondent 120: Female, 60–69, Heterosexual***

It was not uncommon for respondents to regard the transference with LGB clients as a combination of erotic and maternal feelings.

> There is a tendency for the lesbian women I see to find it easier to allow and be pulled towards an erotic transference and an exploration of the maternal attachment needs and the sexual and erotic. This tends to be much slower or hesitant in heterosexual women. ***Respondent 240: Female, 60–69, 'Other' Sexual Orientation***

> As a woman working with male gay patients, the erotic transference is complex e.g., wanting to be held by me. I have taken it up as a primitive pre-Oedipal longing. ***Respondent 093: Female; 70+; Heterosexual***

Some therapists reported that they were often recipients of positive, idealising transferences from their LGB clients.

> In the past I have always struggled with gay patients' idealisation and the difficulty of establishing an understanding of ambivalent feelings. ***Respondent 237: Male, 60–69, Heterosexual***

> Maybe [there is] a faster 'idealised mother' transference to begin with? ***Respondent 072: Female, 50–59, Heterosexual***

Another common transference reaction was the negative, parental transference, in which respondents were experienced as the disapproving and judgemental parent.

> Sometimes some gay men have experienced very difficult relationships with their parents that somehow get stuck in the patient making the 'fact' of being gay or lesbian the sole 'reason' for current emotional difficulties. ***Respondent 155: Male, 70+, Sexual Orientation not specified***

> I notice that the experience of a judgemental parental figure has been located externally [in the therapist], which then relates to transference issues that could be taken up in sessions. ***Respondent 050: Male, 40–49, Heterosexual***

Several respondents noted that when their LGB clients expressed hostility towards them in the transference it was often because they were anxious about being judged or pathologised by the therapist.

> I have noticed in a few gay patients, particularly ones knowing the reputation psychoanalysis has of being homophobic, the tendency to project their own homophobia into me, and to experience me as being critical or judgemental of them for being gay…in the transference…somehow the social stigma that persists (and the reputation psychoanalysis has of pathologising homosexuality) sometimes gives this transference

> more of an edge that can be tricky to work with. ***Respondent 213: Female, 60–69, Heterosexual***

One respondent described how inadequate she could sometimes feel in the countertransference.

> At times the threat of (actual and imagined) victimisation by others is so great that some LGB patients find it hard to tolerate transference interpretations until later in their therapy. Countertransference in these instances is of being forced into a powerless position…being seen as either inconsequential or a threat and thus refused entry. ***Respondent 211: Female, 60–69, Bisexual***

A couple of LGB respondents discussed the role of excessive familiarity in the therapeutic work with LGB clients.

> As a gay clinician, I have some experiences in common with gay patients and I tend to notice what they…assume in terms of similarity and difference. ***Respondent 204; Gender and age not specified, Gay***

> As a gay man myself, I might notice more of a sense of 'familiarity' at times and I may have more concerns about ensuring personal boundaries. ***Respondent 195: Male, 40–49, Gay***

Another countertransference issue related to therapists fearing they held unconsciously homophobic assumptions. Several respondents described their concerns about not having sufficiently analysed their own prejudices in relation to LGB clients.

> I have to be honest and open and aware of any unconscious or unresolved homophobia in myself, reflect on it in supervision and use this awareness to understand my patient. ***Respondent 36: Female, 50–59, Heterosexual***

> I have noticed sometimes with gay male patients that when I am less successful in managing my own confusion or anxiety for periods during the treatment, I can be inclined to attribute this to their sexual orientation. ***Respondent 127: Female, 60–69, Heterosexual***

Therapists reported the necessity of developing their psychic bisexuality and recognising that all clients, regardless of their stated sexual orientation, oscillate between same-sex and opposite sex identifications and object choices throughout the therapeutic experience.

> I…consider what internal object I am for the patient in the transference and via the countertransference. This requires me to identify the homosexual or bisexual part of

myself, which is different to when I am working with a heterosexual patient. ***Respondent 010: Female, 60–69, Heterosexual***

4.14 Psychodynamic Approaches to Teaching Sexual Orientation

Table 4-24 shows respondents' views on whether or not they had received any formal teaching or training on sexual orientation.

Table 4-24: Views on whether training addressed issues relating to sexual orientation

	Total Frequency (n=281)	%
No	132	47.0
Yes	113	40.2
Cannot recall	36	12.8

Missing (n=6)

When asked to describe what they had been taught about sexual orientation during training, respondents provided a range of answers. Several respondents recalled that same-sex sexual orientation had been presented as pathology or perversion.

> I trained a very long time ago. What I was taught is now frankly embarrassing. We had a whole term on sexuality in which we were taught that being LGB was either the sign of a perverse character structure or evidence of an arrest in development and a problem of unresolved Oedipal issues. ***Respondent 100: Female, 60–69, Heterosexual***

> I have attended seminars…where some of the people attending openly expressed views that I saw as very discriminatory in terms of LGB patients. I think there is still a strong prejudice against LGB people. ***Respondent 019: Female, 40–49, Heterosexual***

Other respondents indicated that same-sex sexual orientation had been taught as part of a wider seminar series exploring difference and diversity.

> We had a seminar called 'Diversity' dedicated to exploring issues of difference, including sexuality. ***Respondent 111: Female, 50–59, Heterosexual***

> In seminars on diversity, we covered sexual orientation and the topic came up in other work on theory and practice. ***Respondent 041: Female, 50–59, Lesbian***

Respondents who had not received formal psychodynamic teaching on sexuality and sexual orientation described alternative methods for learning about these topics, including:

Learning from one's own LGB clients:

> One of my training patients was a gay man who did not have an issue with his orientation. Work with him taught me a great deal about facing my own unconscious homophobia. I am eternally grateful to him. ***Respondent 140: Female, 70+, Heterosexual***

Being self-taught:

> I have been largely self-taught through teaching on sexuality, so have done a lot of reading on the subject. ***Respondent 116: Female, 50–59, Heterosexual***

Through supervision:

> In my clinical supervision group, three candidates had LGB training patients, so it was present in the clinical material that we discussed. ***Respondent 184: Female, 40–49, Heterosexual***

Life experience:

> It is important to have knowledge and understanding, both personally and from general life experience, of LGB issues so that this informs practice and avoids prejudice and discrimination in myself. Or when this occurs in myself, to have ways of countering my views. I have close friends who are LGB and this helps me to value and welcome LGB patients into my practice. ***Respondent 162: Female, 50–59, Heterosexual***

Some respondents reported having received no training on same-sex sexual orientation at all.

> I have virtually no experience of working with LGB patients but feel angry that this area was not covered in my training. ***Respondent 028: Female, 70+, Heterosexual***

Although less frequently described, some respondents appear to have received very comprehensive and balanced training on sexual orientation, which included historical and contemporary thinking about same-sex sexual orientation and the issues facing LGB people. One response exemplified this more inclusive and pluralistic approach.

> We were taught the history of LGB [people] and of how thinking and treatments, both negative and positive, have changed over time leading up to the present day. The importance of being open minded and respectful of LGB patients, and of their need to be heard and to give voice to their individual experiences was very much at the forefront of the teaching… The impact of trauma on the psyche caused by early life relationships shaped by disapproval and shame and the impact of HIV/AIDS on LGB people were included, as well as the difficulties in forming a healthy relationship with oneself and/or others. ***Respondent 002: Female, 60–69, Heterosexual***

One respondent recommended that issues of sexual orientation should be embedded across the psychodynamic curriculum rather than taught as a distinct, discrete module.

> I would urge training organisations to include all sexual orientations as the norm across all teaching as we should be doing for other areas of diversity (race, culture) and NOT as a separate module. To split it off as a blob of training would just emulate the way, as a profession, we have split off our understanding and thinking about elements of difference in the past. ***Respondent 240: Female, 60–69, 'Other' Sexual Orientation***

A handful of respondents thought historical context was important and that classical, prejudicial texts should still be taught as long as they were properly contextualised.

> Readings, which are heterosexist or homophobic, are not introduced as such, in the way that anti-Semitic or racist texts might be. ***Respondent 226: Female, 50–59, Heterosexual***

> I think that prejudice is ingrained in the psychoanalytic literature. This should not mean that we don't read important texts anymore, but there does need to be an active questioning of assumptions including that healthy development is always in the direction of heterosexuality. ***Respondent 031: Female, 50–59, Heterosexual***

In addition, respondents were asked whether the teaching they had received on sexual orientation had been effective in preparing them for work with LGB clients. As Table 4-25 indicates, there was little consensus on this question.

Table 4-25: Views on effectiveness of psychodynamic teaching on sexual orientation in preparing therapists for work with LGB clients

	Total Frequency (n=171)	%
Neither effective nor ineffective	48	28.1
Effective	44	25.7
Not at all effective	40	23.4
Only slightly effective	30	17.5
Very effective	9	5.3

Missing (n=116) 40.4 % did not answer

As Table 4-26 indicates, chi-squared (χ^2) tests indicated a significant association between respondents' theoretical affiliation and whether training received on sexual orientation had been effective, χ^2 (Df1, n=171) = 4.459, p=.035.

If we cross tabulate the data relating to theoretical affiliation (see Table 4-27 below), we can see that 40.3% of eclectic therapists thought that teaching on sexual orientation had been effective compared with 25.0% of traditional therapists.

Table 4-26: Associations between respondents' attributes and views on effectiveness of psychoanalytic teaching on sexual orientation (χ^2 analysis)

	χ^2	P value
Gender	1.462	.227
Sexual orientation	.684	.408
Age	2.335	.126
Therapeutic modality	1.531	.216
Theoretical affiliation	4.459	.035

The five-point Likert scale options were recoded as 'effective' and 'ineffective'. The categories of 'very effective' and 'effective' were assigned to 'effective'. The categories of 'neither effective nor ineffective', 'only slightly effective' and 'not at all effective' were assigned to 'ineffective'. Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Therapeutic modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' (that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.

Table 4-27: Views on effectiveness of psychodynamic teaching on sexual orientation and respondents' theoretical affiliation (cross tabulation)

	Eclectic (n=67)	%	Traditional (n=104)	%
Effective	27	40.3	26	25.0
Ineffective	40	59.7	78	75.0

Missing (n=116). The five-point Likert scale options were recoded as 'effective' and 'ineffective'. The categories of 'very effective' and 'effective' were assigned to 'effective'. The categories of 'neither effective nor ineffective', 'only slightly effective' and 'not at all effective' were assigned to 'ineffective'. Theoretical affiliation was recoded as 'eclectic' and 'traditional'.

Many respondents were critical of the emphasis on Oedipal theory in psychodynamic teaching about same-sex sexual orientation.

> It's clear that the Oedipal understandings of sexual orientation are erroneous and unclear what might replace them, if anything. ***Respondent 197: Male, 40–49, Gay***

> The application of classical Freudian/Kleinian Oedipal theory is…too rigid, too simplistic and lacking a dimension that theorises the possibility of healthy same-sex desire. ***Respondent 228: Female, 60–69, 'Other' Sexual Orientation***

As illustrated in Table 4-28, almost half of the respondents agreed that their theories of sexual orientation needed updating.

Table 4-28: Views on whether current theories of sexual orientation need updating

	Total Frequency (n=271)	%
Yes	129	47.6
No	74	27.3
Don't know	68	25.1

Missing (n=16)

As Table 4-29 shows, chi-squared (χ^2) tests indicated a significant association between respondents' therapeutic modality and their views on whether their theories of sexual orientation needed updating, χ^2 (Df=1, n=271) = 5.096 p=.024.

If we cross tabulate the data relating to therapeutic modality (see Table 4-30) we can see that 62% of non-psychoanalytic therapists (i.e., Jungians) thought their theories needed updating compared to 44.3% of psychoanalytic therapists.

Table 4-29: Associations between respondents' attributes and need to update theories of sexual orientation (χ^2 analysis)

	χ^2	P value
Gender	.998	.318
Sexual orientation	.000	.990
Age	3.318	.069
Therapeutic modality	5.096	.024
Theoretical affiliation	.144	.705

Question responses were recoded as 'Yes' and 'No'. The category of 'Don't know' was assigned to the 'No' category. Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Therapeutic modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' (that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.

Table 4-30: Need to update theories of sexual orientation and respondents' therapeutic modality (cross tabulation)

	Psychoanalytic (n=221)	%	Non-psychoanalytic (n=50)	%
Yes, theories need updating	98	44.3	31	62.0
No, theories do not need updating	123	55.6	19	38.0

Missing (n=16). The categories were recoded as 'Yes' and 'No'. The category of 'Don't know' was assigned to 'No'. Therapeutic modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' (that is, Jungian or Other).

Several respondents suggested that theories of sexual orientation needed updating because the profession struggled to keep abreast of new developments.

> Things are changing so fast at present. It is difficult to keep up. Our profession hasn't really begun to take on board the impact of sexual diversity and gender identity. ***Respondent 087: Female, 60–69, Heterosexual***

> Since my training there has been a lot of research on sexuality and gender…critical of traditional psychoanalysis. ***Respondent 126: Male, 70+, Heterosexual***

Respondents identified queer theory and transgender studies as two potential disciplines, which may help therapists critically evaluate their assumptions about sexuality and gender.

> More understanding of queer theory [is needed]. More clinical examples and case histories. ***Respondent 033: Female, 50–59, Heterosexual***

> There is a need for an understanding of transgender people. Perhaps we need also to work towards a better and more accurate understanding of human sexuality and gender identity. ***Respondent 281: Male, 50–59, Heterosexual***

Some respondents identified the need to draw on knowledge from biogenetic and neuroscience research.

> It would be interesting to know about the neuroscience…on this topic. ***Respondent 263: Female, 60–69, Heterosexual***

> I am not up to date with all the genetic and neuroscience data. ***Respondent 118: Female, 70+, Heterosexual***

Not all respondents welcomed the idea of updating psychodynamic education on sexual orientation. A handful of responses perceived a 'social desirability' agenda behind the drive for educational reform within psychodynamic training organisations.

> Some 'politically correct' ideas directly conflict with traditional psychoanalytic thinking (e.g., the importance of coming to terms with difference). They do not convince me: the unconscious is not PC. ***Respondent 268: Female, 70+, Heterosexual***

4.15 Professional Attitudes Towards LGB Colleagues and Trainees

As Table 4-31 shows, respondents were asked to indicate their level of agreement with a series of statements on the attitudes of their training organisation towards LGB colleagues and trainees.

Table 4-31: Professional attitudes toward LGB colleagues and trainees

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Colleagues within my training organisation treat LGB colleagues the same as non-LGB colleagues (n=271)	**41** 15.1%	**110** 40.6%	**88** 32.5%	**29** 10.7%	**3** 1.1%
My training organisation does not assess the aptitude for psychoanalytic work on the basis of sexual orientation (n=274)	**68** 24.8%	**112** 40.9%	**78** 28.5%	**13** 4.7%	**3** 1.1%
My training organisation promotes LGB and non-LGB colleagues equally to senior positions within the organisation (n=271)	**44** 16.2%	**88** 32.5%	**119** 43.9%	**16** 5.9%	**4** 1.5%
Colleagues within my training organisation are less willing to supervise LGB candidates than non-LGB candidates (n=268)	**0** 0%	**9** 3.4%	**121** 45.1%	**86** 32.1%	**52** 19.4%

While just over half the respondents (n=151, 55.7%) either agreed or strongly agreed with the statement that 'colleagues within my training organisation treat LGB colleagues the same as non-LGB colleagues', almost a third (n=88, 32.5%) remained undecided.

Almost two-thirds of the respondents (n=180, 65.7%) supported the statement 'my training organisation does not assess the aptitude for psychoanalytic work on the basis of sexual orientation', while just over a quarter of the respondents (n=78, 28.5%) remained neutral.

Almost half the respondents (n=132, 48.7%) either agreed or strongly agreed with the statement 'my training organisation promotes LGB and non-LGB colleagues equally to senior positions within the organisation', whereas just over two-fifths (n=119, 43.9%) neither agreed nor disagreed.

Over half the respondents (n=138, 51.5%) either disagreed or disagreed strongly with the statement 'colleagues within my training organisation are less willing to supervise LGB candidates than non-LGB candidates', whereas almost another half (n=121, 45.1%) could not commit either way.

As Table 4-32 shows, chi-squared χ^2 tests indicated a significant association between respondents' sexual orientation and their views on whether LGB colleagues were treated the same as non-LGB colleagues, χ^2 (Df1, n=271) = 5.937, p=.015. If we cross tabulate the data relating to sexual orientation (see Table 4-33) we can see that 60.1% of heterosexuals agree that LGB and non-LGB colleagues were treated the same compared with only 42.1% of non-heterosexuals.

Table 4-32: Associations between respondents' attributes and professional attitudes and whether LGB colleagues are treated the same as non-LGB colleagues (χ^2 analysis)

	χ^2	P value
Gender	1.474	.225
Sexual orientation	5.937	.015
Age	2.259	.133
Therapeutic modality	1.704	.192
Theoretical affiliation	.102	.750

The five-point Likert scale for this question was recoded into two categories: 'agree' and 'disagree'. The 'agree' category combined the previous categories of 'strongly agree' and 'agree'. The 'disagree' category combined the previous categories of 'neither agree nor disagree', 'disagree' and 'strongly disagree'. Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Theoretical modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' (that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.

Table 4-33: Views on whether LGB colleagues are treated the same as non-LGB colleagues and respondents' sexual orientation (cross tabulation)

	Not Heterosexual (n=57)	%	Heterosexual (n=206)	%
Agree that LGB and non-LGB are treated the same	24	42.1	124	60.1
Disagree that LGB and non-LGB are treated the same	33	57.8	82	39.8

Missing (n=24). The five-point Likert scale options for this question were recoded as 'agree' and 'disagree'. The 'agree' category combined the previous categories of 'strongly agree' and 'agree'. The 'disagree' category combined the previous categories of 'neither agree nor disagree', 'disagree' and 'strongly disagree'. 'Neither agree nor disagree' was assigned to 'disagree' to ensure the χ^2 test's requirements were met (i.e., expected frequencies in the cells should not be less than five). Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'.

As Table 4-34 indicates, chi-squared (χ^2) tests found a significant association between respondents' therapeutic modality and their views on whether LGB and non-LGB colleagues were equally promoted to senior positions, χ^2 (Df1, n=271) = 13.314, p=.001. If we cross tabulate the data relating to therapeutic modality (see Table 4-35), we can see that 72% of the 'non-psychoanalytic' group (i.e., Jungians) thought that LGB and non-LGB colleagues were equally promoted to senior positions, compared with only 43.4% of the 'psychoanalytic' group.

Table 4-34: Associations between respondents' attributes and whether LGB and non-LGB colleagues are promoted equally to senior positions (χ^2 analysis)

	χ^2	P value
Gender	.707	.401
Sexual orientation	.026	.873
Age	.912	.339
Therapeutic modality	13.314	.001
Theoretical affiliation	1.651	.199

The five-point Likert scale for this question was recoded into two categories: 'agree' and 'disagree'. The 'agree' category combined the previous categories of 'strongly agree' and 'agree'. The 'disagree' category combined the previous categories of 'neither agree nor disagree', 'disagree' and 'strongly disagree'. Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Theoretical modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' (that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.

Table 4-35: Views on whether LGB and non-LGB colleagues are promoted equally to senior positions and respondents' theoretical modality (cross tabulation)

	Psychoanalytic (n=221)	%	Non-psychoanalytic (n=50)	%
Agree *that LGB and non-LGB colleagues are promoted equally to senior roles*	96	43.4	36	72
Disagree that *LGB and non-LGB colleagues are promoted equally to senior roles*	125	56.5	14	28

Missing (n=16). The five-point Likert scale options for this question were recoded as 'agree' and 'disagree'. The 'agree' category combined the previous categories of 'strongly agree' and 'agree'. The 'disagree' category combined the previous categories of 'neither agree nor disagree', 'disagree' and 'strongly disagree'. 'Neither agree nor disagree' was assigned to 'disagree' to ensure the χ^2 test's requirements were met (i.e., expected frequencies in the cells should not be less than five). Therapeutic modality was recoded as 'psychoanalytic' and 'non-psychoanalytic'.

Qualitative responses indicated that pathologising attitudes towards LGB colleagues and trainees were still commonplace at some training organisations.

> Historically our organisation has not been open to LGB trainees and they have had to keep under the radar. I hope this is changing but it can still be very difficult for LGB members to be open about their sexuality. Some members are still ignorant and stuck in old ideas about sexuality. ***Respondent 174: Female, 60–69, Heterosexual***

> It is very sad that the psychoanalytic profession is so very far behind other mental health professions when it comes to being LGB-inclusive. I think there needs to be more acknowledgement of how much psychoanalytic theorising and attitudes about homosexuality contains an unexplored and unacknowledged hatred against LGB people. ***Respondent 195: Male, 40–49, Gay***

The application and interview process for LGB individuals remained particularly arduous.

> When I started my training, I was not clear whether LGB people could apply to do the training and I remember it was difficult to get a clear answer. A colleague told me he hid the fact he was homosexual in his application to the training. Later, my institution made a clear statement that sexual orientation would not be a cause for discrimination. ***Respondent 279: Female, 40–49, Heterosexual***

> A colleague, who did their foundation training with me and who is LGB, applied to do the analytic training and found the interviewer to be scathing of his gay lifestyle. He was not accepted onto the course. Sadly, being LGB has been seen by the psychoanalytic community as a developmental failure for far too long. ***Respondent 153: Female, 40–49, Heterosexual***

A handful of respondents noted how prejudicial attitudes within their organisation may impede LGB individuals from assuming positions of influence.

> Some senior colleagues state openly that homosexuality is a perversion, gay parents are damaging etc. It's hard to debate. I don't think I'd have achieved my seniority if I were a lesbian. ***Respondent 251: Female, 50–59, Heterosexual***

It was not unusual for respondents to present a more ambivalent picture of their training organisation's attitudes towards LGB colleagues and trainees.

> My training organisation's attitude on issues of sex in general is somewhat avoidant, regardless of the sexual orientation... If we learn to talk about sexuality regardless of orientation, we might be better able to register, understand and contain anxieties connected with it. ***Respondent 167: Female, 50–59, Heterosexual***

However, several respondents described their training organisations as adopting an inclusive, self-questioning approach.

> My training organisation is inclusive, I believe, and alive to all forms of working with difference. ***Respondent 208: Female; 50–59; Heterosexual***

> I think [my training organisation's] attitude has been transformed in the last 15 years. Frankly, we were grossly prejudiced before and have done a lot of reflecting and revision … Institutionally, I think we are genuinely reformed. ***Respondent 249: Female, 60–69, Heterosexual***

4.16 Training Experiences of LGB Trainees and Therapists

Table 4-36 shows whether LGB respondents were 'out' and open about their sexual orientation at the time of entering and undergoing analytic training.

Table 4-36: LGB respondents who were openly 'out' when applying to train

	Total Frequency (n=119)	Percent (%)
Not applicable	73	61.3
Yes	28	23.5
No	13	10.9
Prefer not to say	5	4.2

Missing (n=168)

Several 'out' and open LGB respondents described their sexual orientation as an ego-syntonic aspect of their identity. These respondents made an explicit link between being open about their sexual orientation and feeling authentic and true to themselves.

> It's part of who I am, it would be dishonest to keep it undisclosed. ***Respondent 256: Male, 30–39, Gay***

> I am out and open in all aspects of my life and would not want my training to be any different. ***Respondent 148: Male, 50–59, Gay***

For some therapists, being out and open about their sexual orientation had been a way of assessing the organisational reaction as well as developing trust with colleagues.

> I felt I had to be as honest as possible and trust the institution and staff to treat me the same as others. ***Respondent 011: Male, 40–49, Gay***

Other openly LGB therapists recalled experiencing hostile or rejecting treatment during their selection interviews or after they were accepted onto the training.

> One supervisor…asked me directly about my own orientation. He then tried to undermine my position on the course. I am resilient but this did rock me -– the power of that destructive prejudice was very strong… I know other colleagues were pathologised within their training… I certainly did not hide my orientation at interview. ***Respondent 240: Female, 60–69, 'Other' Sexual Orientation***

> The moment I mentioned my sexual orientation [in the interview], the atmosphere in the room changed and I was quickly dismissed. When I applied to [name of training organisation omitted], I did not mention it though my supervisor referee did know. ***Respondent 084: Female, 60–69, Lesbian***

Other respondents did not disclose their sexual orientation because they feared being pathologised.

> I'm afraid I've been to a few public events and also been in group supervision where 'highly esteemed' colleagues have openly said that 'the homosexual' shouldn't be a psychotherapist but remain a patient. ***Respondent 200: Male, 40–49, Gay***

> To be honest, I guess it was because I was concerned that I would not be allowed to train, or treated pathologically, so I think I wanted to see how I was being responded to. ***Respondent 195: Male, 40–49, Bisexual***

One LGB trainee described her supervision as a potential source of conflict, because she believed her sexual orientation may act as a barrier to her making effective use of the supervisory relationship.

> As a trainee, I have concerns about being open as there seems to be a lack of openness around the subject, which makes me cautious… I find myself wondering how a supervisor might respond whilst knowing a situation may arise when I will need to disclose this information in order to make full use of the transference and countertransference material I have to present. ***Respondent 210: Female, 50–59, Bisexual***

Only one LGB respondent described a positive experience in relation to his training organisation.

> I felt that the training committee held a balanced and positive view of my training as a candidate with a homosexual orientation. ***Respondent 286: Male, 40–49, Gay***

4.17 Therapists' Views on the Role of the BPC

The majority of respondents (n=243, 88.0%) reported that they were aware of the BPC Position Statement opposing discrimination in the selection or progression of those who are LGB and who wish to train, are training or train others in psychoanalytically informed practice. Table 4-37 shows

respondents' views on whether the BPC should play a more or a less active role in fostering an inclusive and LGB-friendly profession.

Table 4-37: Views on the role of the BPC in fostering an inclusive and LGB-friendly profession

	Total Frequency (n=273)	Percent (%)
Much more active	51	18.7
More active	126	46.2
Fine as is	90	33.0
Less active	5	1.8
Much less active	1	0.4

Missing (n=14)

Table 4-38 presents respondents' views on a range of initiatives the BPC could deliver in order to foster a more inclusive and LGB friendly training and professional environment.

Table 4-38: Views on proposed LGB-friendly initiatives for the profession

	Important	Somewhat important	Neither important nor unimportant	Not too Important	Not at all important
Revise entry requirements including how LGB applicants are selected (n=272)	**135** 49.6%	**102** 37.5%	**26** 9.6%	**5** 1.8%	**4** 1.5%
Assist training organisations in updating current curricula on sexual orientation (n=272)	**144** 52.9%	**94** 34.6%	**26** 9.6%	**4** 1.5%	**4** 1.5%
Deliver CPD events on sexual orientation for teaching and supervision staff (n=273)	**139** 50.9%	**101** 37.0%	**22** 8.1%	**8** 2.9%	**3** 1.1%
Provide better Information, Advice and Guidance (IAG) on LGB-specific issues (n=270)	**109** 40.4%	**109** 40.4%	**42** 15.6%	**6** 2.2%	**4** 1.5%
Develop partnerships with other organisations working with the LGB community such as Pink Therapy (n=269)	**80** 29.7%	**102** 37.9%	**54** 20.1%	**29** 10.8%	**4** 1.5%
Establish a professional network for LGB members across all BPC training organisations (n=269)	**45** 16.7%	**84** 31.2%	**100** 37.2%	**25** 9.3%	**15** 5.6%
Ensure LGB issues are addressed by the BPC Ethics Committee (n=271)	**130** 48.0%	**116** 42.8%	**19** 7.0%	**4** 1.5%	**2** 0.7%

There appears to be strong appetite amongst the majority of respondents for the following initiatives:

- 90.8% of respondents (n=246) considered it important or somewhat important to ensure LGB issues were addressed by the BPC Ethics Committee.
- 87.9% of respondents (n=240) considered it important or somewhat important for the BPC to deliver CPD events on sexual orientation for teaching and supervision staff.
- 87.5% of respondents (n=238) considered it important or somewhat important for the BPC to assist training organisations in updating current curricula on sexual orientation.
- 87.1 of respondents (n=237) considered it important or somewhat important for the BPC to revise entry requirements including how LGB applicants are selected.

- 80.8% of respondents (n=218) considered it important or somewhat important for the BPC to provide better Information, Advice and Guidance (IAG) on LGB-specific issues.

Respondents expressed discernibly less interest in two of the proposed initiatives:

- 67.6% of respondents (n=182) considered it important or somewhat important for the BPC to work with partnerships organisations specialising in LGB-specific therapy.
- 47.9% of respondents (n=129) considered it important or somewhat important for the BPC to establish a professional network for LGB members.

4.18 Summary

This chapter has reported the results of the questionnaire. As well as providing a description of the sample, several associations were identified between respondents' personal and professional attributes and their responses to particular questionnaire items. The questionnaire findings are best viewed as having generated questions to be clarified in the interview study, the findings of which are outlined in chapter five (see below). The questionnaire findings will be triangulated with the interview results (chapter five, see below) and their implications fully explored in the discussion chapter (chapter six, see below).

5 Interview Results

This chapter presents the results of a Framework Analysis of 36 interviews conducted with psychodynamic practitioners, most of whom were BPC members. Ten main themes were identified. In alignment with Tong, Sainsbury and Craig (2007) and Côté and Turgeon (2005), I quoted extensively in this chapter in order to: (1) provide evidence; (2) illustrate or elaborate the commentary; (3) deepen the reader's understanding; and (4) to give the interviewees 'a voice'. All quotations have been carefully selected to exemplify the particular point(s) under discussion. I aim to enhance the transparency of my findings by indicating clearly each interviewee being quoted (e.g., *Interview 08*) and by providing basic demographic data about them. However, I do not provide respondents' professional characteristics in order to protect identities. The main discussion of the interview data is reserved for chapter six (see below).

5.1 Description of Sample and Setting

A purposive sampling technique was mainly used for recruiting interviewees with a minor element of snowballing (see chapter three, section 3.11). In total, 97 individuals were sent email invitations to participate in the interviews. Eighty-seven individuals were identified based on my own knowledge, existing contacts and desk research (the purposive element). Ten individuals were recommended by my primary supervisor or other therapists (the snowballing element). Overall, 36 individuals, including the four pilot interviewees, agreed to be interviewed. Sixty-one individuals declined to take part (63% non-participation rate), most of whom typically cited lack of time. The majority of interviewees were BPC members (n=33). The three non-BPC interviewees had been recommended because of their specialism in the subject area. All interviews, including pilot interviews, were conducted between July 2017 and May 2018.

Around a third of interviewees had a vested interest in the research. By 'vested interest', I mean that these interviewees had either: (1) conducted extensive clinical work with LGB clients over their careers as well as lecturing and publishing on the subject; or (2) self-identified as LGB and had a personal, professional and sometimes political interest for taking part. The remaining two-thirds of interviewees were senior therapists involved in a diverse range of professional activities (outlined below) but did not have a specialist interest in the topic. Some agreed to participate because they were also researchers and wanted to support another researcher's endeavours. A small minority wanted to clarify their own thinking on the research subject. A few were interested in wider issues of diversity and difference more generally, for example ethnicity, class and gender, rather than sexual orientation *per se*.

Overall, the interview sample included 18 male clinicians, 17 female clinicians and one clinician who identified as 'other gender'. In terms of sexual orientation, interviewees identified as heterosexual (n=25), lesbian (n=5), gay (n=4) and queer (n=1). One interviewee chose not to identify their sexual orientation. Interviewees were a range of ages: 60–69 (n=18), 50–59 (n=8),

70+ (n=6) and 40–49 (n=4). No interviewees were under 40 years of age. Three interviewees identified as Black, Asian and Minority Ethnic (BAME).

In terms of therapeutic modalities, interviewees self-identified as follows: Psychoanalyst (n=13), Psychoanalytic Psychotherapist (n=8), Jungian Analyst (n=5), Psychodynamic Psychotherapist (n=2), Psychoanalyst and Psychoanalytic Psychotherapist (n=2), Couples Psychoanalytic Psychotherapist (n=2), Jungian Analyst and Child Psychotherapist (n=1), Clinical Psychologist (n=1), Child Psychoanalyst and Psychoanalytic Psychotherapist (n=1) and Child and Adult Psychoanalyst (n=1). Theoretically, interviewees variously self-identified either exclusively or in combination[71] as: Kleinian, Contemporary Kleinian, Bionian (n=14), Freudian, Contemporary Freudian (n=12), British Independent (n=11), Jungian, Post-Jungian (n=7), Non-aligned (n=4), Relational (n=4), Object Relational (n=3), Attachment-led (n=2), Lacanian (n=1), Pluralist (n=1), Interpersonal (n=1), Integrative (n=1), Humanistic (n=1) and Cognitive Behavioural (n=1).

Most interviewees were members of the larger, London-based training organisations with very minimal representation from the smaller, regional organisations.[72] Over 50% of interviewees (n=19) were members of the British Psychoanalytical Society (BPAS). The remaining interviewees were members from the British Psychotherapy Foundation (BPF) (n=9), the Tavistock Society of Psychotherapists (TSP) (n=5), the Foundation for Psychotherapy and Counselling (FPC) (n=3) and the Society of Analytic Psychology (SAP) (n=3). Three interviewees were not BPC members. A handful of interviewees (n=6) were members of multiple training organisations. Interviewees engaged in a diverse range of professional activities.[73] Professional activities included: private clinical practice (n=32), teaching within academia or psychodynamic training organisations (n=30), conference speaking (n=30), committee membership (n=30), authoring (n=29), training analyses or supervision (n=25), research (n=18), editorial or journal work (n=18), theoretical development (n=15), national activity (e.g., government policy development) (n= 12), work in the NHS (n=11), work in the third sector (n=11), specialist clinical work (e.g., HIV services for gay men; sexual offenders; gender identity services) (n=5) and other activities (e.g., applied psychoanalysis) (n=1).

Interview duration varied. The shortest interview was 28 minutes. The longest interview was one hour and 17 minutes. The average duration was 45 minutes. In total, 28 hours of interviews were conducted. Participants were interviewed within a range of settings: at their consulting rooms within their homes (n=13), at their public workplace (e.g., hospital, clinic or university department) (n=11), at their private consulting rooms at external locations (not at their homes) (n=7) and at their homes but not in their consulting rooms, that is in the kitchen or lounge (n=5). I was not aware of location having a particularly adverse effect on interview quality. However, I noted that participants interviewed within public work settings were more pressed for time; their interviews were below average duration. Participants interviewed in their homes were probably more relaxed

[71] Numbers do not add up to 36 as some interviewees identified with multiple theoretical positions.
[72] Numbers do not add up to 36 as some interviewees were members of multiple training organisations.
[73] Numbers do not add up to 36 as most interviewees were engaged in multiple professional activities.

and less formal; their interviews were above average duration.

I had previous professional interactions with ten of the interviewees either through teaching work or through the BPC task group. All ten of these interviewees would have been aware of my sexual orientation as well as my personal motivation and interest in the research topic. The other 26 participants would not have been aware of these personal factors and were only given additional information about me if requested. If asked if I was gay, I disclosed my sexual orientation. However, it is not possible to say whether such disclosure inhibited the responses to my questions or not. In some instances, participants assumed I was a gay man from the outset, but they did not seek clarification on this. I did not confirm their assumptions, unless asked.

As well as sharing their thoughts on same-sex sexual orientation specifically, interviewees expanded their reflections to encompass their views on gender, sexuality and relationship diversity more generally. I have opted to include these wider contributions as part of my overall reporting in this chapter. This ensures that same-sex sexual orientation is considered as part of a broader psychodynamic understanding of sexuality and not as something split off and separate.

5.2 Theme 1. 'There's a Risk of Throwing the Baby Out with the Bath Water': The Continuing Value of Freud's Theories of Sexuality

During the interviews, three-quarters of therapists referenced Freud's theories of sexuality. Some interviewees embraced what they perceived to be Freud's less heteronormative conceptualisation of sexuality, that is sexuality as more than just penis-in-vagina sexual intercourse between a man and a woman. In this strand of thinking, interviewees believed that Freud had a more radical approach, theorising sexuality as fluid, contingent and emergent. Other interviewees were critical of Freud's ideas about sexuality, drawing attention to what they viewed as the more conformist, conservative threads in his thinking.

Those interviewees who valued Freud's theories of sexuality commented on his generally tolerant attitude towards sexual matters, while acknowledging his biases and limitations. To these clinicians, Freud was one of the first thinkers who made the exploration of sexuality, in all its dimensions, a legitimate area for psychological study.

> Although there were parts of what Freud wrote that I felt alienating, reading Freud was the first time I really began to have the basis of an understanding about sexuality that was also psychological. ***Interviewee 35: Female, 60+, Lesbian***

One interviewee stated that Freud's open-minded views about same-sex sexual orientation were exemplified in two letters he wrote: one to an American mother, stating that her gay son's sexual orientation was not an illness nor an identity that could or should be changed, and the other to his colleagues, outlining his position that LGB individuals should be allowed to train as psychoanalysts.

> Don't know if you've read those letters that Freud wrote? The letter to the mother and the other one is when some Dutch people wrote saying they wanted a gay person to join the psychoanalytic institute? Freud said we shouldn't line ourselves up with the discrimination or persecution of gay people. ***Interviewee 08: Male, 60+, Heterosexual***

The majority of respondents who valued Freud's theories considered some of his insights on sexuality as highly relevant for clinicians today and worthy of retention. There was a shared impression amongst these practitioners that Freud's theoretical and clinical propositions on sexuality continued to have explanatory power. Some respondents recommended adding to and developing Freud's original contributions on sexuality rather than reformulating them or rejecting them out of hand.

> There's a risk of throwing the baby out with the bath water… I wouldn't want to junk the whole history of thinking and clinical experience entirely… I think there are some valuable things in Freud… I wouldn't want to think everything needs to be jettisoned and we need to start with a blank sheet of paper and…work out a modern theory of sexuality. ***Interviewee 26: Female, 60+, Heterosexual***

A common view was that Freud's concept of polymorphous perversity was particularly valuable for explaining what some interviewees perceived as the fragmentary and plural nature of sexuality. Polymorphous perversity enabled clinicians to imagine sexual desire as something essentially unorganised with the possibilities of pleasure diffused all over the body.

> Freud's notion that sexuality is polymorphous perverse is useful... Sexuality takes many forms, involves all different areas of the body and…there are different component parts to it, looking, touching…as well as more explicitly erotic activities. ***Interviewee 16: Female, 60+, Heterosexual***

An equally common perspective amongst these interviewees was that Freud's concept of the sexual drive was useful. If, as Freud conceptualised, the sexual drive lacked an inborn aim (and was not directed solely towards procreation) and had variable objects (and was not solely directed towards the opposite sex), then no single sexual developmental pathway was the 'natural' one. Heterosexuality was not a foregone conclusion. As one interviewee explains:

> The idea that...there's no natural connection between the drive and its object…that just changes the game… Then, there are multiple possibilities and none of them is the 'natural' possibility… 'The natural' is always complicated by culture – always – and that's one of the things that is important about the concept of the drive… How, out of the polymorphously perverse disposition of the child, does somebody end up with an exclusively heterosexual orientation? ***Interviewee 11: Female, Under 60, Heterosexual***

These clinicians suggested that Freud's concepts of polymorphous perversity and the sexual drive opened up the potential for multiple sexual developmental outcomes, each shaped by a complex interplay of family dynamics, social influences and environmental factors.

> I think one of Freud's most precious discoveries really was that sexuality is never a given. It's always psychosexuality and...is the outcome of a long developmental process… All sexuality, ultimately, is a set of compromises… Sexuality is…the outcome of a multitude of forces. They are social and socially mediated through the complexity of particular family situations that a child finds themselves in. ***Interviewee 04: Female, 60+, Heterosexual***

In contrast, other interviewees were less convinced by Freud's ideas on sexuality, highlighting the more heteronormative, less progressive and therefore contradictory components in his writings. One interviewee described how Freud, at many stages, favours penis-in-vagina (PIV) sexual intercourse, resulting in reproduction, as the healthiest and most natural form of sexual expression.

> Freud conceived of non-pathological sexuality as the man and a woman in a missionary position basically and essentially being there for the purpose of procreation. ***Interviewee 06: Male, 60+, Sexual Orientation not specified***

A handful of interviewees criticised Freud for conflating his theories of sexuality and gender.

> Freud muddled, systematically, to some degree, but not intentionally, gender identity with sexual orientation. Why he did that is not entirely clear. I think…historically…we now know that it was actually an error on his part… He should never have done that and he's not actually consistent with the rest of his theories about it. It's a major problem. ***Interviewee 28: Male; 60+; Heterosexual***

Another relatively common complaint from this group of interviewees was the way Freud sometimes equated same-sex sexual orientation with developmental disturbance or theories of immaturity.

> I accepted, although in a very split way, a view that being homosexual or lesbian, in some way, implied that there was some kind of psychological difficulty… Freud talks…about being gay as…a kind of arrest in development. ***Interviewee 08: Male, 60+, Heterosexual***

Unsurprisingly, Jungian-trained analysts preferred Jung's approach to sexuality, which they viewed as less dogmatic than Freud's. As Jung paid less attention to sexuality in his writings, these interviewees felt sexuality was less of a focus and integrated it into a wider Jungian theory of personality and of development.

> The thing…most helpful from my Jungian training and…has been helpful to me…working in the area of sexuality…is that…Jungian theory about sexuality is less developed than psychoanalytic theory… Jung had a conception of libido that was different to Freud's. For Jung, it was life force rather than just sexual energy and just sexuality. That's really quite liberating…when it comes to thinking about general issues that might be thought of as libidinal. ***Interviewee 34: Male, Under 60, Heterosexual***

One interviewee expressed frustration about the profession's general unwillingness to question some of Freud's theories of sexuality and their relevance today. There was a strong criticism of contemporary practitioners who deliberately made their clinical observations 'fit' Freud's models.

> There's much in psychoanalysis about not losing some of the important things Freud said but that creates a huge obstacle in terms of thinking about…sexuality nowadays…family configurations, the Internet... It's very different… The theory does need updating in that sense... What I'm trying to get at is sometimes it feels too forced to try to link it [sexuality] to something that Freud said. ***Interviewee 01: Female, Under 60, Heterosexual***

5.3 Theme 2. 'The Best Stab We Have Had at It Really': The Uses and Abuses of Oedipal Theory

Just over four-fifths of interviewees discussed the role of the Oedipus complex in relation to sexuality, sexual development and sexual orientation. Their perspectives on its usefulness as a theory were diverse and varied. The Oedipus complex plays a pivotal part in Freud's overall theories of sexuality and it has been presented as a separate theme, because of the detailed attention interviewees gave to it in their responses.

A fairly common view amongst interviewees was that the Oedipus complex was central to shaping the outcome of one's sexual desire. Some interviewees believed that early Oedipal experiences with parental figures informed a child's subsequent sexual choices as an adult.

> I have found the Oedipus complex…helpful… Certainly, the formative nature of the relationship with each parent and the place of desire in that situation…is central for all of us…and in determining the ultimate choices of our sexual desire really, whether we are heterosexual, remain bisexual, homosexual… I don't think we're very good at explaining…sexual desire. The Oedipal situation is the best stab we have had at it really. ***Interviewee 04: Female, 60+, Heterosexual***

One interviewee valued the classical conceptualisation of the Oedipus complex.

> I see the Oedipus complex as three real things: the coming to terms with the division between the sexes...coming to terms with the division between the generations...and, if you like, coming to terms with the existence of a couple and one's relationship to the

> couple or the couple's relationship to you. That is the Oedipus complex roughly. ***Interviewee 10: Male, 60+, Heterosexual***

The majority of interviewees, however, felt that Oedipal theory was too rigidly applied. One of the main criticisms levelled at Oedipal theory was how psychodynamic therapists had, in the past, presented it as a universal developmental truth.

> To take [the Oedipus complex] as if it is a thing, as a kind of developmental fact, seems to me to be completely wrong and that's a mistake. Whether it's absolutely ubiquitous as it was thought to be… I don't know, and I somehow think: why should it be? ***Interviewee 18: Male, 60+, Heterosexual***

One interviewee suggested that the Oedipus complex might be best viewed as geographically and culturally specific.

> I think the Oedipus complex is…a decent theory… There's nothing that says you have to resolve your Oedipus complex in this way or that. It describes that, in a heterosexual normative society, the Oedipus complex will, on the whole, be resolved this way rather than another way... I think you have got to contextualise it properly. We study the Oedipus complex mostly in Western society, which has a particular form and structure. ***Interviewee 14: Male, 60+, Heterosexual***

Many female interviewees criticised Oedipal theory for being phallocentric and sexist, leading to partial and unsatisfactory understandings of female sexual development, female gender identity and the female body.

> I've often wondered why…psychoanalysts…have persisted using the term Oedipus complex because I don't agree with the view of the girl feeling something is lacking or her superego being diminished. ***Interviewee 01: Female, Under 60, Heterosexual***

> I don't think you can stop [Oedipal theory] having its gendered accretions... It has developed into a theory around gender and sexuality, but it is actually rooted in the male body. I think it's forever lopsided. ***Interviewee 27: Female, Over 60, Lesbian***

Female interviewees discussed how feminist analysts made important revisions to Oedipal thinking, critiquing male-dominated concepts, such as penis envy and female castration, and emphasising women's creative capacities in being able to conceive and bear children.

> I think they [feminist analysts] certainly thought that [Freud] got the wrong end of the stick in the notion that penis envy was where women were starting from... It can be a factor in a girl's development, but you also need to note that male envy of female genital organs

> and the capacity to have babies is a large factor in the development of the boy. ***Interviewee 25: Female, 60+, Heterosexual***

Female interviewees who valued the feminist re-visioning of the Oedipus complex noted the shift in thinking towards the mother-child relationship.

> I think there's too much emphasis on patriarchy, the phallus, the penis and not nearly enough emphasis on the mother, the mother as the object of desire and the anxieties aroused by the female and the feminine. ***Interviewee 16: Female, 60+, Heterosexual***

Another interviewee was critical of the way psychodynamic theory sometimes conflated unresolved Oedipal conflicts and same-sex sexual orientation.

> I've had a number of [gay male] patients…who had absent fathers or…complicated relationship with their dads… Do I think it's causal? To me, it's a multi-layered problem that people try to simplify. Oedipus is…a convenient way of making a reductionist explanation. Oedipal accounts are genuine explanations…but ascribing causality to them is a different order of logic altogether. ***Interviewee 28: Male, 60+, Heterosexual***

One interviewee emphasised the central role identification played in the Oedipus complex.

> I think that the crucial issue for me is more about the quality of the identifications, irrespective of which parent it is with. It's about being able to relate to both the female parent and the male parent in both their masculine and feminine aspects… I think it [the Oedipus complex] is about quality of identification rather than the prescriptive path identifications must take. ***Interviewee 02: Female, Under 60, Heterosexual***

Some interviewees considered the Oedipus complex to be a valuable theory if it was viewed more abstractly, as way of conceptualising 'the third' or as a phase of development where triangular relationship structures become established.

> It's meaningful to think about whether or not people have an Oedipal structure… When there's an over-close, fused relationship with the mother, there's a need for a third or somebody to come in between the mother and the child and to aid the separation and individuation. ***Interviewee 16: Female, 60+, Heterosexual***

Several interviewees drew on the Kleinian model of the Oedipus complex rather than Freud's.

> Klein was more interested in primitive processes, which went on before the establishment of a proper neurotic Oedipal conflict of the kind that Freud wrote about... She would have been interested in that earlier period…when the sexual identity was much more fluid. ***Interviewee 30: Male, 60+, Heterosexual***

A few interviewees were aware of LGB relational therapists from the US, such as Richard Isay, who had re-imagined the Oedipus complex and proposed LGB-specific versions that more fully reflected the realities of gay and lesbian sexual desire.

> It's evident that a very classic account of the Oedipus complex and its necessary resolution doesn't really fit for same-sex attraction… There are ways of making some sense of that, partly through the ideas [Richard] Isay developed around a gay version…of the Oedipus complex and the different attachments particularly to the father for a gay boy. ***Interviewee 09: Male, 60+, Gay***

Another interviewee was strongly influenced by Lacan's version of the Oedipus complex.

> Lacan…whose work I love and greatly admire…works with completely non-gendered ideas like 'petit objet a', for example, and came up with a formula for sexual difference that has nothing to do with the binary model... In those ways I find [Lacanian theory] useful… I like it when Lacan says that the sex of the parent is completely irrelevant when it comes to thinking about Oedipus. ***Interviewee 13: Female, Under 60, Lesbian***

Instead of focusing on the Oedipus myth, Jungian-trained therapists drew on other mythical and archetypal material to conceptualise same-sex pairings.

> The other thing that Jung…emphasised was not the resolution of any specific [Oedipal] complex… There were some post-Jungian thinkers who particularly explored more male [to male] psychological scenarios… For example, one archetype, which is typical of this is Senex-Puer… Someone also thought about the archetype of the double, which again is a way of conceptualising a certain kind of intense and deep bond between two persons of the same-sex. ***Interviewee 15: Male, Under 60, Gay***

5.4 Theme 3. 'It's the Kind of Sex I Don't Like': Psychopathology, Perversion and Sexual Practices

The majority of interviewees discussed how psychodynamic theory had historically equated same-sex sexual orientation with psychopathology, perversion or sexual deviance. Several interviewees referred to the American psychoanalyst Charles Socarides, a vociferous supporter of conversion therapy.

> There have been some quite conservative analysts, such as Socarides, who have written some really unpleasant, prejudicial papers around homosexuality… There was a big hoo-ha because he wanted to come and talk [in the UK] and I think the hoo-ha was sufficient that in the end he was dis-invited. Some of the writings within the analytic world have been extreme. ***Interviewee 20: Female, 60+, Heterosexual***

Most interviewees wanted to move away from the legacy of suffering caused by the historical psychodynamic pathologising of same sex desire but recognised that the views represented by Socarides persisted in certain quarters.

> I think there are people who, from an older generation, haven't necessarily changed their thinking, who would still see homosexuality as…inherently pathological. ***Interviewee 16: Female, 60+, Heterosexual***

> I certainly don't feel…and I've heard this said in my own society…that the thing about homosexuality is that it's always a defence against something…psychotic. ***Interviewee 04: Female, 60+, Heterosexual***

Interviewees were aware that some psychodynamic theories equated same-sex desire with an unresolved narcissism.

> I got the impression that my analyst…did tend to think of homosexuality as pathology because it seemed to involve a narcissistic object choice. ***Interviewee 31: Male, 60+, Heterosexual***

However, choosing a same-sex partner did not necessarily mean LGB individuals were narcissistic. One interviewee described same-sex partnerships as representing more than a narcissistic desire for sameness. Same-sex couples were capable of valuing and appreciating their partner's uniqueness.

> All the theory that conflates homosexuality with narcissism…is very unhelpful… Men attracted to men actually can perceive the object of desire as very different from themselves… I think that homosexuality is a particular combination of sameness and otherness which every relationship has. ***Interviewee 15: Male, Under 60, Gay***

Most interviewees did not subscribe to the view that same-sex sexual orientation was perverse because it deviated from heterosexuality.

> I don't make use of…theories which would equate male homosexuality and female homosexuality with forms of what they call 'perversion'… The love of men for other men, the love of women for other women…I don't regard that as perverse in a pathological sense. ***Interviewee 07: Male, 60+, Heterosexual***

Some interviewees still thought the term 'perversion' had a place in psychodynamic thinking and practice and referred to Stoller's idea that some erotic activities (whether practised by LGB or non-LGB clients) were perverse because they represented sexualised aggression.

> I get pushback from [younger] therapists…about things like kink and…BDSM relationships... Whole areas that I would still consider within the category of perversion… I want to retain the concept of there being an area of sexual functioning that is perverse and hateful. ***Interviewee 17: Male, Under 60, Gay***

Other practitioners found value in Glasser's theory of the 'core complex' for thinking about the different forms that sexual behaviour might take for both LGB and non-LGB clients. The core complex enabled clinicians to make a distinction between sexual activities that were defensive in order to stave off fears of intimacy or fusion, and sexual activities that were expressive and about making connections with another person.

> The theories of Glasser have been very helpful in terms of what he called the core complex…finding some way to…cope with all the anxieties of your own fear of intimacy and fear of your own aggression. ***Interviewee 32: Male, 60+, Heterosexual***

A handful of interviewees felt the term perversion was particularly appropriate for defining sexual practices that involved de-humanisation and de-personalisation or did not seem particularly creative or life affirming. One interviewee focused on her clinical work with some gay male clients to illustrate this point, although her wider transcript showed that she, by no means, thought such sexual activities were LGB-specific.

> I have had some [gay male] patients…who have had what I've regarded as quite extreme, sexual lives…that are quite hard to identify with. For example, very chemically charged and drug fuelled binges of four or five days, where…there's certainly been a lot of sex going on with many people in very…part object [ways], very much treating the other partners as objects or collections of body parts almost. This has seemed to me, listening to it, to be a…very de-humanising way of thinking about other people and oneself. ***Interviewee 26: Female, 60+, Heterosexual***

Interviewees frequently emphasised that their non-LGB clients also practised kink or engaged in polyamorous sexual encounters. Some perceived little to no little difference between the sex lives of LGB and non-LGB clients.

> I think that in gay communities and cultures, how one has sex…corresponds with how heterosexual people would have it... I've worked with lots of heterosexuals who love swinging parties and having sex in a way that's not necessarily about relationships and not necessarily about intimacy with the person that you have sex with. ***Interviewee 33: Female, 60+, Heterosexual***

Jungian-trained interviewees entertained the possibility that clients expressing something that seemed unsettling in their sexual fantasies and behaviours could be confronting the repressed, 'shadow' aspects of their sexual natures, those desires they least want to admit to having.

> It really doesn't matter what the [sexual orientation] of the person is or how they're expressing it. What matters are the shadow areas that might need to be looked at. Where is the cruelty in sexuality? Where is the cut off-ness? Where is the violence or the indifference? ***Interviewee 34: Male, Under 60, Heterosexual***

Several interviewees valued Fonagy's and Target's theories about early desire for thinking about sexual behaviours more generally and how sexuality is expressed in adulthood.

> I think...Peter Fonagy's ideas about desire are interesting, the notion that sexuality and sexual organisation is inherently fragile because sexuality is unmirrored in infancy. ***Interviewee 16: Female, 60+, Heterosexual***

> Mothers or fathers do not ever reflect to their kids…that they observe [their] sexual excitement. As a consequence, none of our understanding of our own sexual excitement is really properly symbolically represented... It is fundamentally disorganised. ***Interviewee 28: Male, 60+, Heterosexual***

Several interviewees drew attention to the work of Stein, Laplanche and others, to discuss the enigmatic dimensions of sexuality, in particular how the mother unconsciously transmits aspects of desire to her child who is as yet incapable of understanding it. This makes sexuality something enigmatic, puzzling or 'other'.

> The thinking I'm very drawn to now is much more Ruth Stein…Laplanche…Mary Target…people talking about the enigmatic within sexuality…the something that is not quite understood... It's ineffable. It's difficult to grasp it. ***Interviewee 21: Female, Under 60, Lesbian***

One interviewee described how, compared with psychodynamic practitioners, critical and feminist psychologists were more validating and less pathologising in their approach to understanding relationship diversity such as kink or BDSM relationships.

> There is more of an 'anything goes' attitude amongst my psychology colleagues... Within the psychoanalytic community, there would be the view that there's a certain amount of perversion in that kind of sexuality. In my psychology world, it would mainly be theorised as individuals taking control, having the power to do what you want and would not be seen as pathological. ***Interviewee 20: Female, 60+, Heterosexual***

A small minority of interviewees rejected the term perversion completely, considering it to convey an attitude of moral sanction.

> I feel strongly about the use of the word perversion…I think it's…a word that's very often used to denigrate or to be pejorative. 'It's the kind of sex I don't like' basically…when people use the word perversion. I think it is a very prejudicial, unhelpful word and it's a binary kind of word as well. You either are or you are not. Your [sexual] practice is, or it isn't. ***Interviewee 33: Female, 60+, Heterosexual***

Another frequent observation from interviewees was that clinicians generally found it difficult to talk about sex of any sort. Therapist reluctance to discuss sexual matters was potentially harmful for clinical work with LGB clients who, as a consequence of homophobia and societal stigma, may already feel embarrassment or a sense of illegitimacy about their sexual practices compared with their non-LGB counterparts. As one interviewee explains:

> I do talk a lot about sex with gay patients… It gives a sign that anything can be talked about. I often meet a lot of embarrassment from gay men to talk about their sexuality particularly when it comes to anal penetration or accidents that might happen during the penetration… In those cases, I want them to go into plain descriptions of their sexual practices and phantasies as much as possible… It gives legitimation of exploring that desire. ***Interviewee 15: Male, Under 60, Gay***

One interviewee reported how uninformed his heterosexual colleagues were about the different sexual practices gay and lesbians may discuss in therapy.

> If you are talking clinically with a gay man and the question of anal sex comes up, for example…if you don't have a notion of what's actually involved, what's going on, or if he uses a phrase like barebacking or fisting or whatever it happens to be… Most of my straight colleagues don't really know [about these practices]***. Interviewee 03: Male, 60+, Heterosexual***

When clients engaged in unprotected sexual activities, clinicians reported a struggle in balancing concern for the client's safety against the analytic task at hand.

> Sometimes [gay male clients] might have sex with strangers in what I would consider potentially dangerous places, in the middle of a park, or public toilets, or in a car park, in the middle of the night… I try to help them think about what it means for them and also not bring judgement to the way I'm thinking about their behaviour but also not lose sight of things like risk. When I say risk…are they keeping themselves safe? ***Interviewee 20: Female, 60+, Heterosexual***

When interviewees referred to specific sexual practices they associated with LGB clients, they itemised the following activities: anal sex, rimming, cruising, fisting, barebacking, snowballing, cottaging, sex at bath houses/hooded bars, chemsex, BDSM, kink and autogynephilia.

5.5 Theme 4. 'The Issue Is…Can He Bring Love and Sex Together?': The Desire for Connectedness and Relatedness

Linked to their reflections on sexual practices, over two-thirds of interviewees discussed relationships and relating. Interviewees' theoretical frameworks influenced their overall thinking about relationships. Object relations theory was a dominant theoretical framework, emphasising connectedness and relatedness over psychosexuality and the sexual drive.

> What I'm interested in understanding…whatever the individual's sexual orientation…is the nature of the internalised object relationships… I think that a lot of the problems people present within psychoanalysis are to do…with relationships, particularly early internalised relationships, that continue to exert an impact on current ways of relating to others and to oneself. ***Interviewee 02: Female, Under 60, Heterosexual***

In many interviewees' accounts, object relational theory was strongly supported by attachment theory.

> Some theoretical contributions…attachment theory, for instance…are…fundamental for understanding relationships…and especially the way in which one's growing sense of identity, sexual or otherwise…are embedded in the early relationships and significant relationships with the mother or the caregiver and the immediate family. ***Interviewee 19: Male, Under 60, Heterosexual***

Some interviewees were influenced by dynamic interpersonal theories. By looking in detail at a client's history of relating to others, such as parents or caregivers, current patterns of relating to the self and significant others (particularly partners) could be more fully understood. As one interviewee explains:

> Within [these patterns of relating] there is an internalised representation of the self, how you see yourself in those relationships, as the person who is always needy or who is always being abandoned or who is being judged or is unlovable or whatever you carry around with you as the self-representation. Likewise, the other people you get involved with seem to manifest certain recurrent ways of relating with you so that they treat you badly…or they misunderstand you…or are too critical of you… There are certain emotional buttons that just produce the same impact each time. ***Interviewee 17: Male, Under 60, Gay***

When comparing LGB and non-LGB relationships, most interviewees commented that there was very little to no difference between these relationships.

> The only thing I can say is that in couples work…I don't think I've found that…the issues with a same-sex couple are any different from working with a man and a woman couple.

> There are very similar difficulties and strengths… I don't see they are so different. ***Interviewee 18: Male, 60+, Heterosexual***

Equally, LGB couples were thought to relate to one another just as deeply and as meaningfully as straight couples.

> There's no reason why [LGB individuals] shouldn't be having as committed and as fully intimate and demanding personal, close and sexual relationships as anybody else. ***Interviewee 17: Male, Under 60, Gay***

One of the main relationship issues LGB and non-LGB clients brought to therapy was around intimacy. It was not infrequent for interviewees to identify internalised homophobia as a contributing factor for why some LGB clients sometimes found it difficult to maintain an emotional connection with another person.

> A [gay] male patient I've seen for some years…can't get into and sustain…intimate, sexual and emotional relationships… He can't keep it going for more than a few weeks usually… He had very homophobic parents and has internalised a massive amount of that. There's a real block in him. ***Interviewee 26: Female, 60+, Heterosexual***

Interviewees noted that some LGB clients had yet to fully accept their sexual orientation. This inhibited their capacity to make meaningful, intimate links with other people.

> One of [my gay male clients] has never had a sexual relationship of any kind… The therapy was about his identifying and thinking about the depth of his own longing for closeness and relationship and contact and the degree to which that had been...deprived…because of his struggle around his own sexuality and the way in which that had made him keep himself apart. ***Interviewee 34: Male, Under 60, Heterosexual***

One therapist provided an example of a client whose relationship issues were around how he might synthesise love, sex, intimacy and closeness.

> I think [my client] would like to be able to maintain a close affectionate and sexual relationship with one person. He doesn't know for sure whether that will be with a man or with a woman… The issue for him is not…is he gay? Or is he straight? The issue is…can he bring love and sex together? ***Interviewee 31: Male, 60+, Heterosexual***

Another frequent theme was around clients' lack of sex or how to stay sexually alive in a long-term relationship. As one interviewee describes:

> My gay male client has gone into couples' therapy with his partner and they're working really at whether there is enough togetherness in their relationship and enough life in their

> relationship to commit to each other…for the next period of time. I think they're struggling because the lack of sex has turned into a bitter, angry distance between themselves. I think, as they've started to talk about it in couples' therapy, something has changed actually and looks more hopeful between them. ***Interviewee 34: Male, Under 60, Heterosexual***

Lack of sex was seemingly common in lesbian and heterosexual relationships too. A relationship therapist shared some of her clinical reflections.

> I have had quite a lot of lesbian couples who were not having any sex… It's quite hard to conceptualise around that without going to standard ideas about couples with no sex life… Why do couples not have sex? How does one think about that? Are they just pissed off with each other and therefore they're people who need to feel emotionally engaged to have sex?... I've got a heterosexual couple at the moment and the man is not interested in sex and I think he is a lot angrier than she is. Not having sex is one way of withholding something. ***Interviewee 36: Female, 60+, Heterosexual***

While most interviewees thought that LGB and non-LGB relationships were similar, those therapists with extensive experience of working with LGB couples observed that issues around merger and fusion were a fairly common feature in lesbian relationships.

> One of the things that, clinically, is often a presentation is about how merged lesbians are… Particularly in couple work, what you find is that they have a problem with intimacy. They present as very merged but actually the problem is about making a connection. ***Interviewee 21: Female, Under 60, Lesbian***

In contrast to lesbian relationships, therapists with specialist experience of working with gay men reported that non-monogamous relationships were comparatively more common among this cohort.

> The [gay] male patients I have might be in a stable relationship but there is often also a lot of other sexual activity that takes place outside of the relationship, sometimes with the knowledge of the stable partner and sometimes without the knowledge of the stable partner… It's even manifest at the level of the use made of particular apps for just having sexual encounters. I'm not saying this with a judgemental aspect. It's just what I hear from the couch. ***Interviewee 02: Female, Under 60, Heterosexual***

One interviewee questioned what he perceived to be the widespread prejudice within psychodynamic psychotherapy of viewing monogamous, long-term partnerships as the healthiest type of relationship structure.

> If somebody is in a long-term, committed relationship…whatever 'committed' means…then they must have OK object relations and they're 'good gays'… If you are polyamorous, promiscuous, experimental and all the rest of it, you cannot be a 'good gay', you've got to be a 'bad gay'… There's also something about [relationship] longevity that makes you a 'good gay' or 'good lesbian'... Why? ***Interviewee 03: Male, 60+, Heterosexual***

A handful of therapists discussed the role of parenting in LGB relationships. These interviewees noted how LGB families had become more accepted over time.

> One of the things that I think has changed is that there is much more a sense that gay men [now] feel they can form a family unit. I followed a number of patients through the process of adopting a child. That's something that feels different. I suspect that reflects changing cultural expectations of what is possible [compared to 30 years ago]. ***Interviewee 02: Female, Under 60, Heterosexual***

Lesbian couples were perceived as being successful at combining family life with their long-term relationships with partners.

> I would say [lesbian clients] are much more focused on their relationships and on integrating their relationships with family life and on creating a family. I think that with lesbians, there's a much more positive story there about the progress that's been made in terms of building and creating families. ***Interviewee 17: Male, Under 60, Gay***

5.6 Theme 5. 'Younger People…Aren't Just in Some Heteronormative Strait Jacket': Bisexuality, Sexual Fluidity and Monosexuality

Almost three-quarters of interviewees discussed bisexuality and their bisexual clients. While relatively relaxed when discussing lesbianism and gay male sexuality, interviewees were considerably less comfortable when it came to bisexuality. One clinician described bisexuality as 'the final frontier in many ways' (***Interviewee 03: Male, 60+, Heterosexual)*** and as one of the more difficult client groups to understand.

Several interviewees remarked that there was a lack of contemporary theoretical and clinical thinking about bisexuality. To some, bisexuality had not been as fully conceptualised as gay male sexuality and lesbianism. This meant that bisexual clients were more likely to be misunderstood on some level.

> I think the group who really suffer and are really quite poorly understood is the bisexual group… Bisexuality is perhaps even more pathologised than same-gendered desire… I think it is…poorly theorised… I know in the past when I searched for papers on

> bisexuality, there were less…they were noticeable by their absence. ***Interviewee 21: Female, Under 60, Lesbian***

This perceived theoretical neglect of bisexuality has apparently been redressed in recent years.

> Bisexuality seemed almost invisible back in the 80s and 90s in theory but it's much more in the forefront [now] of what's being written about within psychology. ***Interviewee 20: Female, 60+, Heterosexual***

When interviewees did discuss bisexuality, it was usually in relation to the Freudian idea of a psychic bisexuality.

> I think the idea of [Freud's] constitutional bisexuality makes sense to me, that one can find in somebody who's fairly single-mindedly heterosexual elements of homosexual interest and…vice versa in people who are homosexual, there will be elements of heterosexuality. ***Interviewee 16: Female, 60+, Heterosexual***

Not all interviewees were convinced by Freud's ideas about bisexuality. Some therapists noted Freud's ambivalence in relation to his own sexual orientation and his difficulty in maintaining intimate relationships with other men, for example Wilhelm Fliess.

> Something I was thinking about was…Freud's insistence on bisexuality... It's a funny thing in his theory because it's there from the beginning to the end but in a way it's never fully integrated. I think...it's something that he arrived at in the context of his relationship with Fliess, which obviously had a very difficult end, so it's half in, half out... Maybe it's something that would have been developed a bit more…if it hadn't been so associated with that relationship and its fate. ***Interviewee 11: Female, Under 60, Heterosexual***

A handful of Jungian-trained interviewees alluded to Jung's idea of contrasexuality for conceptualising bisexuality.

> I don't think Jung wrote specifically about homosexuality or bisexuality, but he emphasised that everybody has both the male and female aspect to themselves. ***Interviewee 06: Male; 60+; Sexual Orientation not specified***

However, not all Jungian therapists accepted the concept of contrasexuality with one interviewee acknowledging its gender normative assumptions: 'Is the Anima of a gay man necessarily a female figure?' ***Interviewee 03: Male, 60+, Heterosexual***

A not uncommon view amongst interviewees was that bisexuals were promiscuous. On account of having more than one gender preference, bisexuals were believed to have sex indiscriminately,

flitting between male and female partners. In the following therapist's account, (male) bisexuals are presented as oversexualised, deceptive and unreliable.

> There is a lot of deception in bisexuality and you're always on the lookout for it, trying to find it, trying to interpret it because that's the problem – the deception. The bisexual men with women and then going with men…they're deceiving the women...or the woman… It's a bit more of an attack on the other person… It's all going on at the same time and somebody is being deceived… They [bisexuals] are less reliable in terms of actually trusting or being trusted. ***Interviewee 05: Female, 60+, Heterosexual***

Some interviewees implied that bisexuality represented an avoidance of being gay or lesbian.

> I think…with bisexual people, there's something about…the uncomfortableness of…fully identifying as lesbian or gay and keeping within this comfort zone of a bisexual identity because of something that's too difficult about who one becomes if one fully owns a lesbian or gay identity. ***Interviewee 17: Male, Under 60, Gay***

One interviewee suggested that bisexuality could represent a denial of boundaries and that with some bisexual clients, there was an omnipotent quality to their behaviour. Bisexuals wanted to enjoy the best of both worlds.

> In some of them, I would say that the bisexuality has to do with the difficulty in reconciling themselves to a limit situation in any sense… It is as if there's a wish to be everywhere with everyone all the time and not ever the one looking in on something, being excluded, having to bear loss and difference. That's a quality that comes to mind. ***Interviewee 02: Female, Under 60, Heterosexual***

As most therapists in my sample identified with an exclusively monosexual orientation, they perhaps viewed bisexuality as something quite alien or potentially threatening.

> I think bisexuality is a difficult idea for many people… If you identify as 'I am heterosexual' or 'I am homosexual'…then maybe it's not comfortable to think 'I probably do have a bisexual potential, perhaps everybody does, to some degree or another.' It's not ego-syntonic. ***Interviewee 11: Female, Under 60, Heterosexual***

One clinician implied that bisexuality was often a phase that many individuals experienced but eventually outgrew, gradually moving towards a more heterosexual disposition.

> In my experience of bisexual people, carrying bisexuality fully and, if you like, completely into a more advanced adulthood, is fairly rare. In my experience there are two different groups. There certainly are people who have a bisexual preference or ability…and others who in my clinical experience…have over a period of time moved from something more

> homosexual/lesbian in outlook to something more heterosexual. ***Interviewee 18: Male, 60+, Heterosexual***

A handful of interviewees worked within a less monosexual conception of sexuality, accepting there was potential for variability and diversity in one's sexual object choices.

> It's interesting to me why it is that some people are, it seems, a 100% gay more or less and have never felt any heterosexual attraction. Some people are the opposite. Some people it is clearly both. Quite a number of my patients who were in, say, their 40s or 50s, have had a long period in their life where they've been in straight relationships and then have been in gay relationships more recently. ***Interviewee 26: Female, 60+, Heterosexual***

Some interviewees accepted a level of sexual fluidity amongst their clients. These interviewees perceived sexual identity, desire and behaviour as fluctuating over time. Individuals could be more or less attracted to different genders at different times and engage in different sexual practices with greater or lesser frequency and intensity at different stages in their lives.

> It's not as straightforward as you're either straight, lesbian, gay...actually, in a deeper exploration unconsciously of patients' material you find out that there are many cross-gender phantasies and desires… It seems that in mid-life, many women discover or allow themselves to know about their own same-sex desires in a way that perhaps previously they haven't… On the other hand, it seems like a lot of younger people now feel free to explore their sexuality and aren't just in some heteronormative strait jacket. ***Interviewee 21: Female, Under 60, Lesbian***

Sexual fluidity was frequently observed amongst heterosexual male clients too. One interviewee discussed how some of his ostensibly heterosexual male clients occasionally experienced and reported same-gender sexual phantasies.

> I've worked with male patients, who are heterosexual in terms of their life choices…or it is certainly the dominant orientation…but they have a lot of same-sex phantasies and dreams. Actually, I love this kind of work because it has a very strong impact on the male clients. They are very resistant at the beginning to talk about this aspect of their psyche… But they find it helpful in the end, transforming their notion of being a man. ***Interviewee 15: Male, Under 60, Gay***

5.7 Theme 6. 'Transgender Is the Next Big Thing We Have to Really Face Psychoanalytically': The Trials and Tribulations of Transgender

Transgender was an unanticipated topic of discussion. Although transgender was not the focus of my research, it was notable that over half of the interviewees brought up the subject unprompted, usually to express relief that it had not been the main area of investigation.

> I'm glad we are talking about homosexuality and not transgender. Transgender is the next big thing we have to really face psychoanalytically. ***Interviewee 04: Female, 60+, Heterosexual***

Most interviewees expressed a genuine sense of discomfort or anxiety about how to conceptualise and think about transgender.

> I've supervised people who've worked with transgender patients and struggled with it in my own mind, struggled with it conceptually, theoretically, emotionally... How do I get my head around [this]? ***Interviewee 34: Male, Under 60, Heterosexual***

Interviewees realised that current psychodynamic models for thinking about transgender were not sufficient for preparing practitioners for clinical work with this client group.

> It's a tricky area for me actually… I do feel that…some of the work that we do [with trans and non-binary] doesn't fit some of the models that we are being taught... I think that there are a lot more things to think about...things like pronouns…transitioning… What does it mean about the body?... It heralds these new debates. ***Interviewee 23: Other Gender, Under 60, Queer***

Some interviewees worried whether transgender was 'the new homosexuality' and if the current perceived failure of psychodynamic theory to adequately theorise transgender was a case of history repeating itself.

> We might be doing the equivalent of what happened in relation to homosexuality now in relation to transgender. Would we, 20 or 30 years down the road, be looking back at this debate and having the same sorts of feelings that we had got it wrong? ***Interviewee 04: Female, 60+, Heterosexual***

Echoing how psychotherapists had historically pathologised same-sex sexual orientation, a few interviewees described transgender as being caused by early developmental trauma.

> Every single time I hear of someone who wants to change gender, some completely unprocessed personal family thing has gone on and has not been addressed. ***Interviewee 04: Female, 60+, Heterosexual***

One interviewee criticised how psychodynamic theorising about transgender had become reductive, with some colleagues simply referring to trans people as 'born in the wrong body'. This

was considered a particularly simplistic way of describing the often painful disparity trans people experience between their psychological, gendered self and their biological, physical bodies.

> I think many analytic colleagues would say: 'Oh well, someone's been born in the wrong body' but that's not thinking about what it means and what's going on and what are the psychological aspects to transgender… Somehow not thinking about transgender other than it's 'someone who's been born in the wrong body'…feels like a bit of a shortcut…and closes down discussion. ***Interviewee 20: Female, 60+, Heterosexual***

> We are often stuck in our theorising around gender and sexuality, between the body and the mind split. I don't think we do have a theory that joins those two up yet… You are always talking either the language of the body or the language of the mind. As soon as you try to put the two together, there isn't an easy way of doing it. ***Interviewee 27: Female, 60+, Lesbian***

Some psychotherapists' accounts seemed to imply that being transgender was an omnipotent state of mind and a denial of bodily reality.

> Now I'm seeing…men who are saying to me: 'I want breasts, but I also want to keep my penis.' I'm not sure I yet understand what that's really about except that it does seem to be linked to other aspects of their functioning, to quite an omnipotent state of mind where they are saying to me: 'I want it all. I'll design it myself. I'm not going to renounce anything'. ***Interviewee 02: Female, Under 60, Heterosexual***

A handful of clinicians suggested that some of their clients might identify as transgender in order to defend against acknowledging their same-sex desires.

> I think there is this interesting issue around people wondering if they are transgender as opposed to lesbian or gay and not really being able to find the space to explore that sufficiently so that they can make a confident choice either way. I think…some young people…defensively end up bracketing themselves in a transgender identity because of not really being able to deal with the fear and the shame about the possibility of gay relationships and who they would then have to be in those relationships. ***Interviewee 17: Male, Under 60, Gay***

As a consequence of the main UK psychotherapy organisations signing up to a Memorandum of Understanding (MoU) condemning therapeutic attempts to change a person's gender identity (as well as sexual orientation), some interviewees felt their roles as therapists were being curtailed and that they were no longer able to explore with transgender clients the unconscious conflicts or personal difficulties these clients might have in relation to their gender identity.

> The reason I'm concerned about [the MoU] is…I think it's got caught up in some massive politicisation of something. I think the capacity to think about transgender without being branded as phobic is very difficult. ***Interviewee 08: Male, 60+, Heterosexual***

One queer-identified interviewee recognised that work with non-binary and transgender clients had enhanced her overall clinical approach, helping her face her own prejudices and assumptions about different client groups.

> On the clinical side, I think I'm very fortunate to work with all my clients but the trans and non-binary people that I've worked with…have made me realise just how much I don't know and how humble I have to be in my profession in order not to assume and not take things for granted. ***Interviewee 23: Other Gender, Under 60, Queer***

Another therapist openly and honestly described his difficulties in thinking about and working with transgender clients. Increased exposure to clinical work in this area, via supervision, helped this therapist work with his negative countertransference reactions and to become less defensive in relation to trans people seeking therapy.

> One of my colleagues has a patient who is transitioning from female-to-male, going through the most painful and disturbing physical changes and there's always a risk of suicide. When I first heard about this, I noticed…my resistances…defences…and prejudices. It took me a while before I could…hear descriptions of this person as a full, suffering individual… If I had had a transgender patient before I had allowed myself to understand more about this person, I don't think the kind of [analytic] relationship I would have given to a transgender patient would have been good enough for them. ***Interviewee 07: Male, 60+, Heterosexual***

5.8 Theme 7. 'The Painfulness of Difference that We All Experience': Coming Out as LGB and Feeling Different in a Heteronormative World

Many psychotherapists addressed the conflicts and challenges LGB clients faced growing up in a heteronormative world. A frequent observation was that LGB clients were generally connected by a shared experience of stigma and discrimination.

> The uniting experiences are the ones…about discrimination…about common experiences of depression or isolation or feeling outside something... I think the oppression is what we [LGB people] all have in common. ***Interviewee 27: Female, 60+, Lesbian***

Comparing LGB and non-LGB experiences, several interviewees acknowledged that being LGB was a more difficult life path. On the whole, therapists did not dismiss the impact of prejudice on the lives and mental health of LGB clients.

> Where there's a history of significant and ongoing oppression and discrimination, inevitably [this] has a psychological impact… There is a history that needs to be grappled with in some way and that the [LGB] individual needs to explore in order to achieve a sufficient stability and peace of mind… I think that there is a particular psychological need, which a heterosexual person wouldn't experience in quite the same way. ***Interviewee 09: Male, 60+, Gay***

Interviewees often observed that many LGB clients had internalised negative social attitudes and reactions toward same-sex sexual orientation. As one interviewee describes:

> My own thinking is around…issues to do with stigma and theories about how social stigma can become internalised and taken up as part of one's identity at a level beyond conscious awareness which then functions through an internalised sense of shame about the basis of one's identity… It's actually formed throughout the life cycle… At every stage of life, homophobia will have an impact. ***Interviewee 17: Male, Under 60, Gay***

LGB clients often perceived themselves as abnormal or deviant and expressed their internalised homophobia explicitly in therapy. As one therapist explains:

> I'm seeing three men and two women, who are gay and who, consciously, are absolutely adjusted to being gay… Equally, they aren't really in any doubt that [to them] it's a horrible flaw. There will be things that will come up, usually to do with…making a long-term commitment, maybe getting married after having been living with the same partner for a long time or something. Suddenly they'll start saying things like: 'I know it's disgusting' or 'I know it's not normal' or 'You probably think it's disgusting or something' and so on. ***Interviewee 26: Female; 60+; Heterosexual***

Working with guilt and shame was considered a regular feature of clinical practice with LGB clients.

> I attempt to work with their feelings of guilt and negativity and shame about themselves… Guilt and shame are…never constructive affects in one's psyche… Part of the analytic work is to observe it, identify it and attempt to dissect its roots. ***Interviewee 06: Male, 60+, Sexual Orientation not specified***

In therapy, LGB clients often discussed the painful experience of 'coming out'.

> I don't think I've worked with a single lesbian or gay man or transgender person who hasn't talked to me about 'coming out' or not 'coming out'. You still see people in their twenties and thirties who haven't 'come out' or have 'come out' partially. Their social life is completely open, but they don't tell their parents… The pressure on a gay man, for example, if he can't tell his parents…is horrendously painful…it is not fun. ***Interviewee 03: Male, 60+, Heterosexual***

One interviewee described how 'coming out' was not a one-off experience. LGB individuals often 'come out' in different settings and at different times throughout their lives.

> The point at which…someone who is LGB 'comes out' becomes the crucial point of encountering that risk of homophobia… Once you've taken that step, it's a bit of Rubicon that you've crossed and although you can be grades of being more 'out' and less 'out' in different contexts, you don't actually yourself have total control over that yourself… Once you're 'out', you are subject…to whatever the wider culture you encounter makes of that. ***Interviewee 17: Male, Under 60, Gay***

In order to mitigate against the homophobia LGB clients sometimes expected and feared from therapy, several interviewees described the need to foster an open, sensitive and non-judgemental therapeutic stance.

> I…aim to…offer…a positive, welcoming space for thinking about sexual orientation… I think not necessarily gay affirmative in the full sense of that term, in the way that I would understand it to be used in, say, more humanistic circles... I think my position is that I'm holding an interested, open space whereby the patient is at liberty to develop their own way of thinking and talking about themselves. ***Interviewee 09: Male, 60+, Gay***

Some therapists offered wider reflections about working with difference and diversity.

> Psychoanalysis is…about negotiating difference all the time: the difference between myself and the patient, the difference between their perception of me and the reality of me, and the painfulness of difference that we all experience… I suppose I somewhere feel those are issues that I'm working with all the time, in all their different manifestations and painfulness. ***Interviewee 12: Female, Under 60, Heterosexual***

Intersectional issues were at the forefront of a minority of psychotherapists' accounts.

> Sexual orientation…crosses over into the race area… All these white liberal therapists! Most of them can't understand…especially if you're working with black people…that they are implicated in the situation whatever their views are… There is white guilt and there's straight guilt… I think the two general cultural problematics should relate more: sexual orientation…and racial ethnic issues… Then, you could, of course, add in socioeconomic

> and you could add in feminism, gender stuff and you've got the whole bag. ***Interviewee 03: Male, 60+, Heterosexual***

One interviewee, who trained in the 1970s, was particularly vocal about how psychoanalysis had been and remains unwilling to consider issues of diversity and inclusion.

> I found that psychoanalysis has been very intransigent over the issues of diversity, not just sexuality but race, disability, all sorts of other differences… They [people from diverse groups] are not going to bite you… They've got the same level of knowledge and ability that everybody else has. Black people, gay people and people with disabilities…it's not different. The difference is in how people are perceived; it's not how they are. ***Interviewee 22: Male, 60+, Heterosexual***

Coming from an intersectional perspective, another interviewee acknowledged that therapists had to stay alert to the ways in which they consciously and unconsciously 'othered' people.

> I think that the dynamics that pertain to, say, minority group members of a different race or culture are the same dynamics that are invoked in relation to people of a different sexual orientation… You think of yourself as an ordinary person, 'a human being', in brackets, like everyone else... Then, you walk out your front door and you are confronted by a social reality that 'others' you... Consciously, most of us think that we are reasonable people, that we are tolerant people, that we wouldn't be prejudiced against another person. What I've come to find is that, unconsciously, there's a different story, a different narrative that's also part of our makeup. ***Interviewee 14: Male, 60+, Heterosexual***

5.9 Theme 8. 'Am I Going to Reveal Myself or Something?': The Complexity of the Transference and Countertransference Relationship with LGB Clients

Three-quarters of interviewees talked extensively about the role of transference and countertransference in their therapeutic work with LGB clients. Given the range and variability of transference and countertransference reactions described by interviewees, it is only possible to provide a sample here.

Many heterosexual therapists reported using their countertransference reactions to identify any prejudices or blocks they had when working with LGB clients.

> As an analyst, what you have to recognise is when you come up against something that's a little bit uncomfortable [in the work with LGB clients] … if you're willing to acknowledge that…you can put it to one side and say to yourself there is something that…requires a bit of attention. ***Interviewee 14: Male, 60+, Heterosexual***

One of the challenges therapists mentioned was around the lack of theoretical and clinical writing on transference and countertransference issues in psychotherapy with LGB clients.

> I was thinking more technically, clinically…about...what happens in the transference between a heterosexual analyst and a homosexual patient. I think…what I haven't yet seen articulated…are clinical descriptions of how that plays out... I would really welcome someone who does a lot of work in this domain to be able to write about that. ***Interviewee 02: Female, Under 60, Heterosexual***

Many female therapists reported experiencing negative maternal transferences with some gay male clients where they, the therapists, were perceived as reproachful mother figures.

> My gay male client was very ashamed of his use of gay pornography and very anxious of my condemnation of it… It was in that domain that his anxiety about his analyst being out to change his sexuality was expressed most powerfully. I was this forbidding figure who told him to 'Stop it!' and his elaboration of that was: 'Stop it and find yourself a woman!' ***Interviewee 04: Female, 60+, Heterosexual***

Another heterosexual female therapist experienced positive maternal transferences with some of her gay male clients. This therapist felt herself to be offering the empathy and acceptance her clients might not have received from their mothers or caregivers growing up.

> One thing that often comes across is trying to have a better experience of being parented… A number of gay patients I've had have struck me as still needing a more sympathetic, understanding ear from someone with whom they have a dependent relationship and who they want to be accepted by. ***Interviewee 26: Female, 60+, Heterosexual***

One heterosexual male therapist talked about the sexual excitement he experienced in the countertransference when working with lesbian clients.

> I think male analysts like me might have…many more problems dealing with lesbian women… I think, in the countertransference, we want to be there…too much curiosity… There's too much sexual excitement around it. It's a particular configuration that some men may be susceptible to. ***Interviewee 28: Male, 60+, Heterosexual***

Another heterosexual male therapist shared a very honest account of his own conflicts around intimacy when working in the erotic transference with gay male clients.

> I've had to work with…my defences against intimacy with gay men … to engage erotically with them and to feel curious, aroused… When I first worked with gay men…I kept their sexuality at a distance and treated it as an object for scrutiny. I didn't really let myself

> relate to it as intimately as I thought I was… I think this climate of greater fluidity…has given me permission to be more fluid within myself and…helped me learn something about being less defensive in relation to men actually. ***Interviewee 34: Male, Under 60, Heterosexual***

Some therapists described their reticence in picking up and working with some elements of the erotic transference with LGB clients.

> Sometimes with a patient…I don't get any sense of their sexuality or where it is and then I think: 'Maybe they're gay.' Maybe it's just that it's not heterosexual… There's none of it coming in my direction... I think that, probably, if I were seeing a woman patient who was heterosexual, I might be slower or more careful to take up homosexual feelings towards me because they go across the person's consciously recognised sexual orientation. I think I would definitely feel the same with a male homosexual patient... I'd be slower to take up heterosexual feelings. ***Interviewee 16: Female, 60+, Heterosexual***

Drawing on Laplanche and Stein, one therapist described learning to use her countertransference to make sense of the unverbalised and sometimes enigmatic aspects of a client's sexuality

> Erotic desire and erotic countertransference are very unsettling issues for clinicians… I was helped in supervision not to feel frightened of it but … to maintain thinking and also to understand that in some cases…something very early in development…was being communicated to me unconsciously. My 'not knowing' what to do about it…and certainly my fear and also revulsion helped me to understand the patient's experience with a mother who had felt repulsed by sexuality generally. It was something that the patient couldn't have actually told me about. I was dependent on my countertransference…to help me to understand it really. ***Interviewee 21: Female, Under 60; LGB***

Some therapists discussed the difficulties of developing one's erotic imagination in the transference with LGB clients.

> As a heterosexual woman, sometimes when you're working with a gay or lesbian couple about their sexuality and what they do in the bedroom, it's a bit like: 'Ooooh'… There's something about you reaching for your imaginative capacity to help you have a sense of the terrain you're in... With sexuality, you sometimes reach the limits of understanding, I find I really can't make sense of what it is that is so exciting about this particular thing. It does have that mysterious quality. ***Interviewee 36: Female, 60+, Heterosexual***

One therapist described her struggles in knowing how to help some of her gay male clients who described to her in graphic detail specific sexual practices and behaviours.

> I am very aware of feeling quite inadequate in that I think if the [graphic sexual] descriptions are intended to be shocking and alienating, they do somewhat have that effect on me… It's numbing. I find it quite hard to think about it. I find it easier to think about it on the level of: 'Why is this person using their session like this? What are they actually trying to do to me?' It's as if you're getting fucked basically in the session. They're being so crude often in the way sex is talked about and…so relentless and so determined…to tell me every last detail about it. It feels like a rather abusive situation where I'm a captive audience for them to discharge probably a mixture of fantasies and memories into. ***Interviewee 26: Female, 60+, Heterosexual***

Another therapist also discussed how some LGB clients sexualised the therapeutic relationship as way to ward off anxieties against intimacy and closeness and to defend against feelings of guilt and depression.

> People sometimes tell you their sexual fantasies in the first session. It's right up front and there. To some extent, actually, what one is trying to do is to get behind this flurry of sexuality to what lies behind it. To some extent one's trying to de-sexualise things… There's this paradoxical thing where you're both very used to dealing with upfront sexuality but most of my interpretations are in the direction of de-sexualising things, thinking about what underlies sexuality. ***Interviewee 16: Female, 60+, Heterosexual***

LGB therapists reported having to work through homophobic transferences with some of their heterosexual clients. As one therapist reflects:

> I had one straight man who had some issues with his sexuality who…was anxious about whether I was straight or not. He couldn't figure it out. He had all kinds of phantasies around it all, imagined all kinds of things… Sometimes, I thought he took on a hypermasculine position and said some attacking, homophobic things. Sometimes it felt quite personal… I would feel quite uncomfortable, maybe start to feel self-conscious… Am I going to reveal myself or something? ***Interviewee 29: Male, Under 60, Gay***

The same gay male therapist discussed the unique transference difficulty he encountered after seeing one of his gay male clients at a gay-friendly venue.

> The 'gay scene' can be quite small and when I was younger, I would go out and every now and then a patient would be there. That was an issue… With one gay client [when this happened], he brought it up in therapy and it was a little bit complicated because he had some transference love feelings so…this [chance meeting] amplified it because suddenly I'm now available [in the client's mind] but he did see that I was with somebody. It both excited but also disappointed him. We spoke about it and it was fruitful material for analysis. ***Interviewee 29: Male, Under 60, Gay***

One therapist alluded to the concept of 'pre-transference', the idea that our prejudices and stereotypes about certain groups of people have already been formed long before we even work with these groups therapeutically. The pre-transference had the potential to undermine and bias the therapeutic relationship.

> Long before you meet your patient, you have a relationship with them, and you think you know them. This is the pre-transference... The pre-transference assumption might be that all lesbians are dykes and they are butch, so when you get to your consulting room, there's a mindset: dyke = butch... She [the client] might be very feminine, a very relaxed and feminine woman who happens to be lesbian… You get thrown. You either take the new data…or you go back to your old data and keep trying to say: 'Well, this is a bad example. This is not typical. I'll dismiss this real experience and I'll stick to the stereotype that I have in my head'. ***Interviewee 22: Male, 60+, Heterosexual***

5.10 Theme 9: 'It's Like Showing the Fly the Way Out of the Fly Bottle': Anti-LGB Prejudice Within Psychodynamic Training Organisations

All 36 interviewees shared their perspectives on organisational attitudes towards LGB colleagues and trainees. There was general consensus that the profession had, until fairly recently, been guilty of discriminatory and homophobic recruitment and selection practices. The following extract concretely illustrates this.

> When I did my senior membership, I was having a conversation with the guy who's doing the interview... He took out of his desk a sheet, which included a set of criteria for the selection of candidates. On that…out-of-date sheet…was heterosexuality… This was around 2005… It's now sketchy in my mind but it all had a pretty clear narrative really, about systematic exclusion of people on the basis of their sexuality. ***Interviewee 34: Male, Under 60, Heterosexual***

Several interviewees were concerned that LGB candidates applying for training or job positions were more likely than their non-LGB counterparts to be subjected to additional or inappropriate questioning, especially in relation to their sex lives and sexual practices.

> I'm thinking of a colleague a few years ago, a gay man, talking about and remembering his interview for selection and feeling that the reference to his sexuality led to supplementary questions [about his sex life] which you would imagine someone identifying as heterosexual wouldn't have been asked. ***Interviewee 09: Male, 60+, Gay***

Many LGB candidates remained closeted after they had been accepted for training and/or had circumvented the interview screening process.

> I think…when I trained in the 1970s…you kept it completely secret. There were single people, who you wondered about, but there was no open homosexuality amongst people in the organisation. It wasn't open at all. ***Interviewee 30: Male, 60+, Heterosexual***

Some training organisations historically operated 'don't ask, don't tell' policies, where LGB individuals were allowed to train as long as their sexual orientation was not widely disclosed and/or they behaved in such a way that others assumed they were part of the 'normative' group.

> Those [LGB individuals] who were admitted to institutes had to be very quiet about it... That's also part of the story. You had to basically 'pass', not draw attention to your difference. ***Interviewee 14: Male, 60+, Heterosexual***

Many training organisations have now introduced equal opportunities statements opposing discrimination of LGB trainees. For the majority, however, LGB affirmative policies had not been rolled out quickly enough. As one interviewee strongly put it:

> We've been so slow in Britain. In America, they've got a different history as far as I'm aware. They had people really pushing in that community, presumably with some support to fucking well change it [institutional policy] and it got changed. We haven't had that over here. We've just not been self-reflective about it really and ignoring it, putting our heads in the sand. ***Interviewee 33: Female, 60+, Heterosexual***

A handful of interviewees could not assess whether colleagues had really changed their views on same-sex sexual orientation or were just 'toeing the line'.

> I'm not sure actually how more advanced we are… I do think some changes have taken place, but I don't actually know how many people have really changed their position on these matters. However, I think there are signs that the times are changing but it's less clear whether they're changing fast enough and whether the change is at a deep enough level. ***Interviewee 02: Female, Under 60, Heterosexual***

Some interviewees acknowledged their own shame and guilt in relation to how they and other colleagues had treated and regarded LGB individuals in the past.

> I think…as the world around me changed…my views changed very substantially… I felt, as a citizen of the psychoanalytic community, terribly ashamed of the way we treated gay people. ***Interviewee 08: Male, 60+, Heterosexual***

One interviewee felt strongly that the UK psychodynamic psychotherapy profession owed the LGB community a public apology for the legacy of suffering caused by past discrimination against LGB individuals seeking treatment or wishing to train as psychoanalysts.

> What I wanted was a public apology on behalf of the psychoanalytic institutions to the LGBT community. I still feel that is needed or there needs to be something that is given a lot of publicity around a formal public apology. ***Interviewee 17: Male, Under 60, Gay***

According to some accounts, a generational divide existed in relation to psychotherapists' attitudes towards LGB colleagues and trainees.

> I think that the people who still have doubts about training gay colleagues… It's probably a very small number but a few percent at the most. I think that they are among the oldest members of my training organisation probably. I'd be really surprised if there's anyone under 70 who thought that LGB people shouldn't train. ***Interviewee 26: Female, 60+, Heterosexual***

One interviewee reported that her training organisation wanted to diversify and accommodate people from sexual minority backgrounds but did not know how to address the issue.

> Many people are caught between being aware that, in the wider world, ways of thinking have moved on and that you can't get away with the kind of prejudices that you might have been able to get away with in the 1970s. On the other hand, many of their thinking tools are just so steeped in those kind of prejudices… Do you know that saying of Wittgenstein about philosophy? He says: 'It's like showing the fly the way out the fly bottle.' It feels like that's what is needed. Same-sex desire just gets people so confused, like a fly buzzing around a fly bottle. They haven't got the tools they need to get out. ***Interviewee 11: Female, Under 60, Heterosexual***

One way to show the fly out of the fly bottle is to promote LGB staff members to senior positions. LGB individuals would then be directly involved in decision-making processes on candidate selection or course content.

> At least [two senior staff members] at my training organisation have been gay or lesbian and I think those things are important. It means that there are people there who say: 'Well, why don't we include so and so?'… When there are questions about the curriculum or interviews for new trainees…there's someone who has an interest in these things and raises them. ***Interviewee 24: Female, 60+, Lesbian***

Another solution is to include more openly LGB colleagues on the teaching programme, individuals who could authentically reflect LGB experience.

> There has to be more senior people who are also identified with the different sexual orientations. I think if you are just taught exclusively by people who are heterosexual, I'm not sure what that says. It's a bit like having the token black person and saying: 'We don't discriminate.' I think the change has to be at a much deeper, systemic level, where there

> is openness about sexual orientation amongst candidates. ***Interviewee 02: Female, Under 60, Heterosexual***

The supervisory relationship is another possible site for improving professional relationships between LGB and non-LGB colleagues. One male heterosexual interviewee reported a successful and mutually beneficial supervision with a lesbian colleague.

> I have one supervisee who is lesbian… She started to hear very heteronormative descriptions of the family, the couple, 'the healthy path' if you like. She felt very alienated by it and we had a couple of conversations in supervision in which she was talking through this experience and working out how to respond to it… She did end up having fruitful conversations and setting up dialogues at her organisation… It was a good experience in the end for both of us. ***Interviewee 34: Male, Under 60, Heterosexual***

One interviewee reported that her training organisation had made very committed attempts to become more LGB-inclusive and had pursued a rigorous accreditation process to be certified as an inclusive and 'LGB-friendly' place to work.

> It would be completely complacent to say that my training organisation has sorted this whole thing…but we did lots of work with an accreditation organisation…looking at our website, looking at our policies. We got a silver accreditation award. We were chuffed with that... Whether that's just a sticking plaster...I don't know. What I'm saying is that we did try to deal with those things. We did have some energy behind it. ***Interviewee 36: Female, 60+, Heterosexual***

Some LGB interviewees reported having had positive experiences at their training organisation.

> I've always been out. It's never been my way to hide the fact that I'm a lesbian. It has never, ever been a subject for discussion, to the best of my knowledge, in terms of the organisation's thinking about me… I've never experienced it as a barrier… By the same token, I've never sought to make it something that should be of concern or an issue to the organisation. ***Interviewee 13: Female, Under 60, Lesbian***

Some training organisations empowered their LGB members, offering them career opportunities and valuing their contributions to the organisation. As one interviewee explains:

> I never found any negative comments or preconceptions. If anything, I think my training organisation appreciates diversity. They have encouraged me to teach about this. They are almost eager to get someone to help them update their approach and the way they teach about sexuality. I was quick to be involved in requests for presenting and teaching about sexuality. ***Interviewee 15: Male, Under 60, Gay***

One interviewee reported affectionate social contact between LGB colleagues at his training organisation.

> There's plenty of social openness in terms of contact with colleagues, so men kissing each other, gay colleagues that I'm friendly with. I and others feel comfortable in doing that in the same way we would, I think, in other social settings. I think that's quite an important sign [of progress]. ***Interviewee 09: Male, 60+, Gay***

5.11 Theme 10. 'Psychoanalysis Has Existed in Splendid Isolation': The Diversification and Modernisation of the Sexual Syllabus

All 36 interviewees shared reflections on the content and quality of their psychodynamic education on sexuality. The majority reported having studied a syllabus which presented same-sex sexual orientation as mental illness.

> I think the curriculum that I was taught under…prepared me in a way that was deeply unhelpful because it gave me one perspective, which was the one of pathology. ***Interviewee 02: Female, Under 60, Heterosexual***

Some training organisations, however, now included seminars presenting contemporary theories of sexuality as part of a wider programme on sexual diversity and difference.

> I teach sexuality here with my colleague. I've done quite a lot of work around revising the curriculum, running workshops on sexual diversity and gender nonconformity and trans and so on. ***Interviewee 35: Female, 60+, Lesbian***

A frequent complaint was that same-sex sexual orientation was often not integrated across the training curriculum but treated as a discrete subject.

> When I trained in the late 1990s, early 2000s…there was a [separate] unit about homosexuality… The main change that could be made…is that rather than it being hived off and you spend one six-week block where you have a series of lectures and discussions…it really needs to go through the whole of the training. ***Interviewee 24: Female, 60+, Lesbian***

Several interviewees recognised that insights and data from other disciplines could enrich or, conversely, undermine psychodynamic theories of same-sex desire.

> Psychoanalysis, unfortunately...has existed in splendid isolation…or not so splendid… It's allowed itself to become very insulated from interdisciplinary exchange and it's impoverished itself as a result. ***Interviewee 11: Female, Under 60, Heterosexual***

> I am a great believer in interdisciplinary studies… I think my personal view is that my analytic work has certainly been enriched by interdisciplinary studies. I can't see how psychoanalysis can develop without that cross-fertilisation. ***Interviewee 19: Male, Under 60, Heterosexual***

Some interviewees called for broader engagement and dialogue with disciplines external to traditional psychoanalysis.

> Any discipline that works in isolation and does not engage interdisciplinarity, to me, is dead on its feet because we've got to be able to think across disciplines. We've got to be able to ask questions. We must read widely. We've got to be able to think about our own discipline through other disciplines and learn from those other disciplines. Otherwise, we're taking some kind of doctrinal stance. ***Interviewee 13: Female, Under 60, Lesbian***

Facilitating interdisciplinary exchange is not an easy feat. Interviewees acknowledged it is a challenge to recruit practitioners with specialist knowledge outside psychoanalysis.

> The way learning…is constructed…is in very discrete bundles and working across those bundles is tricky both in terms of how the funding happens, how expertise is gathered and so on. To have people who can straddle more than one area of expertise is not that usual. When people want to grow their academic careers, it's often by narrowing them down rather than broadening them out. ***Interviewee 27: Female, 60+, Lesbian***

Several interviewees referred to queer theory, regarding it as a discipline that could help expose the heteronormative assumptions underpinning psychodynamic theories of sexuality.

> There ought to be a good dialogue between the discipline of queer theory and the discipline of psychoanalysis because it's dealing with [the same] aspects of identity [sexuality and gender] in a non-normative way or in a way that challenges…common-sense understandings of…human subjectivity. ***Interviewee 17: Male, Under 60, Gay***

> Queer theory…gives you a set of theoretical tools to resist naturalisation, questioning the categories that we usually use to organise our thinking… That's what's valuable about it… Anytime you start to want to say that something is 'natural', then alarm bells should be going off. Nature is one of the most important examples of a word that is used descriptively but actually it's prescriptive. ***Interviewee 11: Female, Under 60, Heterosexual***

Many interviewees were familiar with and valued Judith Butler's work.

> I suppose I have been quite influenced by…Judith Butler's work... I particularly like her work, although I find sometimes it's quite confrontational... I enjoy being challenged by

> theories. I suppose what I like about it is that she is a psychoanalytic giant even though she's not a clinician. She can engage with those psychoanalytic theories in a very robust and deep way. ***Interviewee 21: Female, Under 60, Lesbian***

Butler's concept of 'performativity' was particularly valuable.

> I've read a little bit of Judith Butler… The main things I read by her were more to do with social, cultural critique... They made me take her very seriously. Certainly, I think...her interest in performativity…and performativity being part of what life is… I like that idea. ***Interviewee 08: Male, 60+, Heterosexual***

One therapist appreciated the way Butler had re-worked some psychodynamic concepts and ideas to describe the processes of identification and disavowal involved in the construction of one's gender and sexuality.

> I value from Butler the idea of each individual needing to go through a process of mourning, in a sense similar to the dynamics that Freud talked about in *Mourning and Melancholia*, in terms of relinquishing the part of their potential sexuality that they are not going to express. If they don't do that, then what results is a version of the identification with the lost object that Freud talked about originally. ***Interviewee 09: Male, 60+, Gay***

One interviewee felt that queer theory had become too academic. It had become divorced from its activist roots and lost some of its revolutionary power. Queer theory needed to re-engage with the real lives and experiences of queer people if it was going to inform psychodynamic theory.

> When queer theory became much more an academic discipline and subject…I felt that it was losing touch with the realities of lived identities... I think it's only really been in the last two or three years that you are starting to get that dialogue [between psychoanalysis and queer theory] that is grounded in real people, real identities, real situations in the world that people can start to have a conversation around it. ***Interviewee 17: Male, Under 60, Gay***

Not all interviewees, however, embraced queer theory.

> I don't find queer theory particularly useful. In fact, I couldn't give a particularly coherent account of what queer theory is... I'm a dyed-in-the-wool psychoanalyst, so I look for my models in psychoanalysis. ***Interviewee 30: Male, 60+, Heterosexual***

Several interviewees discussed the value of social constructionism in thinking about sexuality

> I think it's always been there…the social constructionist kind of thinking…about how we perceive things in so many different cultures... What it is to be feminine, what it is to be

> male, what it is to be neither one nor the other… In Western heteronormative and patriarchal cultures, we perceive power between the sexes in certain ways… I've learnt a bit about matrilineal societies… There are cultures where…the men look after the kids and the women go into the field and do the work. ***Interviewee 33: Female, 60+, Heterosexual***

For some interviewees, social constructionism opened up new possibilities for thinking about sexuality and sexual orientation. Sexuality could be contextual, cultural and contingent rather than fixed, immutable and essential.

> I had never heard of social constructionism. I had no idea about this debate between that and essentialism. Suddenly it was exciting… Social constructionism definitely affects the brain in some way and suddenly it's a bit like modern art… You see something and you can feel it actually shifting something in your head… We have biological bodies but the meaning of those are socially shaped… It's in the interaction [with culture] where meanings are developed. ***Interviewee 23: Other Gender, Under 60, Queer***

Several interviewees referred to Michel Foucault and his influence on social constructionist thinking. Foucault's work was useful for questioning and denaturalising heteronormative discourses about sexuality.

> I've read people like Foucault and other post-structuralist writers… That was really important for me… I think the value of that whole tradition of thinking, which is derived from the work of the post-structuralists…is the questioning of assumptions. ***Interviewee 11: Female, Under 60, Heterosexual***

Some interviewees found value in biopsychosocial models of sexuality, acknowledging an interaction between genetics and the environment.

> There are probably genetic aspects, but the environment plays a very powerful part in how people develop their ideas about their sexual interests… If we all essentially have the potentiality for either heterosexual or homosexual interests, then is it an interaction between genetic potentiality and the environment? I would have thought it was…just like any other thing about human development. ***Interviewee 36: Female, 60+, Heterosexual***

Several respondents drew on ideas and concepts from literary theory and cultural studies to inform their thinking about sexuality and same-sex desire.

> If we can look at English literature, people such as Eve Kosofsky Sedgwick...these people bring to our attention a way of thinking about bodies and feelings and the psyche in ways that I think need to really be thought through in our models. ***Interviewee 23: Other Gender, 60+, Queer***

> Certainly, from critical theory and cultural studies, a lot of ideas came up which psychoanalysis didn't go anywhere near… I'm thinking of the names usually associated with critical theory: David Halperin, Neil Bartlett, Kaja Silverman… They use symbolic products…to explore phenomenologically the experience of desire. ***Interviewee 15: Male, Under 60, Gay***

A few interviewees advocated a more prominent role for social science research, especially qualitative research, for informing and updating psychodynamic theories of sexuality.

> Most of my ongoing thinking would be from the world of academia and not the scientific end of academia…more the social sciences, the social psychologists, the feminist psychologists…generally not the positivist, biological views around sexuality…much more coming from research…informed by qualitative interviews. ***Interviewee 20: Female, 60+, Heterosexual***

Not all interviewees embraced interdisciplinary dialogue, with some suggesting that scientific paradigms in particular diluted psychodynamic thinking and practice. Psychodynamic psychotherapy had its own unique methods for conceptualising sexuality, which needed to be preserved.

> There's a kind of purity about psychoanalysis in terms of its method. I'm strongly in favour of this very specific psychoanalytic method, which if it's mucked around with too much, it ceases to be what it is… I don't feel strongly that neuroanatomical or brain studies, for example, contribute hugely to psychoanalysis. ***Interviewee 07: Male, 60+, Heterosexual***

5.12 Summary

This chapter has reported the ten themes identified from a Framework Analysis of 36 interviews undertaken with psychodynamic therapists. The first two themes covered interviewees' perspectives on Freudian and Oedipal theories of same-sex sexual orientation. In themes three and four, interviewees discussed clinical issues relating to LGB clients' sex lives and relationships. Interviewees shared their reflections on therapeutic work with bisexual and transgender clients in themes five and six respectively. While theme seven focused on the difficulties LGB people face living in a heteronormative world, theme eight explored therapists' experiences of working in the transference and countertransference with LGB clients. The final two themes addressed organisational culture and training issues within the psychodynamic profession respectively. In the next chapter, these ten themes are integrated with the questionnaire data from chapter four (see above). This synthesis of data will be used to provide answers to the study's research questions.

6 Discussion Chapter

This chapter begins with a reflection on the research participants before reviewing the strengths and limitations of the research methodology and methods. I then highlight 16 main findings from the research. In order to assess where these findings fit within the wider field, I briefly compare and contrast them with the theoretical, clinical and interdisciplinary literature examined earlier in the thesis. Where possible, I aim to avoid repeating results in depth as these are set out in detail in chapters four (see above) and five (see above). I only discuss selective aspects of the data as it is not feasible for me to explore all avenues or cover all possible interpretations of the data. I then reflect on and discuss the findings more broadly: my own understanding of the findings and their implications for the profession. I consider what the findings tell us about the current state of thinking about sexuality within the profession and the role played by institutional psychodynamic training in shaping this thinking. The discussion chapter is best viewed as a springboard for further dialogue and debate with psychodynamic colleagues across the profession. The chapter also outlines my research's contribution to knowledge and suggests potential directions for future studies. Some brief concluding remarks are made. As a recap, the research questions are:

1. How do UK psychodynamic psychotherapists understand and conceptualise same-sex sexual orientation both theoretically and clinically?

2. In what ways has psychodynamic training on sexual orientation shaped the views and practice of UK psychodynamic psychotherapists working with LGB clients?

6.1 Reflection on the Research Participants

This section reflects on the research participants and discusses the generalisability of the findings.

Questionnaire: Response Rate

The questionnaire achieved a response rate of 20%. As the BPC collects very little demographic and professional data on its members, it is impossible to say how representative this 20% is of the wider BPC population (more on this below). While my questionnaire achieved a higher response rate than the questionnaire studies conducted by Friedman and Lilling (1996) and Lingiardi, Nardelli and Tripodi (2015) – these two studies attained response rates of 9% and 11% respectively – it obtained a much lower response rate than many of the other studies that had used questionnaires to measure therapists' attitudes towards same-sex sexual orientation (Garnet et al 1991; Macintosh 1994; Jordon and Deluty 1995; Phillips, Bartlett and King 2001; Lingiardi and Capozzi 2004; Kilgore et al 2005; Bartlett, Smith and King 2009). These other studies all achieved response rates ranging from between 34% and 71%. The low response rate

was disappointing and undermines the generalisability of the findings. Possible explanations for the low response rate include:

1. Ambivalent and/or avoidant attitudes amongst BPC members towards the research topic.

2. Dismissive attitudes towards empirical research. Some therapists may potentially view a questionnaire as a blunt instrument for measuring therapists' attitudes towards something as complex as sexual orientation. Feedback from the pilot study showed that some therapists certainly felt this to be the case.

3. Distrust of the BPC's support for and involvement in the research. There may have been concern over the possible 'political correctness' agenda driving the research. Questionnaire responses indicated that some BPC members were suspicious of wider BPC moves to diversify the field.

4. Therapists' lack of time to engage with the questionnaire due to demanding professional commitments.

5. Insufficient marketing of the questionnaire. However, as section 3.7 shows, the BPC invested some resources, energy and time into the marketing campaign. When BPC members were sent email reminders about the questionnaire, response rates tended to increase very quickly afterwards. Perhaps more targeted email communications might have improved the final response rate.

6. BPC members may not have been aware of the questionnaire due to communication failures (i.e., not checking emails).

7. Some BPC members may have been less digitally skilled and potentially put-off by the online version of the questionnaire.

8. Some BPC members may not have felt that they were sufficiently knowledgeable to complete the questionnaire. As Table 4-24 shows, almost half of respondents reported not having received formal training on gender, sexuality and relationship diversity.

9. Poor questionnaire design. However, pre-piloting and piloting activity had identified and rectified some of the issues around question construction, phrasing and sequencing (see sections 3.4 and 3.5).

10. Researcher credentials. BPC members may have preferred a more established researcher to be conducting the research, although BPC members were informed in all communications that the research was supervised by Professor Mary Hepworth (formerly

Target) and Professor Michael King, both very experienced academics and researchers themselves with track records in conducting research and supervising PhD students.

Questionnaire: Sample

In section 4.2, I described the personal demographics of my questionnaire sample. As the BPC does not systematically collect registrants' demographic data, it is not possible to indicate whether the breakdowns of respondents by gender (Table 4-1), sexual orientation (Table 4-2) and age (Table 4-3) are representative of the overall BPC population.

Gender. The proportion of female respondents (70%) contributes towards a possible bias in the responses.[74] Questionnaire responses from men and women are likely to vary and affect the data. Data from several studies suggests that (heterosexual) women are more accepting of LGB people than (heterosexual) men and are more likely to endorse interventions or policies that are supportive of LGB communities (Kerns and Fine 1994; Kite and Whitely 1996; Jones 2003; Eagly 2004). This may be linked to the fact that women, although not an actual minority themselves, continue to face oppression and discrimination as a result of sexism and are possibly more sensitive and tolerant to minority groups experiencing discrimination. The higher proportion of female respondents to my questionnaire may mean that responses to some questionnaire items are skewed towards a more positive viewpoint. Although only two comments about gender were made in the open text boxes (section 4.2), both comments were insightful. The first comment ('I'm just glad you offered the option of "other" [gender]') expresses relief that the questionnaire considers the possibility that some BPC registrants may identify as non-binary. The second comment ('I am cis female but I don't especially believe in the gender binary') indicates that some BPC registrants are familiar with less normative ways of describing gender identity. This is important to note as, during the piloting, some pilot testers had suggested that I remove the option of 'other' gender in the demographics section either because they assumed that psychodynamic colleagues would only identify as 'male' or 'female' or because they felt alienated by what they perceived to be the 'politically correct' wording.

Sexual Orientation. Almost a quarter of respondents identified as non-heterosexual. This also suggests a possible response bias.[75] It is not surprising that a questionnaire of this nature might have attracted more interest from BPC registrants who are not fully heterosexual. As I wanted to gather the views of non-heterosexual therapists, this could, in some respects, be perceived as a 'happy' bias. However, the relatively high proportion of non-heterosexual respondents to my questionnaire may mean that responses are skewed towards a more positive viewpoint on specific questionnaire items (e.g., acceptance of LGB therapists self-disclosing their sexual orientation to LGB clients in order to facilitate an affirmative psychotherapy environment) or a

[74] Although anecdotal evidence does suggest that there are more female than male therapists working in the psychodynamic psychotherapy profession

[75] Although, we can't say for sure as the BPC does not collect data on the sexual orientation of its members. However, given that the general LGB population across the UK is estimated at 2% (ONS Population Survey 2017), the 22.4% response from non-heterosexual BPC members does seem high and therefore potentially skewed.

more negative viewpoint on other questionnaire items (e.g., perceived or actual discrimination against LGB trainees at psychodynamic training organisations). The open text responses to this question indicated that some BPC registrants perceived their sexual orientation in less traditional and less monosexual terms, some describing themselves as 'queer' or as 'sexually fluid'. Again, this is important to note as it illustrates that some BPC therapists working today define their sexual orientation in more diverse and less heteronormative language than might be realised, although it is likely that they still make up a very small percent of the overall BPC membership.

Age. The majority of respondents were over 50 years old. This is consistent with the anecdotal view that the psychodynamic psychotherapy profession is an older working population. Many private therapists tend to work later in life than people in related settings (e.g., NHS; third sector) or they give up the latter but continue flexibly with private work into old age.[76] However, some research participants suggested that there may be a generational divide in relation to psychotherapists' attitudes towards LGB colleagues and trainees, with therapists over 70 years of age potentially holding more conservative or parochial views. With over 13% of questionnaire respondents aged 70 or above, there may be some responses to questionnaire items that are influenced by factors linked to age but no significant associations relating the age were found when conducting the extensive chi-squared (χ^2) analyses.

In section 4.3, I described the professional characteristics of my questionnaire sample. On the whole, the BPC does not systematically collect data on professional characteristics so it is not possible to indicate whether the breakdowns of respondents by training status, workplace setting (Table 4-4), therapeutic modality (Table 4-5) and theoretical affiliation (Table 4-6) are representative of the overall BPC population. As noted in section 4.3, there were some minor differences in professional characteristics when I compared the final sample (n=287) with the partial responders (n=112)[77] but analysis showed these differences were not significant.

However, the BPC does collect data in relation to each training organisation's membership size. Comparisons of my questionnaire sample with the official BPC data on training organisation show very minor variations, except in relation to the British Psychotherapy Foundation (BPF) and British Psychoanalytical Society (BPAS). A higher proportion of BPF therapists responded to the questionnaire (39%) than we might have expected given that the BPF makes up 30.1% of the overall BPC population. A lower proportion of BPAS therapists responded to the questionnaire (12.5%) than we might expected given that the BPAS makes up 20.2% of the overall BPC population.

[76] Psychoanalytic psychotherapy candidates tend to be older as they are typically expected to possess a certain level of academic, clinical and life experience before undertaking training. Candidates tend to train later in life when personal circumstances allow the freedom to do so and when they are in a more financially secure position.
[77] These 112 respondents had not answered beyond the first six questions on professional characteristics and so did not provide any data on the substantive questionnaire items. Their responses were excluded from the main analysis.

Interviews: Sample

In section 5.1, I described the personal and professional characteristics of my interview sample. I interviewed slightly more male therapists than female therapists: this suggests an oversampling on my part as we know, anecdotally, that there are more female than male therapists working in the field of psychodynamic psychotherapy. However, given the research base (Kerns and Fine 1994; Kite and Whitely 1996; Jones 2003; Eagly 2004) showing that there are differences in how men and women perceive LGB individuals, having more male interviewees may have provided some balance to the higher proportion of female questionnaire respondents. With 30% of interviewees identifying as non-heterosexual, there is likely overrepresentation here too but, as with the questionnaire, this may be a 'happy' bias as the BPC is particularly interested to understand how non-heterosexual therapists perceive the psychodynamic training environment. I did not interview any therapists under the age of 40 years, so there is a predominance of older therapists participating in the interviews, with 6 out of the 36 interviewees being over 70. As with the questionnaire, the age of the therapist may have some influence on the views expressed. At 50%, there is an overrepresentation of interviewees from British Psychoanalytical Society (BPAS). As my primary supervisor is a BPAS member herself and is a well-known colleague, BPAS members invited to interview may have been more predisposed to accepting the invitation because of Professor Hepworth's involvement. However, interviewees came from multiple theoretical backgrounds, covering all major BPC traditions (e.g., Freudian, Jungian, Kleinian, Independent etc). Interviewees' modalities also reflected the main BPC categories of registrant (e.g., Psychoanalyst, Psychoanalytic Psychotherapist, Psychodynamic Psychotherapist, Jungian Analyst etc). Interviewees were involved in a diverse range of professional activities beyond the clinic, including research.

6.2 Review of Methodology and Methods

In chapter three (see above), I outlined my methodology and methods. In this section, I reflect on the strengths and limitations of my methodological approach.

Strengths of Methodological Approach

I adopted a pragmatic philosophy for my research. This allowed me to pursue both a theory-led deductive and a data-led inductive approach (Bryman 2012; Gray 2014; Punch 2014). The questionnaire, for example, was mostly deductive in design. The questionnaire items were structured and aimed to verify therapists' views on key issues or theories I had already identified from the literature (e.g., LGB therapists' self-disclosure of their sexual orientation to LGB clients, the use of reparative techniques in clinical practice with LGB clients). The interviews were more inductive in design. This allowed interviewees to share their opinions and experiences in a less structured, freer fashion and for new and unexpected themes to emerge (e.g., the unanticipated focus on transgender). However, this interplay between deductive and inductive approaches is most clearly exemplified in relation to therapists' theories about the possible origins (or aetiology)

of same-sex sexual orientation. Some questionnaire items were designed to identify the proportion of respondents ascribing to specific theories I had identified from the literature and other research (e.g., same-sex sexual orientation is shaped by Oedipal factors). The interviews, on the other hand, allowed therapists to describe in their own words the theories they themselves found useful when considering same-sex sexual orientation. When both the questionnaire and the interview data on theories of aetiology are combined, a more nuanced and richer picture emerges. In particular, we observe the tensions between the Freudian/Oedipal theories many practitioners use to guide their practice and the places where these theories break down or come into conflict with alternative explanations for understanding sexuality (e.g., biogenetic data, queer theory, social constructionism).

A mixed method approach helped highlight inconsistencies and ambiguities across the dataset. As will be seen in the main discussion, there is evidence of discrepancy between therapists' theoretical and clinical models. There appears to be a conflict between what Sandler (1983, pp. 35-38) describes as therapists' *private theories* (what they personally feel and think about same-sex desire and LGB clients, and what their clinical experience has led them to believe in practice) and therapists' *official theories* (what they have been taught to think about same-sex desire and LGB clients during their analytic training). While, for example, the majority of research participants did not consider same-sex sexual orientation as pathological (see qualitative responses, in the questionnaire and interviews), a high proportion of questionnaire respondents ascribed to the theory that same-sex sexual orientation was a result of Oedipal conflict or environmental failures, thus implying pathology. We also observe from the combined data the ways in which practitioners struggle to make sense of their theories and practices, navigate identity positions as 'progressive' and 'traditional', and deal with their own anxieties around the subject area.

The questionnaire provided context and generated additional questions for clarification in the interviews. For example, the questionnaire could only identify respondents' level of agreement with a range of statements about professional attitudes towards LGB trainees and colleagues within psychodynamic training organisations whereas the interviews offered therapists the opportunity to discuss in depth the attitudes prevalent within their training organisations and to provide examples or vignettes to illustrate their claims.

Limitations of a Pragmatic Philosophy

Methodological purists may challenge the validity of my pragmatic approach, arguing that researchers should operate either within the quantitative or qualitative paradigm (Johnson and Onwuegbuzie 2004). While pragmatism represents a 'middle way', it is perceived by some as a compromise or 'sell-out', bypassing the philosophical dilemmas involved in choosing one purist approach (i.e., positivism) over another (i.e., interpretivist). Furthermore, as Johnson and Onwuegbuzie (ibid., p. 19) point out, pragmatism tends to offer 'incremental change rather than more fundamental, structural, or revolutionary change'. The results from my study may be best thought of as a tentative first step in addressing gender, sexuality and relationship diversity within

the profession and may, in the first instance, be used to initiate BPC-wide discussions about policy development in this area and possible next steps.

Researcher Limitations

Although I have been involved in quantitative, qualitative and mixed methods research projects in the past, I have usually been part of a wider research team and these projects have been delivered in the arts and creative industries rather than in the psychotherapy field. This was the first time I had delivered a complex, mixed methods research project on my own. Competence in both quantitative and qualitative methods took time to acquire. A great deal of time and thought was invested in the piloting and refinement of my research instruments (see sections 3.4, 3.5 and 3.10). I made good use of this piloting work to refine the questionnaire and to focus the direction of the interviews. I also attended several research courses organised by the UCL Doctoral Skills Development Programme in order to enhance my overall research skills. Over time, I became aware of my growing preference for qualitative work. In the data analysis and writing-up, I had to be careful not to emphasise one type of data over another.

Limitations of the Self-Completion Questionnaire

The questionnaire findings are unlikely to be generalisable to the whole BPC population as the response rate (20%) was low and respondents were self-selecting. As noted earlier, there was a likely overrepresentation of both female and non-heterosexual respondents. Weighting[78] may have been a way of compensating for problems with representativeness or generalisability but, as the BPC does not collect demographic data, this option was not possible. My questionnaire also relied on subjective measurement and self-report. This is a potential source of response bias as questionnaire respondents may have misunderstood specific questions or misremembered their clinical experiences with LGB clients.

Some respondents may have attempted to construct an account that conforms to a socially acceptable model of belief or behaviour, especially with questions about the use of conversion therapy with LGB clients. In hindsight, I might have included a social desirability component to counteract this.[79] In line with Callegaro (2008), I might have used specific wording techniques, such as offering an array of 'subtle' response options to questions that might have been expected to show social desirability or worded questions in such a way as to assume that respondents had already engaged in the specific behaviour(s) being investigated. I might also have included a forced choice format asking respondents to choose between alternatives of equal social desirability (Barker, Pistrang and Elliott 2016).

[78] Bethlehem (2008, p. 958) defines weighting as 'statistical adjustments that are made to survey data after they have been collected in order to improve the accuracy of the survey estimates and … compensate for survey nonresponse'. Weights are applied to a sample to make it more representative of the population it was designed to reflect.

[79] Although it should be noted that some respondents in their qualitative responses commented that 'the unconscious is not PC' and stated that they would not be answering the questionnaire in a politically correct manner.

As the questionnaire produced mostly categorical data, chi-squared (χ^2) analyses of cross tabulations were undertaken to examine the associations between variables. The main statistical problems with my analysis were as follows: (1) lack of power, which essentially means many of my comparisons had insufficient numbers to demonstrate clearly significant findings. I tried to overcome that by condensing my categories into 2 x 2 comparisons but thereby lost precision, and (2) the risk of spurious results from multiple testing. If one selects a statistical threshold for significance of 5% (0.05), this means that there is a risk that one comparison in every 20 will be significant purely by chance. Thus, when one makes multiple comparisons in the same data, one may choose a more stringent level of significance like 0.02. Few of my findings reach this level mainly because of the small sample sizes, thus I cannot regard the statistical tests as indicating anything more than trends that need confirmation in further research.

Limitations with the Interviews

My primary use of a purposive sampling technique (Flick 2014) could be a potential source of researcher bias: decisions about who to invite for interview were largely left to my judgement. However, as described in section 3.11, my judgements were based on a clear selection criterion, discussed with and approved by my primary supervisor.

Social interaction effect was another limitation of the interview process (Yin 2016). In section 3.12, I referred to my field notes and discussed how my reactions to specific interviewees differed depending on the quality of our interactions (e.g., becoming more empathetic to one interviewee who was upset; feeling threatened by another who was quite domineering). Although it is difficult to quantify, I was aware of certain assumptions I made about interviewees based on our demographic differences. For example, I expected male heterosexual therapists to be more homophobic and interviewees from BAME backgrounds to be better informed and more interested in discussing issues linked to diversity and inclusion. While, as noted earlier, data from other studies (Kerns and Fine 1994; Kite and Whitely 1996; Jones 2003; Eagly 2004) indicate heterosexual men are less accepting than women of LGB individuals, experience would tell me that this is not universal and there are many heterosexual men who are accepting and supportive of the LGB community. Similarly, people from non-BAME backgrounds can be equally committed to issues of diversity and inclusion as people from BAME backgrounds. It is also the case that individuals from BAME backgrounds may hold relatively conservative social, religious and cultural attitudes about family members being gay, and this could outweigh their concern for diversity.

Interviewees were asked a number of retrospective self-report questions about their clinical practice with LGB clients. As Barker, Pistrang and Elliott 2016 indicate, self-reported data potentially contains several sources of bias. These biases include: (1) selective memory (i.e., not remembering key experiences); (2) telescoping (i.e., conflating two experiences); and (3) exaggeration (i.e., presenting clinical outcomes as more positive or more negative than were actually the case).

I also engaged in participant checking (Tong, Sainsbury, Craig 2007) and shared my interview transcripts with the interviewees. Could this have led to sanitisation of data? Some researchers might argue that the raw, unedited transcript was the most valid and that, because five of my 36 interviewees did not review their transcript, there might be some bias or distortion. However, participant checking seemed extremely valuable for clarifying ambiguous passages of transcript text as well as providing new information or elaboration of views. None of the interviewees, who participated in the review process, retracted any of their original statements. In most cases, requests for modification were usually made in relation to clinical vignettes where there was a wish to further disguise clients or protect client confidentiality.

Limitations of the Framework Analysis

Although Framework Analysis (FA) offered systematic and easy-to-follow procedures for organising and managing the interview data, there was a danger of my becoming too process focused rather than immersing myself in the data and the work of interpretation (Gale et al 2013; Parkinson et al 2015). FA also required a proficiency in coding, indexing, charting and interpreting data. These were very specific skills that took time to develop. In the early phases of interpretation, the thematic charts – essentially Excel spreadsheets – seemed to encourage a more quantitative approach to analysis, such as counting or quantifying cases, rather than facilitating deeper engagement with the diverse range of viewpoints inherent in the dataset. I was conscious of the possibility of over coding and being overwhelmed by the detail, given the amount of data generated from the interviews (i.e., 100,000 words, 533 pages of transcripts).

Other Approaches and Methods Considered

I considered using focus groups (Blaxter, Hughes and Tight 2010; Bryman 2012; Gray 2014) as a third and final component of surveying the thoughts and opinions of BPC registrants. However, the historical context and sensitivity around the research topic made me concerned that participants might find it difficult to express their opinions honestly in a focus group setting. In particular, I imagined specific group dynamics might distort, silence or overemphasise certain perspectives (e.g., there may be tension in a group with a LGB trainee, a proponent of conversion therapy and an academic expert in the field.)

Instead of a Framework Analysis, it was suggested by colleagues that I might consider conducting an Interpretative Phenomenological Analysis (IPA) (Smith, Flowers and Larkin 2009) on my interview data. However, IPA was incompatible with my pragmatic approach, as IPA is philosophically aligned with the interpretivist tradition and particularly with phenomenology, hermeneutics and ideography. The variation in theory and clinical practice I wanted to explore in my study (36 interviewees in the end) meant that an IPA would not have been suitable because IPA relies on small sample sizes of usually not more than 8 interviewees (Hefferon and Rodriquez 2011). IPA also adopts a three-pronged approach to data analysis, focusing on the descriptive, linguistic and conceptual elements of a transcript. As I eventually adopted a denaturalised

approach to transcription, I had removed dialogue conventions from my scripts (e.g., pauses, verbal tics): a linguistic analysis would not have been possible. Additionally, given interviewees' anxiety in relation to the topic of sexuality, I had already assured several participants during the fieldwork that when coding the data that I would use 'semantic' rather than 'latent' codes (Braun and Clarke 2013, p. 207). In other words, the codes I applied would be constructed at face value; I would not 'dig deeper' for meanings beneath the surface. The data analysis would concentrate on the content of what was said – its informational value – rather than how it was said. I did not want to alienate my research participants by 'getting behind' their words or their stated views. The study was deliberately designed to collect descriptive data, and I had not set out to understand the unconscious meaning underlying participants' words. This is not to say, however, that the data collected does not lend itself to a phenomenological analysis, but speech conventions would need to be added back into the transcripts and perhaps a smaller sample of transcripts selected for this deeper analysis. Interviewee consent would need to be sought for this type of analysis.

Researcher Reflexivity

In section 3.16, I discussed researcher reflexivity and how the researcher, as the research instrument, may shape or affect the research process. It is important to recognise that, to an extent, subjectivity is unavoidable in the research process, especially in qualitative work. However, it is good research practice to be explicit about our preconceptions as researchers (Gibbs 2007; Dean 2017). Using Dean's (2017, pp. 1-2) criteria, I have mapped my own biases against four different domains of the research experience:

1. *Methodological*. In chapter three (see above), I closely reflected on my own philosophical assumptions and how these shaped my choice of methods. I was as clear as possible about my own ontological, epistemological and axiological position(s) and how these informed my view of the world and my place within it. I indicated from the outset my own preference for philosophical and methodological pluralism.

2. *Theoretical.* In my literature review (chapter two, see above), I examined a number of theoretical perspectives on sexuality and same-sex sexual orientation, including psychodynamic theory, queer theory, social constructionism, biogenetic theory etc. I indicated a preference for interdisciplinary thinking and for a biopsychosocial approach.

3. *Practical.* In section 3.2 (5th layer of the research onion), I considered the practicalities of what I could realistically deliver as a PhD student. Given the limited money, time and resources of a PhD, a cross-sectional study, consisting of two parts (a questionnaire followed by interviews), was deemed the most appropriate and practical approach for my study.

4. *Personal.* In the Introduction (see above), I was open about my own personal and professional characteristics (i.e., gay male researcher and a student of psychotherapy)

and my general position in the field of research (i.e., involvement with the BPC Task Group). In chapter 3 (see above), I provided examples of how the piloting process revealed my own heteronormative biases in the early drafting of the questionnaire. Where I have been aware of my non-neutrality during the research design and fieldwork, I have noted it in the writing-up.

6.3 Discussion of Main Findings

In this section, I present 16 main findings from my research and aim to triangulate the questionnaire and interview data to provide a more rounded picture of psychodynamic therapists' theoretical, clinical and professional perspectives in relation to same-sex sexual orientation. Where relevant, I refer back to the literature (chapter two, see above) and other empirical attitudes studies I have reviewed (section 3.3. and Appendix D, see below). In this section, I aim to assess where my findings fit within the wider field, and I compare and contrast my findings with the theoretical, clinical and interdisciplinary literature examined earlier in the thesis.

Finding One: Depression and anxiety are the most common mental health issues presented by LGB clients in therapy

Therapists' perception of depression and anxiety as the most common mental health issues reported by LGB clients in therapy (see Figure 4-2) is consistent with wider research showing that LGB individuals are vulnerable to depression and generalised anxiety disorders (Warner et al 2004; King et al 2008; Chakraborty et al 2011; Elliott et al 2015; Semlyen et al 2016). This also reflects the broader evidence that depression and anxiety are amongst the most common mental health problems experienced by the general population regardless of sexual orientation (NICE 2011). From the qualitative responses (questionnaire and interviews), there is an awareness amongst therapists that depression and anxiety in LGB clients is often, though not universally, linked to internalised homophobia as well as actual experiences of stigma, discrimination and homophobia (APA 2012; Pachankis and Goldfried 2013 BACP 2017; BPS 2019). In line with other research in this area, qualitative responses (questionnaire and interviews) also suggest that many therapists recognise that depression and anxiety in LGB clients may be associated with lack of parental acceptance and/or with wider family rejection as well as emotional conflicts linked to the process of 'coming out' (Friedman and Downey 2008; Ryan et al 2010; APA 2012; Pachankis and Goldfried 2013; Reyes 2015; Watson et al 2019).

Finding Two: Relationship difficulties are the most common reasons LGB clients give for seeking therapy

Therapists' perception of relationship difficulties as the most common reasons LGB clients give for seeking therapy (see Figure 4-1) aligns with broader evidence that suggests a bi-directional link between relationship issues and common mental health problems, such as depression and anxiety (see finding 1 above) (Whisman and Uebelacker 2003; Snyder and Whisman 2004). On the whole and in line with the literature (APA 2012; Pachankis and Goldfried 2013), qualitative

responses indicated that most therapists consider LGB and non-LGB relationships to be similar. Therapists perceived LGB relationships as attaining the same levels of emotional satisfaction and connection as non-LGB relationships as well as sharing common relationship frustrations, such as communication issues or problems with intimacy. While both LGB and non-LGB couples were perceived to experience similar relationship difficulties, some therapists were aware that there might be different psychodynamics underlying these difficulties for LGB couples. In line with the literature (see Meyer and Dean 1998; Lynch 2015), some therapists' accounts showed awareness that intimacy issues in LGB relationships may be linked to one or both partner's unresolved internalised homophobia. Therapists' accounts also recognised that LGB individuals have very different relationship norms to heterosexual individuals. In line with the literature (Denman 2004; LaSala 2008; APA 2012), some therapists recognised that gay male relationships often accommodated greater levels of non-monogamy than heterosexual or lesbian relationships. Also reflecting the literature (Bepko and Johnson 2000), therapists reported that lesbians often described feelings of differentiation and merger in their relationships. Most therapists, however, perceived merger or fusion in lesbian relationships negatively and linked these issues to difficulties in establishing boundaries in relationships and a loss of sexual desire. Therapists' accounts did not acknowledge, as some of the literature suggests (Green et all 1996; Burch 1997; Friedman and Downey 2002), that merger and fusion in lesbian relationships may be viewed more positively as a capacity for deep emotional relatedness and cohesiveness.

Therapists' accounts show that LGB clients often discussed their sex lives as part of their wider relationship difficulties. I occasionally felt that therapists perceived gay men as having more 'extreme' or unusual sex lives than their heterosexual or lesbian counterparts. Whereas interviewees only made a few references to lesbian sex lives, they itemised a whole range of sexual practices they associated with gay male sexuality, including anal sex, rimming, cruising, fisting, barebacking, snowballing, cottaging, sex at bath houses, chemsex, polyamory and group sex. However, as discussed in the literature review, not all these activities are gay male specific (e.g., anal sex, polyamory, group sex) and many heterosexual people engage in similar activities and many gay men do not (Coxon and McManus 2000). A few qualitative responses (questionnaire and interviews) made specific reference to anal intercourse, with therapists often conflating anal sexuality with gay men as well as expressing their difficulties and sometimes disgust in hearing gay men's accounts of having anal intercourse. This is striking, as research (McBride et al 2010) shows that anal sex is almost as common in heterosexuals as in gay males and therefore, statistically, it is far more common in the wider population. Another interesting example is cruising. Again, some therapists seemed to equate such activity with gay men, but as the literature indicated, heterosexual people (of both genders) may engage in sexual activities in public places, such as dogging (Ashford 2012) or attend swing parties and have sex with multiple partners (Richards and Barker 2013).

When interviewees discussed their lesbian clients' sex lives, they often reported lesbian clients as not having much sex. I had the feeling that some therapists viewed this rather negatively and seemed not to consider that lack of sex does not necessarily mean that these relationships are

not affectionate or do not involve other forms of emotional and physical intimacy (e.g., kissing, cuddling, caressing, togetherness). It is possible that some therapists may still define sex heteronormatively as penis-in-vagina penetration and may not be fully aware of other, non-penetrative sexual practices in women-women relationships, such as scissoring or cunnilingus (Richards and Barker 2013; Clarke et al 2016). It should also be noted that several therapists did not come with any assumptions or judgements about the lesbian 'death bed' scenario (some actually seemed surprised by it) but were rather just reporting to me a complaint that their lesbian patients themselves had expressed or brought to the therapy.

Finding Three: Almost three-quarters of questionnaire respondents attribute same-sex sexual orientation to Oedipal conflicts, disturbed attachment and trauma (i.e., developmental or environmental factors)

It is noteworthy that a majority of psychodynamic therapists continue to think that Oedipal conflicts, disturbed attachments or early trauma (i.e., developmental or environmental factors) are causative of same-sex sexual orientation (see Table 4-15), especially since the scientific evidence (discussed in section 2.8) shows that such factors play a negligible role in the development of same-sex sexual orientation.[80] Complicating the matter further, psychodynamic therapists do not share a unified Oedipal or developmental theory of sexual orientation. There are multiple understandings of Oedipal theory, for example, which appear to mean different things to different therapists (see section 5.3, theme two).[81] Although there is minimal scientific support for the proposition that developmental or environmental factors cause same-sex sexuality, there is, however, evidence that the family environment or conflictual parent-child relationships may influence a number of other features of later life, including intelligence, character development and emotional functioning (see ASAAF 2015; Bailey et al 2016). As the qualitative responses show (section 4.14 and 5.11, theme ten), many psychodynamic training organisations emphasise Oedipal and developmental models when teaching sexuality, so it is perhaps unsurprising that a majority of therapists ascribe to this view.

Finding Four: Over 80% of questionnaire respondents are either undecided or disagree that same-sex sexual orientation is shaped by genetic factors

It is notable that the majority of therapists remain undecided or disagree about the role of genetics in shaping sexual orientation (see Table 4-15). In section 2.8, I reviewed the scientific literature relating to same-sex sexual orientation, including family, twin, genetic, neuroanatomical, socio-behavioural, evolutionary and environment studies. These studies, taken together, provide good evidence for genetic and non-social environmental effects on the development of sexual orientation. Finding four, therefore, raises important questions about therapists' theoretical models and whether there is an argument for broadening psychodynamic teaching about

[80] This perspective may not be limited to same-sex sexual orientation but to sexual preferences generally.

[81] Some therapists do not view Oedipal theory as a developmental/environmental theory and apply it in a more abstract and metaphorical way or use it as a theory to describe an individual's psychic reality.

sexuality to include the genetic, psychobiological and neuroscientific evidence where this is not currently the case, especially since this evidence offers a direct challenge to the Oedipal and development theories currently favoured and taught within psychodynamic training organisations. There is some appetite for this, as qualitative responses indicated that a handful of research participants wanted to be more familiar with the broader, scientific literature on sexual orientation (section 4.14 and 5.11, theme ten). Interestingly, Lingiardi and Capozzi (2004) also found in their study that three-quarters of psychoanalytic and Jungian therapists did not believe that same-sex sexual orientation had a strong biogenetic component.

Finding Five: The majority of questionnaire respondents think same-sex sexual orientation is a combination of 'nature/nurture' or multiply determined

On the surface, this finding suggests that psychodynamic therapists work within a multi-factorial, potentially biopsychosocial, framework for understanding same-sex sexual orientation (see Table 4-15). However, I do not think this is actually the case**.** Taken together, findings three and four (see above) indicate that the majority of psychodynamic therapists readily accept Oedipal or developmental 'nurture' explanations while, simultaneously, holding mixed or negative attitudes in relation to genetic 'nature' explanations. In other words, psychodynamic therapists lean more heavily towards 'nurture' rather than 'nature'. Furthermore, when interviewees were asked to describe which psychodynamic and non-psychodynamic theories were useful for thinking about same-sex sexualities, few alluded to the scientific or biogenetic literature. Only a handful of therapists mentioned scientific explanations (e.g., epigenetics) and/or considered a genetic potentiality (see section 5.11, theme ten). If interviewees discussed non-psychodynamic theories, they were more likely to draw on disciplines from within psychosocial studies, such as queer theory or social constructionism (again, see section 5.11, theme ten). Qualitative responses further confirmed that, in addition to their favoured Oedipal or developmental theories, therapists were more open to the idea that sexuality was socially or culturally constructed rather than genetically or biologically influenced. Finding five, then, also raises important questions about therapists' theoretical models and whether there is an argument for broadening psychodynamic teaching about sexuality to include biopsychosocial perspectives (Friedman and Downey 2002; Denman 2004) where this is not currently the case. Biopsychosocial models may represent an important theoretical alternative for therapists, drawing on wider scientific data as well as social and cultural evidence from other disciplines.

Finding Six: Three-quarters of questionnaire respondents disagree with the statement that sexual orientation can be changed or redirected through therapeutic means

At first glance, this finding (see Table 4-16) seems reassuring and in line with the empirical evidence discussed in the literature review that: (1) sexual orientation cannot be changed through reparative means; and (2) reparative therapies have adverse effects on the mental health of LGB clients. However, given the substantial evidence base, we might have expected more respondents to disagree with this statement. In fact, almost a quarter of respondents were

undecided. We should not take finding six at face value either as we are aware of an overrepresentation of non-heterosexual respondents in my sample, whose responses may have potentially skewed the answers to this question towards a more positive or reassuring picture than might be the case in reality. In addition, the frequency of reparative practices may be underestimated in the study as it is less likely that BPC members who actively use reparative techniques would have responded to the questionnaire. Also, in light of the BPC's diversity and equality agenda, we cannot discount the possibility that some respondents may have given socially desirable answers while holding different clinical views in reality. Interestingly, Lingiardi, Nardelli and Tripodi (2015) found 58% of Italian mental health professionals held reparative attitudes. Although we must recognise that Italy has a different cultural, political and social context to the UK, it is quite possible that UK psychodynamic therapists, like their Italian counterparts, may be more reparative in practice than my results indicate. Alternatively, we must be mindful that the quarter of respondents who were undecided about this question may, in line with existing research (Diamond 2008; Savin-Williams 2017), hold the view that sexual orientation is fluid and changes over time. In the qualitative responses, several interviewees discussed clinical cases where a client's sexual orientation had changed incidentally over the course of a therapy, but the therapy had not been instrumental in making that change. It is not unreasonable, therefore, to speculate that some of the questionnaire respondents may have had these kinds of clinical experiences or ways of thinking in mind when answering this question.

Finding Seven: Non-heterosexual therapists are significantly more likely than heterosexual therapists to agree that it is appropriate for LGB clinicians to self-disclose their sexual orientation to their LGB clients

Although this finding is interesting (see Table 4-20), I am mindful of the multiple statistical tests I conducted during the questionnaire analysis. The level of significance, therefore, is marginal and cannot be noted as anything beyond a trend. Intuitively, however, this finding makes sense. Many non-heterosexual therapists have themselves experienced living in a predominantly heteronormative and homophobic world and may more readily appreciate that LGB clients are distrustful of psychotherapy and that LGB therapists' self-disclosure (of their sexual orientation) may reassure these clients that they are entering an accepting and respectful therapeutic space. In line with the empirical research referred to in the literature review (Borden 2010; Kronner 2013; Porter, Hulbert-Williams and Chadwick 2015; Danzer 2019), some qualitative responses showed that therapists were aware that LGB therapists' self-disclosure (of their sexual orientation) to their LGB clients may have positive therapeutic benefits, including role-modelling, validation and improvements in LGB client self-esteem. Crucially, it is also important to note that Table 4-20 shows that the majority of both heterosexual therapists (just over 90%) and non-heterosexual therapists (almost 80%) think it is inappropriate for LGB clinicians to self-disclose their sexual orientation to their LGB clients. We know from the qualitative responses (section 4.11) that many therapists view non-disclosure of sexual orientation (as well as any other personal characteristic) as a matter of basic psychodynamic technique for both heterosexual and non-heterosexual

therapists. This aligns with the literature that most therapists consider self-disclosure of any type as impeding the transference and phantasy work.

Finding Eight: Male therapists are significantly more likely than female therapists to think LGB clients have a right to access LGB therapists

Although this finding is noteworthy (see Table 4-23), the level of significance is marginal as multiple statistical tests were applied in the questionnaire analysis and there was a low number of male therapists in my final sample. This finding is particularly striking because it is counter-intuitive and is in conflict with data from other studies that shows (heterosexual) women are more accepting of LGB people than (heterosexual) men and are more likely to endorse interventions or policies that are supportive of LGB needs (Kerns and Fine 1994; Kite and Whitely 1996; Jones 2003; Eagly 2004). However, it is possible that because women have been reported to be more supportive to the LGB community, female therapists are perhaps confident of their own supportiveness in clinical work with LGB clients and hence why they are less likely to think LGB clients should access treatment with LGB therapists. We also must remember that, of the 79 male questionnaire respondents, 26 identified as non-heterosexual (i.e., one-third of the male respondents were not heterosexual). This may partially account for why male therapists were significantly more in favour of this particular intervention than female therapists. Having said that, several other attitudes studies have confirmed finding eight, also reporting that that female therapists were less likely than male therapists to hold positive views about LGB-affirmative therapeutic interventions or policies, such as the right to access a LGB therapist (Lingiardi and Capozzi 2004; Lingiardi, Nardelli and Tripodi 2015). Only one attitudes study (Kilgore et al 2005) found that women therapists were more supportive than male therapists of LGB-affirmative clinical interventions or policies.[82] It is clear that gender differences in attitudes towards LGB clients requires further empirical investigation.

Finding Nine: Pluralistic/eclectic therapists[83] are significantly more likely than traditional therapists[84] to report that their training had been effective preparation for clinical practice with LGB clients

This finding (see Table 4-27) is consistent with an attitudes study conducted by Lingiardi and Capozzi (2004) that also found that therapists' theoretical affiliation influenced their understanding of same-sex sexual orientation. It is unsurprising that eclectic therapists felt their training had better prepared them for clinical practice with LGB clients, because eclectic therapists draw on post-classical theories (e.g., relational, intersubjective), which more readily embrace interdisciplinary approaches to sexuality and aim to integrate psychodynamic theory with ideas from feminism, queer theory, social constructionism and critical studies (Domenici and Lesser

[82] Kilgore et al's study was conducted with clinical psychologists rather than psychodynamic psychotherapists.
[83] By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.
[84] By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories.

1995; Dean and Lane 2001; Giffney and Watson 2017; Rapoport 2019). Traditional therapists, on the other hand, appear to adhere more strictly to a classical Oedipal or psychosexual model. However, qualitative responses indicated that many traditional therapists were beginning to think more critically about some of these models.

Finding Ten: Non-psychoanalytic therapists (i.e., Jungians) are significantly more likely than psychoanalytic therapists to think their theories of sexual orientation need updating

This finding (see Table 4-30) is in line with Lingiardi and Capozzi (2004) whose attitudes study also found that Jungians were much more questioning of their existing theoretical models than their psychoanalytic counterparts and much more likely to want to update their thinking in this area. In addition to theories from analytic psychology, Lingiardi and Capozzi (2004) found that Jungians were also more likely to embrace relational and interpersonal theories of sexuality and to reject theories positing that developmental or environmental factors influenced the direction of one's sexual orientation. From the qualitative responses in my study, Jungian interviewees appeared to be less dogmatic about sexual issues and to have a richer, more imaginative capacity for conceptualising same-sex desire. In light of what appears to be a more pluralistic attitude and approach, it is perhaps unsurprising that, in my study, the non-psychoanalytic therapists (Jungians) recognised more readily than psychoanalytic therapists that their theories of sexual orientation may need updating. There appears to be a willingness and openness amongst Jungians for embracing new and creative ways for thinking about sexuality.

Finding Eleven: Non-heterosexual therapists are significantly less likely than heterosexual therapists to agree that LGB colleagues are treated the same as non-LGB colleagues

In light of the history of pathologisation and anti-LGB discrimination within the psychodynamic profession, this finding (see Table 4-33) is unsurprising. Qualitative responses (questionnaire and interviews) indicate that anti-LGB prejudice persists within some psychodynamic training organisations, especially in relation to trainee selection and interviews. Some therapists' accounts suggest that, until very recently, LGB candidates continued to experience extraordinarily intrusive questioning about their sex lives at their selection interviews. Qualitative responses (questionnaire and interviews) highlighted other forms of anti-LGB discrimination within psychodynamic training organisations, such as senior therapists making explicitly prejudicial comments during seminars or LGB trainees encountering persistent homophobic attitudes in supervision. However, the picture was not always negative. Some LGB interviewees reported having had positive experiences at their training organisation, where their sexuality was not an object of scrutiny and had never been a barrier.

Finding Twelve: Non-psychoanalytic therapists (i.e., Jungians) are significantly more likely than psychoanalytic therapists to agree that LGB and non-LGB colleagues are equally promoted to senior positions

This finding (see **Table 4-35**) is consistent with the study by Lingiardi and Capozzi (2004) which found that Jungian institutes were less pathologising towards LGB colleagues and more likely to offer career progression for LGB colleagues than psychoanalytic institutes. This 2004 study also noted that Jungians were more likely than psychoanalytic therapists to think LGB colleagues could become training analysts. Some therapists' qualitative responses in my study acknowledged the conservative and hierarchical nature of psychodynamic training organisations. Despite the BPC Position Statement, some therapists' accounts in my study suggest that institutional reform has mostly been cosmetic and incremental, although some organisations were leading the way on issues of diversity and difference. Furthermore, qualitative responses indicate that more must be done to tackle professional or progression barriers for LGB therapists.

Finding Thirteen: Therapists' accounts indicate that there are similarities and differences in the transference and countertransference work with LGB and non-LGB clients

In line with the literature (see section 2.10), qualitative responses from the questionnaire (section 4.13) and interviews (section 5.9, theme eight) indicate that therapists perceived themselves to be the recipients of several types of transferences from LGB clients. Such transferences included positive, negative, erotic, affectionate, paternal, maternal, overidentified, idealised or a combination of all of these. Therapists also reported experiencing a wide range of countertransference reactions towards their LGB clients. Therapists could feel protective, caring, judgemental, confused, disgusted, sexually aroused, critical or a mixture of all of these responses. However, over half of the questionnaire respondents reported experiencing very little difference in the transference and countertransference between LGB clients and non-LGB clients. These therapists indicated that transference and countertransference reactions were very individual and were no more influenced by sexual orientation than by any other aspect of a client's personality (e.g., client's competitiveness, desire for love, aggression, narcissism, envy).

While acknowledging that the different types of transferences and countertransference reactions (e.g., positive, negative, erotic) could be experienced with both LGB and non-LGB clients, many therapists noted that there was a 'qualitative' difference in their experiences of, thoughts about and emotional responses towards LGB clients. Some therapists' accounts suggested that this difference may, in some cases, be attributed to the unique developmental and social experiences LGB clients may have had growing up. Some therapists' accounts suggested that LGB clients' positive (parental) transferences may reflect the LGB client's desire for connectedness or intimacy with a longed-for parent figure, perhaps after experiencing parental rejection in childhood or adolescence due to being LGB. Similarly, because many LGB clients have internalised negative views from parents or relatives about their sexuality, therapists reported that LGB clients may act

defensively or negatively towards the therapist, in order to protect themselves from perceived therapist (parental) censure and denunciation.

Finding Fourteen: Therapists' understanding of bisexuality was not as fully developed as their understanding of gay male sexuality and lesbianism

Many therapists (see section 5.6, theme five) expressed negative attitudes towards bisexuality and bisexual clients. Interviewees variously defined bisexuals as promiscuous, incapable of fidelity, untrustworthy, in denial about their true sexual orientation or as going through a phase of experimentation. It is clear from the work of bisexual activists and theorists that these views represent inaccurate and distorted stereotypes about bisexuality, amount to biphobia, and perpetuate the belief in the superiority of both monosexual people and monosexuality (Eadie 1993; Garber 1995; Ault 1996; Guidry 1999; Alexander and Anderlini-D'Onofrio 2012). One interviewee, for example, generalised that bisexuals, particularly men, were inherently deceptive and incapable of establishing and maintaining trusting, monogamous relationships. While there is evidence that bisexuals often view polyamory as a relationship ideal, most bisexuals still pursue and are in monogamous relationships (APA 2012). Another interviewee suggested that, on account of having a simultaneous attraction to more than one gender, bisexuals experience 'the best of both worlds'. Again, this attitude is not supported by the evidence and, as the APA (2012) clinical guidelines indicate, bisexuals are not only the victims of both heterosexism and homophobia but are also often marginalised by some gay or lesbian individuals who think they [bisexuals] are 'really gay' or 'really lesbian'. Far from experiencing the 'best of both worlds', bisexuals are actually more likely to face increased levels of marginalisation and exclusion (APA 2012) and bisexual identities are often de-legitimised or made invisible.

Finding Fifteen: Transgender was an unanticipated topic of discussion for therapists

The majority of therapists I interviewed (see section 5.7, theme six) admitted not having an adequate theoretical or clinical model for conceptualising transgender. As with bisexual clients, therapists seemed to either pathologise or draw on distorted stereotypes about trans people. Interviewees variously defined transgender as a delusion, as an omnipotent fantasy, as a person 'in the wrong body' or as the result of an unprocessed childhood trauma. However, there was a noticeable difference in the way therapists talked about transgender compared with how they talked about bisexuality. While therapists were mostly unaware that their views on bisexuality would today be viewed as biphobic, they worried excessively that I might misinterpret their views on transgender as transphobic. Therapists' anxiety about being perceived as transphobic was perceptible throughout the fieldwork. On many occasions, I felt that therapists' sensitivity about transgender could be displaced feelings that were not worked through sufficiently in relation to same-sex sexual orientation. There was another discernible trend in therapists' accounts of transgender. Some therapists thought the profession had become overly defensive about this issue and that transgender had become very politicised. While most interviewees recognised that trans-affirmative policies were well meaning, several felt strongly that analytic work with

transgender clients was being significantly impeded. My general impression was that many therapists still thought it may be useful and good therapeutic practice to analyse any personal difficulties or unconscious conflicts that a trans client may have in relation to their gender identify – not in order to change the gender identity – but rather to assist the trans client in achieving a greater degree of self-acceptance.

Finding Sixteen: The BPC (and BPC training organisations) has a more active role to play in fostering an inclusive and LGB-friendly profession

Almost two-thirds of participants felt the BPC had a more active role to play in fostering an inclusive and LGB-friendly profession (see Table 4-37), not least continuing efforts to address anti-LGB prejudice where it continues to exist and re-evaluating institutional psychodynamic training relating to same-sex sexual orientation. Respondents provided overwhelming support for a number of initiatives including revising training entry and selection requirements within psychodynamic training organisations. Looking across the qualitative responses, BPC training organisations may need to redouble their efforts to 'oppose discrimination on the basis of sexual orientation…in the selection or progression of those who wish to train, who are training and who train others in psychoanalytically-informed practice' and ensure that 'aptitude for psychoanalytic work, from the selection of candidates to the appointment of training and supervising analyst or therapist roles, is assessed across many areas and not on the basis of sexual orientation.' (BPC Position Statement 2011).

6.4 Reflections on the Main Findings and their Implications

In this section, I reflect on and discuss the 16 findings outlined above as whole: my own understanding of the findings and their implications for the profession. I consider what the findings tell us about the current state of thinking about sexuality within the profession and the role played by institutional psychodynamic training in shaping this thinking

Research Question 1: How do UK psychodynamic psychotherapists understand and conceptualise same-sex sexual orientation both theoretically and clinically?

Overall, my research findings indicate that psychodynamic therapists' ways of thinking about and working with same-sex sexual orientation oscillates between good practice in line with existing psychotherapy guidelines for clinical work with LGB clients (APA 2012; BACP 2017; and BPS 2019) and practice that is biased, out-dated and potentially harmful. It is encouraging that, on the whole, most therapists appear well informed about the ways in which societal stigma, family rejection, internalised homophobia, anti-LGB discrimination and the 'coming out' process contribute to the anxiety, depression and relationship conflicts reported by LGB clients in therapy. We know from the literature review that this clinical view is supported by empirical data. It is also reassuring that the majority of therapists no longer accept same-sex desire as an indicator of pathology or perversion, nor do the majority of therapists think it is possible or desirable to change

the sexual orientation of LGB clients. Again, these clinical positions are sound, represent best practice and are supported empirically.

However, on the other hand, many therapists participating in the research do not appear as fully informed about specific aspects of LGB lives and norms as perhaps they could be. Many therapists' accounts – but not all of them – show that therapists have a predominantly heteronormative and monosexual understanding of love, relationships and sex. This is most evident in therapists' accounts of LGB sex lives and relationship diversity (see finding 2 above). Perhaps because the majority of (heterosexual) therapists define 'healthy sex' and 'healthy relationships' as penis-in-vagina (PIV) intercourse and monogamy respectively, it is difficult for them to become aware of, let alone challenge, the heteronormativity underlying these assumptions and to recognise the multiple sexual and relationship possibilities that exist for both LGB as well as non-LGB individuals.

Earlier in the discussion, I noted that there were contradictions in therapists' theoretical models relating to sexual orientation. I partially attributed this to an incompatibility between therapists' *private theories* (what they personally feel and think about same-sex desire and LGB clients, and what their clinical experience has led them to believe in practice) and therapists' *official theories* (what they have been taught to think about same-sex desire and LGB clients during their analytic training). Therapists seem genuinely caught between wanting to retain valuable insights from the Freudian/Oedipal theories they have been taught during their psychodynamic training (see section 5.2, theme one and see section 5.3, theme two) while also drawing on insights and data emerging from other disciplines (see section 5.11. theme ten).

We observe from the data that some therapists participating in the research were influenced by psychosocial perspectives (e.g., queer theory or social constructionism) and understood sexuality and gender as being inextricably shaped by cultural, social and historical factors. Although less commonly the case, we also observed from the data that a handful of therapists were aware of and engaged with the scientific evidence on sexual orientation and/or were interested in learning more about the neuroscientific and biogenetic studies in this domain. In line with Auchincloss and Vaughan (2001), there was a growing recognition amongst therapists that psychodynamic theory alone may not be sufficient to provide a robust theoretical model for thinking about and conceptualising same-sex sexual orientation.

Could the different theoretical perspectives – i.e., the scientific, the psychosocial and the psychodynamic perspectives – be reconciled in some way? We know from the literature review that there is good scientific evidence to suggest that genetic, hormonal and intra-uterine factors seem to be important in influencing the direction of one's sexual orientation but developmental and environmental effects during childhood and adolescence do not. The scientific evidence, then, suggests a biological or genetic basis for sexual orientation, seemingly contradicting the psychodynamic developmental perspective (i.e., sexual orientation as Oedipally and/or

environmentally shaped) and the psychosocial perspective (i.e., sexual orientation as socially and culturally constructed).

However, the scientific evidence is more complicated than this. While embracing the scientific data, Bailey et al (2016) propose that we should not understand the scientific studies as offering a completely deterministic account of human sexuality or as ignoring the role of human agency. Rather the scientific studies suggest that people make choices about who they want to be, and how they want to live, within the constraints of biology and environment which they can neither choose nor change. So, while sexuality may have a genetic or biological basis, its meaning is still shaped within the context of culture and varies over time. Such a position allows a degree of accommodation between the scientific and the psychosocial points of view.

Similarly, in line with Auchincloss and Vaughan (2001), several interview participants (see section 5.3, theme two) thought that psychodynamic theories about sexuality, particularly the Oedipus complex, may still be useful therapeutic tools for thinking about aspects of sexuality and relating (e.g. thirdness, identification, omnipotence, generational conflict, rivalry/exclusion) so long as they are not assumed by practitioners to be 'scientific' theories of causation or aetiology of non-heterosexuality. In other words, certain interpretations of the Oedipus complex can still be usefully applied in therapeutic practice, but as Auchincloss and Vaughan (2001) propose, therapists must not commit the classical mistake of conflating Oedipal psychodynamics and developmental/aetiological causal theory of non-heterosexuality. There is an argument, then, for retaining those aspects of Oedipal theory/thinking that are valuable when working with sexuality and relating but locating these aspects within a broader theory of sexuality that incorporates insights from the sciences and other academic disciplines.

It is important, however, to acknowledge that some research participants were highly critical of the recent attempts to reformulate Oedipal theory. To these therapists, Oedipal theory will always have an in-built bias that reinforces conventional gender norms and overvalues heterosexuality. For these clinicians, retention of Oedipal theory is a form of misplaced nostalgia and a sign that the psychodynamic profession is out-of-touch. Those psychodynamic therapists who were influenced by social constructionist, feminist and queer perspectives were the most vocal about the need for psychodynamic profession to reject the Oedipal model outright. At the other extreme, we must also be mindful of the small minority of therapists who were not in favour of interdisciplinary exchange and who perceived the scientific data in particular as diluting the specificity of psychodynamic thinking about sexuality and/or as a reversion to a modernised version of a 19th century model based on heredity factors.

One creative solution to the theoretical and clinical questions being discussed here may be to locate therapists' thinking about gender, sexuality and relationship diversity within a wider biopsychosocial framework (Friedman and Downey 2002; Denman 2004; Lehmiller 2014; Barker 2016). A biopsychosocial framework may allow therapists to understand gender, sexuality and relationship diversity as multiply determined and informed by a complex interaction between the

biological (e.g., body, brain, genes), the psychological (e.g., interpersonal, intrapsychic, psychosexual) and the social (e.g., upbringing, relationships, cultural norms). None of the three approaches – the scientific, the psychological and the social – are sufficient on their own to account for the complexity inherent in human sexuality. While each approach has generated a compelling range of arguments and data (see the literature review), no singular approach has produced conclusive evidence to justify a definitive 'claim to knowledge'. At best, each approach can only offer a partial explanation. At present, a biopsychosocial model may offer the best theoretical framework to aid therapists' understanding of and clinical practice with LGB clients. Therapists' engagement with a biopsychosocial framework may also encourage the interdisciplinarity and critical thinking several research participants perceived to be lacking in existing psychodynamic models of sexuality.

A biopsychosocial account of human sexuality may help clinicians understand why individuals experience their sexuality and sexual orientation so differently, for instance why some people identify as exclusively gay/straight, while others experience their sexuality as something in flux and/or as fluid or why some people experience sexuality monosexually while others experience it bisexually. It is possible that we observe such wide variations in sexual experience and sexual subjectivity because the interplay between the biological, the psychological and the social is so individually unique for each of us. At a clinical level, a biopsychosocial model might translate as an open and non-judgemental therapeutic attitude and approach that: (1) pays minimal attention to the causes of sexual orientation and focuses more on meanings; (2) accepts all forms of gender, sexuality and relationship diversity within a broad spectrum of natural variance; (3) respects complexity and plurality in all clinical work relating to sexual orientation; and (4) encourages an ongoing questioning of assumptions and biases about sexuality and sexual development.

Other areas of theoretical and clinical contention identified from the research relate to bisexuality and transgender. As we have seen, therapists' understanding of bisexuality is not as fully developed as their understanding of gay male sexuality and lesbianism. The research also identifies a clear divergence of views amongst therapists in relation to transgender. These two aspects of gender and sexuality have not received anywhere near the same amount of theoretical and clinical revision as gay male sexuality and lesbianism. Therapists' difficulties in thinking about bisexuality and working with bisexual clients may be due to the dominant monosexual model of sexuality we have in the West. Therapists who identify as exclusively gay or exclusively straight may not have sufficiently developed erotic imaginations to work effectively with bisexual clients. Perhaps because Freud's theory of psychic bisexuality and Jung's theory of contrasexuality emphasised bisexuality as a psychological capacity to identify with both sexes, psychodynamic theorists have written less about bisexuality as a sexual orientation and therefore therapists may be less familiar with bisexuality as a sexual preference, behaviour and/or identity. We know that, in recent years, the concept of bisexuality as sexual orientation has received more academic and clinical attention (e.g., Eisner 2013) and in the literature review, I discussed how contemporary psychodynamic practitioners (e.g., Rapoport 2019) have re-examined bisexuality in light of new

and emerging disciplines such as bisexuality studies. As Rapoport (2019) illustrates, bisexuality studies offer psychodynamic therapists a new lens through which to view and conceptualise bisexuality. The research, then, has identified a gap in therapists' knowledge and practice base around the unique experiences of bisexual individuals and the need to respect diversity and ambiguity in clinical practice with bisexual clients.

In relation to transgender, the majority of therapists participating in the research seemed to be making the same theoretical and clinical mistakes they had historically made in relation to gay men and lesbians. When discussing transgender, there was an unquestioned heteronormativity and cisgenderism in some of the research participants' responses, exemplified in the enduring belief that being transgender was pathological in some way and represented a form of developmental trauma, likely stemming from an Oedipal origin. The research has highlighted the need to provide therapists with a foundational knowledge to work sensitively and in an informed way with transgender and gender nonconforming (TGNC) clients seeking therapy. In much the same way that therapists are now better informed about issues affecting gay men and lesbians, such foundational knowledge for supporting clinical work with TGNC clients might address the stigma, discrimination, developmental challenges and barriers to care experienced by this client group and consider a broadly interdisciplinary approach, covering perspectives from other relevant disciplines such as psychology, psychiatry, social work, endocrinology and urology, to name a few (see APA 2015).

On the whole, research participants were familiar with key debates relating to psychodynamic technique with LGB clients, including how to work with LGB-specific transference and countertransference dynamics and whether LGB therapists should self-disclose their sexual orientation to LGB clients. While there was good therapist awareness of these debates, there was also acknowledgement that more thought on and engagement with these technical questions was needed. This included, for example, therapists reflecting on the ways in which self-disclosure of sexual orientation may impede (as well as enhance) the transference and phantasy work with LGB clients. Therapists also recognised that their countertransference responses towards LGB clients differed depending on: (1) the particular configuration of sexual orientation and gender in the therapeutic dyad (e.g., lesbian client and heterosexual male therapist or bisexual male client and lesbian therapist), and (2) the specific issues, discrimination and developmental challenges LGB clients may have encountered growing up. It was difficult for therapists to discuss all the intricacies of the transference and countertransference in clinical practice with LGB clients: therapist-client dyads and client life histories were so unique and variable. The overall feeling, however, was that most therapists considered their therapeutic work LGB clients to be similar to therapeutic work with non-LGB clients. Therapists seemed to broadly accept that, regardless of sexual orientation, each therapeutic couple will create its own dynamics and both therapist and client will provoke a wide range of affects, phantasies and associations in each other. Sexual orientation appears to be only one factor shaping the therapeutic relationship.

There was a polarised response from therapists about whether LGB client preferences for LGB therapists should be accommodated. Although there is very little specific data about the extent to which accommodating preferences for psychotherapy based on client sexual orientation impacts on clinical outcomes, evidence suggests, on the whole, that client preference accommodation facilitates better psychotherapy outcomes (Swift et al 2018). Until there is more data in this area, therapists may wish to accommodate LGB client preferences through making a specific referral to a LGB therapist where this is possible. Where LGB client preferences cannot be met, therapists may need to ensure their understanding of LGB specific issues is fully up to date as well as explore the individual client's preferences as part of the therapy in order to build up trust.

The research identified several associations between psychodynamic therapists' demographic, sociocultural and professional characteristics and their views on and clinical practice with LGB clients. However, as the chi-squared (χ^2) tests in my study were limited by their lack of statistical power and the risk of spurious results from multiple testing, we cannot regard any of the associations between therapists' personal and professional attributes and their therapeutic and professional views about same-sex sexual orientation as indicating anything more than trends that need confirmation in further research.

Research Question 2: In what ways has psychodynamic training on sexual orientation shaped the views and practice of UK psychodynamic psychotherapists working with lesbian, gay and bisexual (LGB) clients?

The questionnaire (section 4.14) and interview results (section 5.11, theme ten) indicate that, on the whole, therapists feel insufficiently prepared for clinical practice with LGB clients. While therapists' accounts indicate that some BPC training organisations have a more inclusive approach to teaching sexuality and occasionally deliver broader modules addressing diversity and difference, most therapists report having received very little training on sexual orientation. Where training on sexuality has been received, therapists report that, largely, this training presented same-sex sexual orientation as pathology and/or as perversion, and often without providing historical contextualisation or indicating that many classical ideas and concepts have been revised and reformulated by contemporary practitioners and theorists. It is also clear from therapists' accounts that Oedipal theory remains the key staple of psychodynamic teaching on sexuality, and as discussed earlier, there is a tension amongst therapists about the primacy given to Oedipal theory in psychodynamic trainings. In addition to their psychodynamic theories about same-sex sexual orientation, the research indicates that psychodynamic therapists may benefit from being better acquainted with the wider cultural and scientific evidence about sexual orientation that more fully accounts for and reflects LGB sexualities, including the evidence base demonstrating that: (1) sexuality has some biological and genetic basis; and (2) its meaning is inextricably shaped by cultural, social and historical factors. This may involve a significant broadening of the psychodynamic curriculum on sexuality and sexual orientation. As previously hinted, trainings may wish to introduce some biopsychosocial perspectives on sexuality and sexual orientation in order to achieve a more balanced and varied syllabus in this area.

Furthermore, several research participants seemed to think it was important for trainings to provide opportunities for therapists/trainees to reflexively engage with their own assumptions – and cultural norms – around gender, sexuality and relationship diversity. I am mindful, however, that the questionnaire and interview samples consisted of a much older therapist demographic and some of these older therapists may have been recalling the training environment of a few decades ago. Teaching in this area may be more varied today than some of these older therapists realise. On the other hand, I also interviewed several senior therapists who were currently involved in curriculum development and teaching and who were fully informed about the present teaching landscape at their training organisation. It is likely, therefore, that the overall picture presented in the thesis is accurate and realistic.

At the institutional level, therapists' accounts were mixed. The findings indicate that while some BPC training organisations were moving in the direction of greater organisational equality and were implementing policies that were consistent with the BPC Position Statement (2011), other organisations appeared to have made only minor changes and the BPC Position Statement had inspired minimal institutional reform. The research raises questions about how equitably LGB colleagues are treated compared to non-LGB colleagues and whether there may be barriers (real or perceived) to LGB career progression within training organisations. There is also data to indicate that anti-LGB discrimination persists at many organisational levels. This is particularly evident at candidate selection interviews, where some LGB therapists recalled being asked for unnecessary details about their sex lives. Such questioning is wholly inappropriate and does not conform to the principles outlined in the BPC Position Statement. The purpose of selection interviews is to identify a candidate's suitability for training and aptitude for psychodynamic work: a candidate's sex life is private and should have no bearing on such decisions. However, it is important to acknowledge that there are some positive LGB therapist accounts too. Not all LGB therapists felt their sexuality had been an object for scrutiny and reported feeling valued at their training organisation for the skills, experience and knowledge they brought with them.

On the whole, however, the data from both the questionnaire and interviews suggests that the majority of BPC training organisations are complacent about LGB issues, or worse, are in denial about the need to implement change. There appears to be a lack of transparency about how issues of gender, sexuality and relationship diversity are thought about across the profession. Psychodynamic training organisations appear, for the most part, to be highly hierarchical, conservative and parochial, where it is difficult for new voices to emerge and for new ways of doing things to take root. During the interview field work, I was aware that interviewees were anxious when talking about their organisations, seemingly wanting to voice loyalty to their organisation but, in many ways, also being deeply ambivalent about their organisation's approach and attitudes towards same-sex sexuality. The data also suggests that some BPC training organisations are in a state of transition: wanting to embrace change but not really being sure how to implement reform. With very few openly 'out' LGB psychodynamic therapists within BPC training organisations, it has been difficult to challenge prejudice and discrimination from within.

The research hinted at several ways that BPC training organisations might create professional and learning environments where diversity and inclusion may be discussed openly and without censure. These included: (1) creating an open and inclusive environment where LGB colleagues feel more at ease and are able to be openly 'out'; (2) putting robust procedures in place for LGB trainees and colleagues to report homophobic behaviour; (3) recruiting more LGB colleagues to the teaching programme/faculty; and (4) making LGB colleagues more visible in positions of power, influence and decision making within psychodynamic training organisations (e.g. President, Training Analyst), so LGB trainees and colleagues can see themselves reflected at senior level. There may be a case for positive discrimination here if this could be done without reinforcing a sense of difference or offering special treatment. Positive discrimination could be perceived as affirming and valuing LGB members and their contributions to the organisation. These simple measures would be in keeping with the BPC's Position Statement (2011). Given the mixed picture emerging from the data and the fact that BPC training organisations differ in terms of size and resource, curriculum reform and institutional change may take time to implement and are likely to be longer-term projects for the psychodynamic profession in the UK.

6.5 Contribution to Knowledge

This research study makes a modest, two-fold original contribution to knowledge.

Contribution One: The research provides an up-to-date descriptive analysis of psychodynamic theoretical, clinical and professional attitudes towards same-sex sexual orientation

The research aimed to redress the limitations of previous attitudes studies by: (1) addressing broader therapeutic issues than just conversion therapy (e.g., LGB therapists' self-disclosure of sexual orientation, transference and countertransference dynamics in psychotherapy work with LGB clients); (2) considering clinical attitudes towards bisexuals in addition to gay and lesbian clients; (3) adding questions relating to the training and organisational context alongside questions of theory and technique; (4) adopting a mixed methods approach (i.e., self-completion questionnaire plus semi-structured interviews) so data can be triangulated and synthesised; and (5) restricting the research focus to the attitudes and experiences of psychodynamic therapists only. My study updates existing UK-specific research in this area (e.g., Bartlett, Smith and King 2009; Ciclitira and Foster 2012).

Contribution Two: The research produces relevant and timely data on psychodynamic therapists' attitudes towards same-sex sexual orientation, which can be used to effect change within the UK psychodynamic profession

The research findings can be used as starting point for a re-evaluation of psychodynamic thinking, technique and training in relation to same-sex sexual orientation. As outlined in the Impact Statement (see above), the results and discussion can be used to: (1) complement existing

guidelines for psychological practice with LGB clients; (2) influence change within psychodynamic training organisations, for example by updating the content of clinical training to more fully reflect LGB lives and concerns; and (3) inform BPC policy work in this area, particularly its commitment to developing diverse professional identities across the UK psychodynamic psychotherapy field.

6.6 Future Directions

Future research in this area of study could:

1. Investigate more closely the relationship between psychodynamic therapists' demographic, sociocultural and professional characteristics and their views on same-sex sexual orientation and clinical work with LGB clients.

2. Examine psychodynamic therapists' clinical attitudes towards gender, sexuality and relationship diversity (GSRD) more broadly, including intersectional considerations, such as how a person's experience of their sexual orientation intersects with other aspects of their identity, including gender, race, class, disability, cultural background, faith, age etc.

3. Explore LGB clients' experiences of therapy with psychodynamic therapists. My PhD study only provides one side of the story. In particular, it might be useful to see how LGB clients view the therapeutic relationship with psychodynamic practitioners (e.g., LGB clients' views on LGB therapists' self-disclosure of their sexual orientation).

4. Involve other UK counselling and psychotherapy bodies, including the British Association for Counselling and Psychotherapy (BACP) and the UK Council for Psychotherapy (UKCP), in a joint study exploring clinical attitudes towards all aspects of gender, sexuality and relationship diversity (GSRD) and comparing psychodynamic and non-psychodynamic therapists across the UK to identify differences in theory and practice.

5. Involve the International Psychoanalytical Association (IPA) and the International Association of Analytical Psychology (IAAP) in a global study exploring clinical attitudes towards all aspects of gender, sexuality and relationship diversity (GSRD) and making comparisons between countries to identify international trends and patterns in theory and practice.

6.7 Chapter Summary

This chapter has discussed the research participants, reviewed the methodological strengths and limitations of the research and highlighted 16 main results. I have also reflected on my own understanding of the data and the data's implications for the profession. My study's contribution to knowledge has been briefly outlined and some future directions for research have been recommended.

6.8 Concluding Remarks

In addition to their psychodynamic theories about same-sex sexual orientation, psychodynamic therapists may benefit from being better acquainted with the wider cultural and scientific evidence about sexual orientation that more fully accounts for and reflects LGB sexualities, particularly the evidence demonstrating that, while sexuality may have a biological and genetic basis, its meaning is inextricably shaped by cultural, social and historical contexts. UK psychodynamic training organisations must continue their efforts to create a learning and professional environment that is non-discriminatory to LGB individuals. This may involve a broadening of the psychodynamic curriculum on sexuality and further institutional reform consistent with the BPC equality and non-discrimination polices. The study contributes to knowledge by providing an up-to-date, descriptive analysis of UK psychodynamic therapists' theoretical and clinical thinking about same-sex sexual orientation, consolidating findings from previous empirical attitudes research in this area.

Reference List

Academy of Science of South Africa (ASSAF) (2015). *Diversity in human sexuality: implications for policy in Africa*. Pretoria: Academy of Science of South Africa. Available at: http://www.assaf.co.za/wp-content/uploads/2015/06/8-June-Diversity-in-human-sexuality1.pdf. A Last accessed: 09.07.2020.

Adams, J., Dickinson, P. and Asiasgia, L. (2013). Mental health issues for lesbian, gay, bisexual and transgender people: a qualitative study. *International Journal of Mental Health Promotion*, 15(2): 105-120.

Alexander, J. and Anderlini-D'Onofrio, S. (2012). *Bisexuality and Queer Theory: Intersections, Connections and Challenges.* London: Routledge.

American Psychological Association (APA) Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009). *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Washington, DC: American Psychological Association.

American Psychological Association (APA) (2012). Guidelines for psychological practice with lesbian, gay and bisexual clients. *American Psychologist*, 67 (1): 10-42.

American Psychological Association (APA) (2015). Guidelines for psychological practice with transgender and gender non-conforming people. *American Psychologist*, 70 (9): 832-864.

Armitage, A. (2007). Mutual research designs: redefining mixed methods research design. Paper presented at the British Educational Research Association Annual Conference, Institute of Education, University of London, 5th - 8th September 2007. Available at: http://www.leeds.ac.uk/educol/documents/167799.htm. Last accessed: 09.07.2020.

Ashford, C. (2012). Heterosexuality, public places and policing. In: P. Johnson and E. Dalton (eds.), *Policing Sex*. London: Routledge, pp. 41-53.

Auchincloss, E. L. (2015). *The Psychoanalytic Model of the Mind.* Arlington: American Psychiatric Association Publishing.

Auchincloss, E. L. and Samberg, E. (2012). *Psychoanalytic Terms and Concepts*. New Haven: University Press.

Auchincloss, E. L. and Vaughan, S. C. (2001). Psychoanalysis and homosexuality: do we need a new theory? *Journal of the American Psychoanalytic Association,* 49: 1157-1186.

Ault, A. (1996). Ambiguous identity in an unambiguous sex/gender structure: the case of bisexual women. *Sociological Quarterly*, 37 (3): 449-463.

Bacon, C. L. (1956). A developmental theory of female homosexuality. In: S. Lorand and M. Balint (eds.), *Perversions: Psychodynamics and Therapy*. New York: Random House, pp. 131-160.

Bailey, J. M. and Benishay, D. S. (1993). Familial aggregation of female sexual orientation. *American Journal of Psychiatry*, 150 (2): 272-277.

Bailey, J. M. and Pillard, R. C. (1995). Genetics of human sexual orientation. *Annual Review of Sex Research*, 6: 126-150.

Bailey, J. M., Dunne, M. P. and Martin, N. G. (2000). Genetic and environmental influences on sexual orientation and its correlates in an Australian twin sample. *Journal of Personality and Social Psychology*, 78: 524-536.

Bailey, M. J., Vasey, P. L., Diamond, L. M., Breedlove, S. M., Vilain, E. and Epprecht, M. (2016). Sexual orientation, controversy and science. *Psychological Science in the Public Interest*, 178: 45-101.

Bailly, L. (2009). *Lacan: Beginner's Guide*. Oxford: Oneworld.

Bailly, L. (2018) Lacan's version of the Oedipus Complex. In: L. Bailly, D. Lichtenstein and S. Bailly (eds.), *The Lacan Tradition*. Oxon: Routledge, pp. 97-108

Bailly, S. (2018) Editors' introduction. In: L. Bailly, D. Lichtenstein and S. Bailly (eds.), *The Lacan Tradition*. Oxon: Routledge, pp. 95-96.

Bak, R. (1956). Aggression and perversion. In: S. Lorand and M. Balint (eds.), *Perversions: Psychodynamics and Therapy*. New York: Random House, pp. 231-240.

Balint, M. (1956). Perversions and genitality. In: S. Lorand and M. Balint (eds.), *Perversions: Psychodynamics and Therapy*. New York: Random House, pp. 16-27.

Bao, A. M. and Swaab, D. F. (2011). Sexual differentiation of the human brain: relation to gender identity, sexual orientation and neuropsychiatric disorders. *Frontiers in Neuroendocrinology*, 32 (2): 214-226.

Baraitser, L. (2019). Introduction. *Studies in Gender and Sexuality*, 20 (4): 209-213.

Baraitser, L. (2015a). Psychoanalysis and feminism and… *Psychoanalysis, Culture and Society,* 20 (2): 151-159.

Baraitser, L. (2015b). Temporal drag: transdisciplinarity and the 'case' of psychosocial studies. *Theory, Culture and Society*, 32 (5-6): 207-231.

Barden, N. (2015). Disrupting Oedipus: the legacy of the Sphinx. In: A. Lemma and P. E. Lynch (eds.), *Sexualities: Contemporary Analytic Perspectives*. London: Routledge, pp. 81-100.

Barker, C., Pistrang, N. and Elliot, R. (2016). *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners* (3rd edn.). Wessex: Blackwell.

Barker, M-J. (2016). *Queer: A Graphic Story*. London: Icon Books.

Bartlett, A., King, M. and Phillips, P. (2001). Straight talking: an investigation of the attitudes and practice of psychoanalysts and psychotherapists in relation to gays and lesbians. *British Journal of Psychiatry*, 179: 545-549.

Bartlett, A., Smith, G. and King, M. (2009). The response of mental health professionals to clients seeking help to change or redirect same-sex sexual orientation. *BMC Psychiatry*, 9: 11.

Bazeley, P. and Jackson, K. (2013). *Qualitative Data Analysis with NVivo*. London: Sage Publications.

Beasley, C. (2005). *Gender and Sexuality: Critical Theories, Critical Thinkers.* London: Sage Publications.

Beckstead, A. L. (2012). Can we change sexual orientation? *Archive of Sexual Behaviour,* 41: 121-134.

Bell, J. (2010). *Doing Your Research Project: A Guide for First-time Researchers in Education, Health and Social Sciences*. London: Open University Press.

Benjamin, J. (1991) Father and daughter: identification with difference – a contribution to gender heterodoxy. *Psychoanalytic Dialogues*, 1 (3): 277-299.

Benjamin, J. (1998). *The Shadow of the Other: Intersubjectivity and Gender in Psychoanalysis.* New York: Routledge.

Bepko, C. and Johnson, T. (2000). Gay and lesbian couples in therapy: perspectives from the contemporary family therapist. *Journal of Marital and Family Therapy*, 26 (4): 409-419.

Bergler, E. (1944). Eight prerequisites for the psychoanalytic treatment of homosexuality. *Psychoanalytic Review*, 31: 253-286.

Bergler, E. (1956). *Homosexuality: Disease or Way of Life*. New York: Hill and Wang.

Berman-Brown, R. and Saunders, M. (2008). *Dealing with Statistics: What You Need to Know*. Maidenhead: Open University Press.

Bethlehem, J. (2008). Weighting. In: P. J. Lavrakas (ed.), *Encyclopedia of survey research methods*. Thousand Oaks, CA: SAGE Publications, pp. 958-960

Bieber, I. (1962). *Homosexuality: A Psychoanalytic Study*. New York: Basic Books.

Bieber, I. (1965). Clinical aspects of male homosexuality. In: J. Marmor, (ed.), *Sexual Inversion: The Multiple Roots of Homosexuality*. New York: Basic Books, pp. 248-267.

Blanchard, R. and Zucker, K. J. (1994). Re-analysis of Bell, Weinberg, and Hammersmith's data on birth order, sibling sex ratio, and parental age in homosexual men. *American Journal of Psychiatry*, 151 (9): 1375-1376.

Blanchard, R., Zucker, K. J., Bradley, S. J. and Hume, C. S. (1995). Birth order and sibling sex ratio in homosexual male adolescents and probably prehomosexual feminine boys. *Developmental Psychology*, 31 (1): 22-30.

Blaxter, L., Hughes, C. and Tight, M. (2010). *How to Research*. Maidenhead: Open University Press.

Blechner, M. (1993). Homophobia in psychoanalytic writing and practice – commentary on Trop and Stolorow's 'defense analysis in self psychology: a developmental view' and Hanna's 'false-self sensitivity to countertransference: anatomy of a single session'. *Psychoanalytic Dialogues*, 3 (4): 627-637.

Blechner, M. J. (1998). Maleness and masculinity. *Contemporary Psychoanalysis*, 34 (4): 597-613.

Blechner, M. J. (2015). Bigenderism and bisexuality. *Contemporary Psychoanalysis*, 51 (3): 503-522.

Blosnich, J. and Bossarte, R. (2012). Drivers of disparity: difference in socially based risk factors of self-injurious and suicidal behaviours among sexual minority college students. *Journal of American College Health,* 60 (2): 141-149.

Blumstein, P. W. and Schwartz, P. (1977). Bisexuality: some psychological issues. *Journal of Social Issues*, 33 (2): 30-45.

Bogaert, A. F. (2003). Number of older brothers and sexual orientation: new tests and the attraction/behaviour distinction in two national probability samples. *Journal of Personality and Social Psychology*, 84 (3): 644-652.

Bogaert, A. F. and Skorska, M. (2011). Sexual orientation, fraternal birth order and the maternal immune hypothesis: a review. *Frontiers in Neuroendocrinology*, 32 (2): 247-254.

Bonaparte, M. (1951). *Female Sexuality*. Paris: Presse Universitaire de France.

Bond Stockton, K. (2017). Jouissance: the gash of bliss. In: N. Giffney and E. Watson (eds.), *Clinical Encounters in Sexuality: Psychoanalytic Practice and Queer Theory*. Brooklyn, NY: Punctum Books, pp. 101-122.

Boomsma, D., Busjahn, A. and Peltonen, L. (2002). Classical twin studies and beyond. *Nature Reviews Genetics*, 3 (11): 872-882.

Borden, L. A., Lopresto, C. T., Sherman, M. F. and Lyons, H. Z. (2010). Perceptions of self-disclosing counsellors among lesbian, gay, and bisexual individuals. *Journal of LGBT Issues in Counselling*, 4 (2): 54-69.

Braun, V. and Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners.* London: Sage Publications.

Brill, A. (1934). Homoeroticism and paranoia. *American Journal of Psychiatry*, 13: 957-74.

British Association for Counselling and Psychotherapy (BACP) (2017). Good practice across the counselling professions: gender, sexuality and relationship diversity. Available at: https://www.bacp.co.uk/media/5877/bacp-gender-sexual-relationship-diversity-gpacp001-april19.pdf. Last accessed: 09.07.2020

British Psychological Society (2019). Guidelines for psychologists working with gender, sexuality and relationship diversity. Available at: https://www.bps.org.uk/news-and-policy/guidelines-psychologists-working-gender-sexuality-and-relationship-diversity. Last accessed: 09.07.2020.

Britton, R. (1988) *Belief and Imagination.* London: Routledge.

Bryman, A. (2012). *Social Research Methods.* Oxford: Oxford University Press.

Burch, B. (1997). *Other Women: Lesbian/Bisexual Experience and Psychoanalytic Views of Women*. New York: Columbia University Press.

Butler, J. (1990). *Gender Trouble*. London: Routledge.

Callegaro, M. (2008). Social desirability. In P. J. Lavrakas (ed.), *Encyclopaedia of Survey Research Methods*. Thousand Oaks, CA: Sage Publications, pp. 826-826.

Camperio-Ciani, A., Corna, F. and Capiluppi, C. (2004). Evidence for maternally inherited factors favouring male homosexuality and promoting female fecundity. *Proceedings of the Royal Society: Biological Sciences*, *271* (1554): 2217-2221.

Castillo-Montoya, M. (2016). Preparing for interview research: the interview protocol refinement framework. *Qualitative Report*, 21 (5): 811-831.

Chakraborty, A., McManus, S., Brugha, T. S., Bebbington, P. and King, M. (2011). Mental health of the non-heterosexual population of England. *British Journal of Psychiatry*, 198: 143-148.

Chodorow, N. (1978). *The Reproduction of Mothering, Psychoanalysis and the Sociology of Gender*. Berkeley: University of California Press.

Chodorow, N. (1994). *Femininities, Masculinities, Sexualities.* Lexington: University of Kentucky Press.

Ciclitira, K. and Foster, N. (2012). Attention to culture and diversity in psychoanalytic trainings. *British Journal of Psychotherapy,* 28 (3): 353-373.

Clark, T. and Foster, L. (2015). Chi-squared: introducing the 'goodness of fit' test and the 'test of association'. University of Sheffield and Higher Education Academy. Available at: http://www.social-policy.org.uk/wordpress/wp-content/uploads/2015/02/workbook-4-01.2.15-BEST-FOR-SPA.pdf. Last accessed: 09.07.2020.

Clarke, V., Ellis, S. J., Peel, E. and Riggs, D. W. (2016). *Lesbian, Gay, Bisexual, Trans and Queer Psychology* (3rd edn.). Cambridge: Cambridge University Press.

Cohen, J. N. and Byers, E. S. (2014). Beyond the lesbian bed death: enhancing our understanding of the sexuality of sexual minority women in relationships. *Journal of Sex Research*, 51 (8): 893-903.

Cohler, B. J. and Galatzer-Levy, R. M. (2000). *The Course of Gay and Lesbian Lives: Social and Psychoanalytic Perspectives.* London: University of Chicago.

Cohler, B. J. and Galatzer-Levy, R. M. (2013). The historical moment in the analysis of gay men. *Journal of the American Psychoanalytic Association*, 61 (6): 1139-1173.

Corbett, K. (1993). The mystery of homosexuality. *Psychoanalytic Psychology*, 10: 345-357.

Corliss, K. L., Cochran, S. D., Mays, V. M., Greenland, S. and Seeman, T. E. (2009). Age of minority sexual orientation development and risk of childhood maltreatment and suicide attempts in women. *American Journal of Orthopsychiatry*, 79 (4): 511-521.

Côté, L. and Turgeon, J. (2005). Appraising qualitative research articles in medicine and medical education. *Medical Teacher,* 27 (1): 71-75.

Coxon, P. M. and McManus, T. J. (2000). How many account for how much? Concentration of high-risk sexual behaviour among gay men. *The Journal of Sex Research*, 37 (1): 1-7.

Craib, I. (2001). *Psychoanalysis: A Critical Introduction.* Cambridge: Polity.

Cramer, R. J., Golom, F. D., LoPresto, C. T. and Kirkley, S. M. (2008). Weighing the evidence: empirical assessment and ethical implications of conversion therapy. *Ethics and Behaviour*, 18 (1): 93-114.

Danzer, G. S. (2019). Sexuality. In: G. S. Danzer (ed.), *Therapist Self-Disclosure: An Evidence Based Guide for Practitioners.* Oxon: Routledge, pp. 71-81.

Daumer, E. (1992). Queer ethics or the challenge of bisexuality to lesbian ethics. *Hypatia*, 7 (4): 90-105.

David, C. (2018). The beautiful differences. In: R. J. Perelberg (ed.), *Psychic Bisexuality: A British-French Dialogue*. London: Routledge, pp. 58-80.

Davidson, C. (2009). Transcription: imperatives for qualitative research. *International Journal of Qualitative Methods*, 8 (2): 36-52.

Davis, C. (2013). *SPSS Step by Step: Essentials for Social and Political Science*. Bristol and Chicago: Policy Press.

Dawood, K., Bailey J. M. and Martin N. G. (2009). Genetic and environmental influences on sexual orientation. In Y.-K. Kim (ed.), *Handbook of Behaviour Genetics*. Springer: New York, pp. 269-279.

Dean, J. (2017). *Doing Reflexivity: An Introduction*. Bristol and Chicago: Policy Press.

Dean, T. and Lane, C. (2001). *Homosexuality and Psychoanalysis*. London: University of Chicago.

Denman, C. (2004). *Sexuality: A Biopsychosocial Approach.* Hampshire: Palgrave.

Denton, F. N. (2012). Minority stress and physical health in lesbians, gays, and bisexuals: the mediating role of coping self-efficacy (doctoral thesis). Available at: http://uknowledge.uky.edu/edp_etds/2/. Last accessed: 09.07.2020.

Deutsch, H. (1925). Psychology of women in relation to the functions of reproduction. *International Journal of Psychoanalysis*, 6: 405-418.

Deutsch, H. (1930). The significance of masochism in the mental life of women. *International Journal of Psychoanalysis*, 11: 48-60.

Deutsch, H. (1933). Homosexuality in women. *International Journal of Psychoanalysis,* 14: 34-56.

Deutsch, L. (1995). Out of the closet and on to the couch: a psychoanalytic exploration of lesbian development. In: J. M. Glassgold and S. Iasenza (eds.), *Lesbians and Psychoanalysis: Revolutions in Theory and Practice*. New York: Free Press, pp. 19-37.

Diamond, L. M. (2008). *Sexual Fluidity: Understanding Women's Love and Desire*. London: Harvard University Press.

DiFluvio, G. T. (2011). Sexual minority youth, social connection and resilience: from personal to collective identity. *Social Science and Medicine*, 72 (10): 1611-1617.

Dimen, M. (1995). Introduction. *Psychoanalytic Dialogues*, 5 (2): 157-163.

Dimen, M. (2001). Perversion is us? Eight notes. *Psychoanalytic Dialogues*, 11: 825-860.

Dimen, M. and Goldner, V. (2012). Gender and sexuality. In: G. O. Gabbard, B. E. Litowitz and P. Williams (eds.), *Textbook of Psychoanalysis* (2nd edn.). Washington, DC: American Psychiatric Publishing, pp. 133-152.

Domenici, T. and Lesser, R. C. (1995). *Disorienting Sexuality: Psychoanalytic Reappraisals of Sexual Identities.* London: Routledge.

Downing, C. (1995). An archetypal view of lesbian identity. In: J. M. Glassgold and S. Iasenza (eds.), *Lesbians and Psychoanalysis: Revolutions in Theory and Practice*. New York: Free Press, pp. 265-285.

Downing, L. (2017). Perversion and the problem of fluidity and fixity. In: N. Giffney and E. Watson, (eds.), *Clinical Encounters in Sexuality: Psychoanalytic Practice and Queer Theory*. Brooklyn, NY: Punctum Books, pp. 123-144.

Drescher. J. (1995). Anti-homosexual bias in training. In: T. Domenici and R. C. Lesser (eds.), *Disorienting Sexuality: Psychoanalytic Reappraisals and Sexual Identities*. New York: Routledge, pp. 227-241.

Drescher, J. (1998). *Psychoanalytic Therapy and the Gay Man*. Hillside, NJ: Analytic Press.

Drescher, J. (2002). Causes and becauses: on etiological theories of homosexuality. *Annual of Psychoanalysis*, 30: 57-68.

Drescher, J. (2004). Homosexuality and its vicissitudes: the 'homosexual other' in psychoanalytic theory and praxis, Embodied Psyches/Life Politics' Seminar. CSISP, Goldsmith College, October 15th, 2004. Available at: https://www.researchgate.net/publication/238079111. Last accessed: 09.07.2020.

Drescher, J. (2007). From bisexuality to intersexuality: rethinking gender categories. *Contemporary Psychoanalysis*, 43: 204-228.

Drescher, J. (2008). A history of homosexuality and organised psychoanalysis. *Journal of the American Academy of Psychoanalysis*, 36: 443-460.

Drescher, J. (2010). Queer diagnoses: parallels and contrasts in the history of homosexuality, gender variance, and the diagnostic and statistical manual. *Archive of Sexual Behaviour,* 39: 427-460.

Eadie, J. (1993). Activating bisexuality: towards a bi/sexual politics. In: J. Bristow and A. R. Wilson (eds.), *Activating Theory: Lesbian, Gay and Bisexual Politics*. London: Lawrence and Wishart, pp. 139-170.

Eagly, A. H., Diekman, A. B., Johannesen-Schmidt M. C. and Koenig, A. M. (2004). Gender gaps in socio-political attitudes: a social psychological analysis. *Journal of Personality and Social Psychology*, 87: 796-816.

Eisenberg, M. E. and Resnick, M. D. (2006). Suicidality among gay, lesbian and bisexual youth: the role of protective factors. *Journal of Adolescent Health*, 39 (5): 662-668.

Eisner, S. (2013). *Bi: Notes for a Bisexual Revolution*. Berkeley, California: Seal Books.

Elise, D. (1998). Gender repertoire: body, mind, and bisexuality. *Psychoanalytic Dialogues*, 8: 379-397.

Elise, D. (2020). The primary maternal Oedipal situation and female homoerotic desire. In: L. Hertzmann, and J. Newbigin (eds.), *Sexuality and Gender Now: Moving Beyond Heteronormativity*. London: Routledge, pp. 104-120.

Engel, G. L. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry,* 137 (5): 535-544.

Ellis, M. (1994). Lesbians, gay men and psychoanalytic training. *Free Associations*, 4 (D): 501-517.

Elliott, R., Fischer, C. T. and Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38: 215-229.

Elliott, M. N., Kanouse, D. E., Burkhart, Q., Abel, G. A., Lyratzopoulos, G., Beckett, M. K. and Roland, M. (2015). Sexual minorities in England have poorer health and worse health care experiences: a national survey. *Journal of General Internal Medicine*, 30 (1): 9-16.

Evans, D. (1996). *An Introductory Dictionary of Lacanian Psychoanalysis*. London: Routledge.

Fast, I. (1984). *Gender Identity: A Differentiation Model*. Hillside, NJ: Analytic Press.

Ferenczi, S. (1912). On the part played by homosexuality in the pathogenesis of paranoia. In: *First Contributions to Psychoanalysis*. London: Karnac, pp. 154-184.

Ferraro, F. (2003). Psychic bisexuality and creativity. *International Journal of Psychoanalysis*, 84: 1451-1467.

Flanders, S. (2018). French psychoanalysis and Lacan. In: L. Bailly, D. Lichtenstein and S. Bailly (eds.), *The Lacan Tradition*. Oxon: Routledge, pp. 53-71.

Flick, U. (2014). *An Introduction to Qualitative Research* (5th edn.). London: Sage Publications.

Flower, S. (2007). On the slopes of Brokeback Mountain: countertransference impediments to an analytic attitude in work with gay men. *British Journal of Psychotherapy,* 23: 431-443.

Fonagy, P. (2008). A genuinely developmental theory of sexual excitement and its implications for psychoanalytic technique. *Journal of the American Psychoanalytic Association*, 56 (1): 11-36.

Fonagy, P. (2009). Psychosexuality and psychoanalysis: an overview. In: P. Fonagy, R. Krause and M. Leuzinger-Bohleber (eds.), *Identity, Gender and Sexuality: 150 Years After Freud*. London: Karnac, pp. 1-19.

Fonagy, P., and Target, M. (2003). Psychoanalytic Theories: Perspectives from Developmental Psychopathology. London: Whurr Publishers.

Ford, C. S. and Beach, F. A. (1951). *Patterns of Sexual Behaviour.* New York: Harper and Row.

Foucault, M. (1976). *The History of Sexuality 1: The Will to Knowledge*. London: Penguin Books.

Freud, S. (1905a). *Three Essays on the Theory of Sexuality*. Standard Edition 7. London: Hogarth.

Freud, S. (1905b). "Fragment of an Analysis of a Case of Hysteria" (Dora). Standard Edition 7. London: Hogarth.

Freud, S. (1908). Hysterical Phantasies and their relation to Bisexuality. Standard Edition 7. London: Hogarth.

Freud, S. (1909a). "Analysis of a Phobia in a Five-Year-Old Boy" (Little Hans). Standard Edition 10. London: Hogarth.

Freud, S. (1909b). "Notes upon a Case of Obsessional Neurosis". (Rat man) Standard Edition 10. London: Hogarth.

Freud, S. (1910). *Leonardo Da Vinci and a Memory of his Childhood.* Standard Edition 11. London: Hogarth.

Freud, S. (1911). "Psychoanalytic Notes on an Autobiographical Account of a Case of Paranoia. Standard Edition 12. London: Hogarth.

Freud, S. (1914). "On Narcissism: An Introduction". Standard Edition 14. London: Hogarth.

Freud, S. (1915). "A Case of Paranoia Running Counter to the Psychoanalytic Theory of the Disease". Standard Edition 14. London: Hogarth

Freud, S. (1918). "From the History of an Infantile Neurosis" (the Wolf Man). Standard Edition 17. London: Hogarth.

Freud, S. (1920). "The Psychogenesis of a Case of Homosexuality in a Woman". Standard Edition 18. London: Hogarth.

Freud, S. (1923a). *The Ego and the Id.* Standard Edition 19. London: Hogarth.

Freud, S. (1923b). “The Infantile Genital Organisation: An Interpolation into the Theory of Sexuality. Standard Edition 19. London: Hogarth.

Freud, S. (1924). “The Dissolution of the Oedipus Complex.” Standard Edition 19. London: Hogarth.

Freud, S. (1925). “Some Physical Consequences of the Anatomical Distinction between the Sexes”. Standard Edition 19. London: Hogarth.

Freud, S. (1926). *The Question of Lay Analysis.* Standard Edition 20. London: Hogarth.

Freud, S. (1930). *Civilisation and Its Discontents.* Standard Edition 21. London: Hogarth

Freud, S. (1931). “Female Sexuality”. Standard Edition 22. London: Hogarth.

Friedman, R. C. (1988). *Male Homosexuality: A Contemporary Psychoanalytic Perspective*. New Haven: Yale University Press.

Friedman, R. C. and Downey, J. I. (1995). Internalized homophobia and the negative therapeutic reaction. *Journal of American Academy of Psychoanalysis*, 23: 99-113.

Friedman, R. C. and Downey, J. I. (1998). Psychoanalysis and the model of homosexuality as psychopathology: a historical overview. *American Journal of Psychoanalysis*, 58: 249-270.

Friedman R. C. and Downey, J. I. (1999). Internalized homophobia and gender-valued self-esteem in the psychoanalysis of gay patients. *Psychoanalytic Review,* 86: 325-347.

Friedman, R. C. and Downey, J. I. (2002). *Sexual Orientation and Psychodynamic Psychotherapy: Sexual Science and Clinical Practice*. New York: Columbia University Press.
Friedman, R. C. and Downey J. I. (2008). Homosexuality: psychotherapeutic issues. *British Journal of Psychotherapy*, 24: 429-466.

Friedman, R. C. and Lilling, A. A. (1996). An empirical study of the beliefs of psychoanalysts about scientific and clinical dimensions of male homosexuality. *Journal of Homosexuality,* 32 (2): 79-89.

Friedman R. M. (1986). The psychoanalytic model of male homosexuality: a historical and theoretical critique. *Psychoanalytic Review*, 73 (D): 79-115.

Frommer, M. S. (1994). Homosexuality and psychoanalysis: technical considerations revisited. *Psychoanalytic Dialogues*, 4: 215-233.

Frommer, M. S. (2000). Offending gender: being and wanting in male same-sex desire*. Studies in Gender and Sexuality*, 1: 191-206.

Frosh, S. (2012). *A Brief Introduction to Psychoanalytic Theory.* Hampshire: Palgrave.

Frosh, S. (2017). A plague on both your houses. In: N. Giffney and E. Watson (eds.), *Clinical Encounters in Sexuality: Psychoanalytic Practice and Queer Theory*. Brooklyn, NY: Punctum Books, pp. 385-390.

Frosh, S. and Baraitser, L. (2008). Psychoanalysis and psychosocial studies. *Psychoanalysis, Culture and Society,* 13 (4): 346-365.

Full, W. (2013). A critical reappraisal of psychoanalytic approaches to male homosexuality (master's thesis). Psychoanalysis Unit, University College London (UCL).

Furber, C. (2010). Framework analysis: a method for analyzing qualitative data. *African Journal of Midwifery and Women's Health*, 4 (2): 97-100.

Gagnon, J. H., and Simon, W. (1973). Sexual Conduct: The Social Sources of Human Sexuality. London: Hutchinson and Co.

Gale, N. K., Heath, G., Cameron, E., Rashid, S. and Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, 13: 117.

Galsinski, D. and Kozlowska, O. (2010). Questionnaires and lived experience: strategies of coping with the quantitative frame. *Qualitative Inquiry,* 16 (4): 271-284.

Galatzer-Levy, R. M. and Cohler, B. J. (2002). Making a gay identity: coming out, social context and psychodynamics. *Annual of Psychoanalysis,* 30: 255-286.

Ganna, A., Verweij, K. J. H., Nivard, M. G., Maier, R., Wedow, R., Busch, A. S., Abdellaoui, A., Guo, S. J., Sathirapongsasuti, F., Lichtenstein, P., Lundström, S., Långström, N., Auton, A., Harris, K. M., Beecham, G .W., Martin, E. R., Sanders, A. R., Perry, J. R. B., Neale, B. M. and Zietsch, B. P. (2019). Large-scale genome-wide association study (GWAS) reveals insights into the genetic architecture of same-sex sexual behaviour. *Science,* 365 (6456): 869-870.

Garber, M. (1995). *Vice Versa: Bisexuality and the Eroticism of Everyday Life*. London: Penguin Books.

Gardner, G. (1931). Evidence of homosexuality in one hundred and twenty unanalysed cases with paranoid content. *Psychoanalytic Review*, 18: 57-62.

Garnets, L., Hancock, K. A., Cochran, S. D., Goodchilds, J. and Peplau, L. A. (1991). Issues in psychotherapy with lesbians and gay men: a survey of psychologists. *American Psychologist*, 46: 964-971.

Gay, P. (2006). *Freud: A Life for Our Time.* New York: W.W. Norton & Co.

Geldhof, A. and Verhaghe, P. (2017). Queer as a new shelter from castration. In: N. Giffney and E. Watson (eds.), *Clinical Encounters in Sexuality: Psychoanalytic Practice and Queer Theory*. Brooklyn, NY: Punctum Books, pp. 211-222.

Giaccardi, G. (2015). Same-sex desire through a post-Jungian lens. *New Associations*, 17: 3-4.

Giaccardi, G. (2020). Mending the symbolic when a place for same-sex desire is not found. In: L. Hertzmann and J. Newbigin (eds.), *Sexuality and Gender Now: Moving Beyond Heteronormativity*. London: Routledge, pp. 121-164.

Gibbs, G. (2007). *Analysing Qualitative Data*. London: Sage Publications.

Giffney, N. (2017). Introduction. In: N. Giffney and E. Watson, E. (eds.), *Clinical Encounters in Sexuality: Psychoanalytic Practice and Queer Theory*. Brooklyn, NY: Punctum Books, pp. 19-48.

Giffney, N. and Watson, E. (2017). *Clinical Encounters in Sexuality: Psychoanalytic Practice and Queer Theory*. Brooklyn, NY: Punctum Books.

Gillespie, W. (1956). The structure and aetiology of sexual perversion. In S. Lorand and M. Balint (eds.), *Perversions: Psychodynamics and Therapy*. New York: Random House, pp. 28-41.

Gillham, B. (2000). *Developing a Questionnaire*. London: Continuum.

Glasser, M. (1979). Some aspects of the role of aggression in sexual perversions. In: I. Rosen (ed.), *Sexual Deviance*. Oxford: Oxford University Press, pp. 278-305.

Glover, E., (1960). The problem of male homosexuality. In: Glover, E., *The Roots of Crime*: *Selected Papers in Psychoanalysis*. New York: International Universities Press, pp. 197-243.

Goldbach, J. T., Tanner-Smith, E. E., Bagwell, M. and Dunlap, S. (2014). Minority stress and substance abuse in sexual minority adolescents: a meta-analysis. *Prevention Science*, 15: 350-363.

Golden, C. (1987). Diversity and variability in women's sexual identities. In: Boston Lesbian Psychologies Collective (ed.), *Lesbian Psychologies: Aspirations and Challenges*. Urbana: University of Illinois Press, pp. 19-34.

Goldsmith, S. J. (1995). Oedipus or Orestes? Aspects of gender identity development in homosexual men. *Psychoanalytic Inquiry*, 15: 112-124.

Goldsmith, S. J. (2001). Oedipus or Orestes? Homosexual men, their mothers, and other women revisited. *Journal of the American Psychoanalytic Association*, 49 (4): 1269-1287.

Gray, C. D. and Kinnear, P. R. (2012). *IBM SPSS Statistics 19 Made Simple.* Hove and New York: Psychology Press.

Gray, D. E. (2014). *Doing Research in the Real World.* London: Sage.

Greasley, P. (2008). *Quantitative Data Analysis Using SPSS: An Introduction.* Maidenhead: Open University Press.

Green, R. J., Bettinger, M. and Zacks, E. (1996). Are lesbian couples fused and gay male couples disengaged? Questioning gender straightjackets. In: J. Laird and R. J. Green, (eds.), *Lesbians and Gays in Couples and Families: A Handbook for Therapists*. San Francisco: Jossey-Bass, pp. 185-230.

Grossman, G. (2002). Queering Psychoanalysis. *Annual of Psychoanalysis*, 30: 287-299.

Greene, J. C., Caracelli, V. J. and Graham, W. F. (1989). Towards a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis,* 11 (3): 255-274.

Guba, E. G. and Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In: N. K. Denzin and Y. S. Lincoln (eds.), *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publications, pp. 105-117.

Guidry, L. L. (1999). Clinical intervention with bisexuals: a contextualized understanding. *Professional Psychology: Research and Practice,* 30 (1): 22-26.

Guss, J. R. (2010). The danger of desire: anal sex and the homo/masculine subject. *Studies in Gender and Sexuality*, 11 (3): 124-140.

Guthrie, C. (2006). Disclosing the therapist's sexual orientation: the meaning of disclosure in working with gay, lesbian, and bisexual patients. *Journal of Gay and Lesbian Psychotherapy*, 10 (1): 63-77.

Haldeman, D. C. (2002). Gay rights, patient rights: the implications of sexual orientation conversion therapy. *Professional Psychology: Research and Practice*, 33 (3): 260-264.

Hamer, D. H., Hu, S., Magnuson, V. L., Hu, N. and Pattatucci, A. M. (1993). A linkage between DNA markers on the X chromosome and male sexual orientation. *Science,* 261 (5119): 321-327.

Harding, C. (2001). The power of sex. In: C. Harding (ed.), *Sexuality: Psychoanalytic Perspectives*. London: Routledge, pp. 170-187.

Harper, G. W., Brodsky, A. and Bruce, D. (2012). What's good about being gay? Perspectives from youth. *Journal of LGBT Youth*, 9 (1): 22-41.

Harris, A. (1991). Gender as contradiction. *Psychoanalytic Dialogues*, 1: 197-220.

Hatterer, L. (1970). *Changing Homosexuality in the Male*. New York: McGraw Hill.

Heenan-Wolff, S. (2011). Infantile bisexuality and the 'complete Oedipal complex': Freudian views on heterosexuality and homosexuality. *International Journal of Psychoanalysis*, 92: 1209-1220.

Hefferon, K. and Gil-Rodriguez, E. (2011). Methods: interpretative phenomenological analysis. *The Psychologist,* 24 (10): 756-759.

Herek, G. M., Norton, A. T., Allen, T. J. and Sims, C. L. (2010). Demographic, psychological, and social characteristics of self-identified lesbian, gay, and bisexual adults in a US probability sample. *Sexuality Research and Social Policy*, 7 (3): 176-200.

Hertzmann, L. (2015). Objecting to the object: encountering the internal parental couple relationship for lesbian and gay couples. In: A. Lemma and P. E. Lynch (eds.), *Sexualities: Contemporary Analytic Perspectives*. London: Routledge, pp. 156-174.

Hinshelwood, R. D. (2017). On not thinking straight: comments on a conceptual marriage. In: N. Giffney and E. Watson (eds.), *Clinical Encounters in Sexuality: Psychoanalytic Practice and Queer Theory*. Brooklyn, NY: Punctum Books, pp. 197-210.

Homer, S. (2005). *Jacques Lacan.* London: Routledge.

Hooker, E. (1957). The adjustment of the male overt homosexual. *Journal of Projective Techniques,* 21: 18-31.

Hopcke, R. H. (1988). Jung and homosexuality: a clearer vision. *Journal of Analytic Psychology*, 33: 66-80.

Hopcke, R. H. (1991). *Jung, Jungians and Homosexuality*. Oregon: Resource Publications.

Horney, K. (1932). The dread of women. *International Journal of Psychoanalysis,* 13: 348-360.

Horney, K. (1933). The denial of the vagina. *International Journal of Psychoanalysis*, 14: 57-70.

Horrocks, R. (1997). *An Introduction to the Study of Sexuality*. London: Macmillan Press.

Howe, K. R. (1988). Against the quantitative-qualitative incompatibility thesis (or dogmas die hard). *Educational Researcher,* 17: 10-16.

Hu, S., Pattatucci, A. M., Chavis Patterson, L. L., Fulker, D. W., Cherny, S. S., Kruglyak, L. and Hamer, D. H. (1995). Linkage between sexual orientation and chromosome Xq28 in males but not in females. *Nature Genetics*, *11*: 248-256.

Igartua K. J. and Des Rosiers, P. (2004) Transference and countertransference in therapy with lesbian patients. *Journal of Lesbian Studies,* 8 (1-2): 123-141.

Isay, R. A. (1986). The development of sexual identity in homosexual men. *Psychoanalytic Study of the Child*, 41: 467-489.

Isay, R. A. (1989). *Being Homosexual: Gay Men and Their Development.* New York: Farrar Strauss Giroux.

Isay, R. A. (1991). The homosexual analyst – clinical considerations. *Psychoanalytic Study of the Child*, 46: 199-216.

Izzard, S. (2006). Oedipus – baby or bathwater? A review of psychoanalytic theories of homosexual development*. British Journal of Psychotherapy*, 16 (1): 43-55.

Jagose, A. (1996). *Queer Theory: An Introduction*. New York: New York University Press.

Johnson, K, (2015). *Sexuality: A Psychosocial Manifesto*. Cambridge: Polity Press.

Johnson, R. B. and Onwuegbuzie, A. J. (2004). Mixed methods research: a research paradigm whose time has come. *American Educational Research Association*, 33 (7): 14-26.

Johnson, R. B., Onwuegbuzie, A. J. and Turner, L. A. (2007). Toward a definition of mixed method

research. *Journal of Mixed Methods Research*, 1 (2): 112-133.

Johnson, W., Turkheimer, E., Gottesman, I. I. and Bouchard, T. J. (2009). Beyond heritability: twin studies in behavioural research. *Current Directions in Psychological Science*, 18 (4): 217-220.

Jones, E. (1927). The early development of female sexuality. *International Journal of Psychoanalysis*, 8: 459-472.

Jones, E. (1932). The phallic phase. *International Journal of Psychoanalysis*, 14: 1-33.

Jones, M. A., Botsko, M. and Gorman, B. S. (2003). Predictors of psychotherapeutic benefit for lesbian, gay, and bisexual clients: the effects of sexual orientation matching and other factors. *Psychotherapy: Theory, Research, Practice, Training,* 40: 289-301.

Jordan, B. (2020). End of the road for the 'homosexuality gene'. *Medical Sciences* (Paris), 36 (2): 181-184.

Jordan, D. and Deluty, R. H. (1995). Clinical interventions by psychologists with lesbians and gay men. *Journal of Clinical Psychology*, 51 (3): 448-456.

Kast, V. (2006). Anima/Animus. In: R. K. Papadopoulos (ed.), *The Handbook of Jungian Psychology*. London: Routledge, pp. 113-129.

Kerns, G. J. and Fine, M. A. (1994). The relation between gender and negative attitudes towards gay men and lesbians: do gender role attitudes mediate these relations? *Sex Roles* 31: 297-307.

Knafo, D. and Lo Bosco, R. (2020). *The New Sexual Landscape and Contemporary Psychoanalysis.* London: Confer.

Khan, M. (1964). The role of infantile sexuality in early object relations in female homosexuality. In: I. Rosen (ed.), *The Pathology and Treatment of Sexual Perversions.* Oxford: Oxford University Press, pp. 221-292.

Kilgore, H., Sideman, L., Amin, K., Baca, L. and Bohanske, B. (2005). Psychologists' attitudes and therapeutic approaches toward gay, lesbian, and bisexual issues continue to improve: an update. *Psychotherapy: Theory, Research and Practice*, 42 (3): 395-400.

King, M. (2011). The queer relationship between psychoanalysts and their gay and lesbian patients. *Psychoanalytic Psychotherapy*, 25 (4): 308-318.

King, M., Green, J., Osborn D. P. J., Arkell, J., Hetherton, J. and Pereira, E. (2005). Family size in white gay and heterosexual men. *Archives of Sexual Behavior,* 34: 117-122.

King, M., Semlyen, J., Tai, S., Killaspy, H., Osborn, D., Popelyuk, D. and Nazareth, I. (2008). A systematic review of mental health disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. *BMC Psychiatry,* 8: 70.

Kinsey, A., Pomeroy, W. and Martin, C. (1948). *Sexual Behaviour in the Human Male*. Philadelphia: W. B. Saunders.

Kirkpatrick, M. (2002). Clinical notes on the diversity in lesbian lives. *Psychoanalytic Inquiry*, 22: 196-208.

Kite, M. E. and Whitley, B. (1996). Sex differences in attitudes toward homosexual persons, behaviours, and civil rights: a meta-analysis. *Personality and Social Psychology Bulletin*, 22: 336-353.

Klein, F. (1978). *The Bisexual Option: A Concept of One Hindered Percent Intimacy*. New York: Priam Books.

Klein, M. (1932). *The Psychoanalysis of Children*. London: Vintage.

Knox, S. and Hill, C. E. (2003). Therapist self-disclosure: research-based suggestions for practitioners. *Journal of Clinical Psychology*, 59 (5): 529-539.

Kosofsky Sedgwick, E. (1990). Epistemology of the Closet. Los Angeles: University of California Press.

Krestan, J., and Bepko, C. (1980). The problem of fusion in the lesbian relationship. *Family Process*, 19: 277-289.

Kronner, H. (2013). Use of self-disclosure for the gay male therapist: the impact on gay males in therapy. *Journal of Social Service Research*, 39 (1): 78-94.

Kulkarni, C. (1997). *Lesbians and Lesbianisms: A Post-Jungian Perspective*. London: Routledge.

Kulkarni, C. (2017). Queer theory meets Jung. In: N. Giffney and E. Watson (eds.), *Clinical Encounters in Sexuality: Psychoanalytic Practice and Queer Theory*. Brooklyn, NY: Punctum Books, pp. 245-259.

Kwawer, J. (1980). Transference and countertransference in homosexuality: changing psychoanalytic views. *American Journal of Psychotherapy*, 34: 72-80.

Lampl De Groot, J. (1927). The evolution of the Oedipus complex in women. *International Journal of Psychoanalysis*, 9: 333-345.

Lampl De Groot, J. (1933). Contribution to the problem of femininity. *Psychoanalytic Quarterly*, 2: 489-518.

Laplanche, J. (1995). Seduction, persecution and revelation. *International Journal of Psychoanalysis*, 78: 653-666.

Laplanche, J. and Pontalis, J-B. (1973/2006). *The Language of Psychoanalysis*. London: Karnac.

LaSala, M. (2008). Practice with gay individuals and couples. In: G. P. Mallon (ed.), *Social Work Practice with Lesbian, Gay, Bisexual and Transgender People* (3rd edn.). London: Routledge, pp. 90-111.

Layton, L. B. (2000). The psychopolitics of bisexuality. *Studies in Gender and Sexuality*, 1 (1): 41-60.

Leader, D. (2010). *Lacan: A Graphic Guide*. London: Icon Books.

Leavy, S. A. (1985). Demythologising Oedipus. *Psychoanalytic Quarterly*, 54 (3): 444-454.

Lehmiller, J. L. (2014). *The Psychology of Human Sexuality*. West Sussex: Wiley Blackwell.

Lemmola, F. and Camperio Ciani, A. (2009). New evidence of genetic factors influencing sexual orientation in men: female fecundity increase in the maternal line. *Archives of Sexual Behaviour,* 38 (3): 393-399.

LeVay, S. (1991). A difference in the hypothalamic structure between heterosexual and homosexual men. *Science,* 253 (5023): 1034-1037.

Lewes, K. (1998). A special Oedipal mechanism in the development of male homosexuality. *Psychoanalytic Psychology*, 15: 341-359.

Lewes, K. (2009). *Psychoanalysis and Male Homosexuality.* Plymouth: Aronson.

Limentani, A. (1979). Clinical types of homosexuality. In: I. Rosen (ed.), *Sexual Deviance*. Oxford: Oxford University Press, pp. 195-205.

Lingiardi, V. (2002). *Men in Love: Male Homosexualities from Ganymede to Batman*. Chicago: Open Court.

Lingiardi, V. (2015). No maps for uncharted lands: what does gender expression have to do with sexual orientation? In: A. Lemma and P. E Lynch (eds.), *Sexualities: Contemporary Analytic Perspectives*. London: Routledge, pp. 101-121.

Lingiardi, V. and Capozzi, P. (2004). Psychoanalytic attitudes towards homosexuality: an empirical research. *International Journal of Psychoanalysis*, 85: 137-158.

Lingiardi, V., Nardelli, N. and Tripodi, E. (2015). Reparative attitudes of Italian psychologists towards lesbian and gay clients: theoretical, clinical and social implications. *Professional Psychology: Research and Practice*, 46: 132-139.

Lynch, P. E. (2015). Intimacy, desire and shame in gay male sexuality. In: A. Lemma and P. E. Lynch (eds.), *Sexualities: Contemporary Analytic Perspectives*. London: Routledge, pp. 138-155.

Macintosh, H. (1994). Attitudes and experiences of psychoanalysts in analyzing homosexual patients. *Journal of the American Psychoanalytic Association*, 42: 1183-1205.

Magee, M. and Miller, D. (1997). *Lesbian Lives: Psychoanalytic Narratives Old and New.* Hillsdale, NJ: Analytic Press.

McBride, K. R. and Fortenberry, J. D. (2010). Heterosexual anal sexuality and anal sex behaviours: a review. *Journal of Sex Research*, 47 (2): 123-136.

McCabe, S., Hughes, T., Bostwick, W., West, B. and Boyd, C. (2009). Sexual orientation, substance use behaviours and substance dependence in the United States. *Addiction*, 104, 1333-1345.

McClintock, M. K. and Herdt, G. (1996). Rethinking puberty: The development of sexual attraction. *Current Directions in Psychological Science*, 5 (6): 178-183.

McDougall, J. (1964). Homosexuality in women. In: J. Chasseguet-Smirgel (ed.), *Female Sexuality: New Psychoanalytic Views*. London: Routledge, pp. 171-212.

McDougall, J. (1980). *Plea for a Measure of Abnormality*. New York: International Universities Press.

McKenzie, S. (2006). Queering gender: anima/animus and the paradigm of emergence. *Journal of Analytical Psychology*, 51: 401-421.

Mero-Jaffe, I. (2011). 'Is that what I said?' Interview transcript approval by participants: an aspect of ethics in Qualitative Research. *International Journal of Qualitative Methods*, 10 (3): 231-247.

Mertens, D. M. (2010). Philosophy in mixed methods teaching: the transformative paradigm as illustration. *International Journal of Multiple Research Approaches*, 4 (1): 9-18.

Meyer, I. H. and Dean, L. (1998). Internalized homophobia, intimacy, and sexual behaviour among gay and bisexual men. In G. M. Herek (ed.), *Psychological perspectives on lesbian and gay issues, Vol. 4. Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals*. Thousand Oaks, CA: Sage Publications, pp. 160-186.

Miles, M. B. and Huberman, A. M. (1994). *Qualitative Data Analysis* (2nd edn.). Thousand Oaks, CA: Sage Publications.

Mitchell, J. (1973). *Psychoanalysis and Feminism*. Harmondsworth: Penguin.

Mitchell, J. and Rose. J. (1982). *Feminine Sexuality: Jacques Lacan and the Ecole Freudienne*. London: MacMillan.

Mitchell, S. A. (2002). Psychodynamics, homosexuality and the question of pathology. *Studies in Gender and Sexuality,* (3): 3-31.

Morgan, D. (2007). Paradigms lost and pragmatism regained: methodological implications of combining qualitative and quantitative methods**.** *Journal of Mixed Methods Research*, 1: 48-76.

Newbigin, J. (2013). Psychoanalysis and homosexuality: keeping the discussion moving. *British Journal of Psychotherapy,* 29 (3): 276-291.

National Institute for Health and Care Excellence (NICE) (2011). *Common mental health disorders: guidance and guidelines*. Available at: https://www.nice.org.uk/guidance/cg123. Last accessed 09.07.2020.

Nichols, M. (2004). Lesbian sexuality/female sexuality: rethinking the lesbian death bed. *Journal of Sexual and Relationship Therapy*, 19: 363-371.

Nobus, D. (2017). Undoing psychoanalysis: towards a clinical and conceptual Metistopia. In: N. Giffney and E. Watson (eds.), *Clinical Encounters in Sexuality: Psychoanalytic Practice and Queer Theory*. Brooklyn, NY: Punctum Books, pp. 343-356.

Nodin, N., Peel, E., Tyler, A. and Rivers, I. (2015). *The RaRE Research Report: LGB&T Mental Health – Risk and Resilience Explored.* London: Project for Advocacy, Counselling and Education (PACE).

Nunberg, H. (1938). Homosexuality, magic and aggression. *International Journal of Psychoanalysis*, 19:1-16.

O'Connor, N. and Ryan J. (1993). *Wild Desires and Mistaken Identities: Lesbianism and Psychoanalysis*. London: Virago.

Oliver, D. G., Serovich, J. M. and Mason, T. L. (2005). Constraints and opportunities with interview transcription: towards reflection in qualitative research. *Social Forces*, 84 (2): 1273-1289.

Ovesey, L. (1969). *Homosexuality and Pseudohomosexuality*. New York: Science House.

Pachankis, J. E. and Goldfried, M. R. (2013). Clinical issues in working with lesbian, gay, and bisexual clients. *Psychology of Sexual Orientation and Gender Diversity*, 1 (S): 45-58.

Pallant, J. (2013). *SPSS Survival Manual* (5th edn.). Maidenhead: Open University Press.

Panozzo, D. (2013). Advocating for an end to reparative therapy: methodological grounding and blueprint for change. *Journal of Gay and Lesbian Social Services*, 25: (3) 365-377.

Parkinson, S., Eatough, V., Holmes, J., Stapley, E. and Midgley, N. (2015). Framework analysis: a worked example of a study exploring young people's experiences of depression. *Qualitative Research in Psychology*, 13 (2): 109-129.

Pattatucci, A. M. and Hamer, D. H. (1995). Development and familiality of sexual orientation in females. *Behaviour Genetics*, 25 (5): 407-420.

Payne, C. R. (1915). Some Freudian contributions to the paranoia problem. *Psychoanalytic Review,* 2 (2): 200-202.

Peplau, L. A. and Garnets, L. D. (2000). A new paradigm for understanding women's sexuality and sexual orientation. *Journal of Social Issues*, 56 (2): 330-350.

Peplau, L. A., Frederick, D. A., Yee, C., Maisel, N., Lever, J. and Ghavami, N. (2009). Body image satisfaction in heterosexual, gay and lesbian adults. *Archives of Sexual Behaviour*, 38 (5): 713-725.

Perelberg, R. J. (2005) Introduction. In: R. J. Perelberg (ed.), *Freud: A Modern Reader,* London: Routledge, pp. 1-27.

Perelberg, R. J. (2018). Introduction: a psychoanalytic understanding of bisexuality. In: R. J. Perelberg (ed.), *Psychic Bisexuality: A British-French Dialogue,* London: Routledge, pp. 1-57.

Phillips, P., Bartlett, A. and King, M. (2001). Psychotherapists' approaches to gay and lesbian patients/clients: a qualitative study. *British Journal of Medical Psychology*, 74: 73-84.

Pillard, R. C. and Weinrich, J. D. (1986). Evidence of familial nature of male homosexuality. *Archives of General Psychiatry*, 43 (8): 808-812.

Pillard, R. C., Poumadere, J. and Carretta, R. A. (1981). Is homosexuality familial? A review, some data and a suggestion. *Archives of Sexual Behaviour*, 10 (5): 465-475.

Porter, J., Hulbert-Williams, L. and Chadwick, D. (2015). Sexuality in the therapeutic relationship: an interpretative phenomenological analysis of the experiences of gay therapists, *Journal of Gay and Lesbian Mental Health*, 19 (2): 165-183.

Pramaggiore, M. (1996). BI-ntroduction I: epistemologies of the fence. In: M. Pramaggiore and D. E. Hall (eds.), *RePresenting Bisexualities: Subjects and Cultures of Fluid Desire*. New York: New York University Press, pp. 1-7.

Punch, K. (2014). *Introduction to Social Research: Quantitative and Qualitative Approaches*. London: Sage Publications.

Quindeau, I. (2013). *Seduction and Desire: The Psychoanalytic Theory of Sexuality since Freud.* London: Karnac.

Quinodoz, J.-M. (1989). Female homosexual patients in psychoanalysis. *International Journal of Psychoanalysis,* 70: 55-63.

Quinodoz, J-M (2005). *Reading Freud: A Chronological Exploration of Freud's Writings*. London: Routledge.

Rado, S. (1940). A critical examination of the concept of bisexuality. *Psychosomatic Medicine*, 2: 459-467.

Rado, S. (1949). An adaptational view of sexual behaviour. In: P. Hoch and J. Zubin (eds.), *Psychosexual Development in Health and Disease.* New York: Grune and Stratton, pp. 52-78.

Rapoport, E. (2019). *From Psychoanalytic Bisexuality to Bisexual Psychoanalysis: Desiring in the Real*. Oxon: Routledge.

Reed, K. (2002). Listening to themes in a review of psychoanalytic literature about lesbianism. *Psychoanalytic Inquiry*, 22 (2): 229-258.

Reyes, M. E. S., Victorino, M. C., Chua, A. P., Oquendo, F. Y., Puti, A. S., Reglos, A. A. and McCutcheon, L. E. (2015). Perceived parental support as a protective factor against suicidal ideation of self-identified lesbian and gay Filipino adolescents. *North American Journal of Psychology*, 17 (2): 245-249.

Richards, C. and Barker, M. (2013). *Sexuality and Gender for Mental Health Professionals: A Practical Guide.* London: Sage Publications.

Ritchie, J. and Spencer, L. (1994). Qualitative data analysis for applied policy research. In: A. Bryman and R. G. Burgess (eds.), *Analyzing Qualitative Data.* London: Routledge, pp. 173-194.

Ritchie, J., Lewis, J., McNaughton Nicholls, C. and Ormston, R. (2014). *Qualitative Research Practice*. London: Sage Publications.

Rohleder, P. (2020). Homophobia, heteronormativity and shame. In: L. Hertzmann, and J. Newbigin (eds.), *Sexuality and Gender Now: Moving Beyond Heteronormativity*. London: Routledge, pp. 40-56.

Rossi, A. S. (1994). Eros and Caritas: a biopsychosocial approach to human sexuality and reproduction. In: A. S. Rossi (ed.), *Sexuality across the Life Course.* London: University of Chicago Press, pp. 3-36.

Rosario, M. and Schrimshaw, E. W. (2014). Theories and etiologies of sexual orientation. In: D. L. Tolman and L. M. Diamond (eds.), *American Psychological Association (APA) Handbook of Sexuality and Psychology* Volume 1: Person-Based Approaches, pp. 555-596.

Rose, J. (2017). Something amiss. In: N. Giffney and E. Watson (eds.), *Clinical Encounters in Sexuality: Psychoanalytic Practice and Queer Theory*. Brooklyn, NY: Punctum Books, pp. 391-395.

Rosenfeld, H. (1949). Remarks on the relation of male homosexuality to paranoia, paranoid anxiety and narcissism. *International Journal of Psychoanalysis*, 30: 36-47.

Roughton, R. (2001). Four men in treatment: an evolving perspective on homosexuality and bisexuality 1965 to 2000. *Journal of the American Psychoanalytic Association*, 49: 1187-1217.

Roughton, R. (2002). Rethinking homosexuality: what it teaches us about psychoanalysis. *Journal of the American Psychoanalytic Association*, 50: 733-763.

Rubin, G. (1984). Thinking sex: notes for a radical theory of the politics of sexuality. In: C. S. Vance (ed.), *Pleasure and Danger: Exploring Female Sexuality*. Boston: Routledge and Kegan Paul, pp. 267-319.

Russell, G. M. and Greenhouse, E. M. (1997). Homophobia in the supervisory relationship: an invisible intruder. *Psychoanalytic Review,* 84: 27-42.

Ryan, C., Russell, S. T., Huebner, D., Diaz, R. and Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23 (4): 205-213.

Ryan, J. (2002). Where now? Recent thinking on psychoanalysis and homosexuality**.** Paper for WTC and Freud Museum conference, *Women Today,* June 2002. Available at: http://www.the-site.org.uk/publications/where-now-recent-thinking-on-psychoanalysis-and-homosexuality-by-joanna-ryan/. Last accessed 09.07.2020.

Samuels, A. (1986). *A Critical Dictionary of Jungian Analysis*. London: Routledge.

Sanders, A. R., Martin, E. R., Beecham, G. W., Guo, S., Dawood, K., Rieger, G., Badner, J. A., Gershon, E. S., Krishnappa, R. S., Kolundzija, A. B., Duan, J., Gejman, P. V. and Bailey, J. M. (2015). Genome-wide scan demonstrates significant linkage for male sexual orientation. *Psychological Medicine*, 45: 1379-1388.

Sandler, J. (1983). Reflections on some relations between psychoanalytic concepts and psychoanalytic practice. *International Journal of Psychoanalysis*, 64: 35-45.

Saunders, M., Lewis, P. and Thornhill, A. (2012). *Research Methods for Business Students* (6th edn.). Essex: Pearson Education Limited.

Savic, I., Garcia-Falgueras, A. and Swaab, D. F. (2010). Sexual differentiation of the human brain in relation to gender identity and sexual orientation. *Progress in Brain Research*, 186: 41-62.

Savin-Williams, R. C. (2017). *Mostly Straight: Sexual Fluidity Among Men*. London: Harvard University Press.

Savin-Williams, R. C. and Vrangalova, Z. (2013). Mostly heterosexual as a distinct sexual orientation group: a systematic review of the empirical evidence. *Developmental Review*, 33: 58-88.

Schoenberg, E. (1995). Psychoanalytic theories of lesbian desire: a social constructionist critique. In: T. Domenici and R. C. Lesser (eds.), *Disorienting Sexuality: Psychoanalytic Reappraisals and Sexual Identities*. New York: Routledge, pp. 203-223.

Schwartz, D. (1999). Is a gay Oedipus a Trojan horse? Commentary on Lewes's 'a special Oedipal mechanism in the development of male homosexuality'. *Psychoanalytic Psychology*, 16 (1): 88-93.

Sedgwick, E. K. (1990). *Epistemology of the Closet*. Berkeley, CA: University Press.

Semlyen, J., King, M., Varney, J. and Hagger-Johnson, G. (2016). Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys. *BMC Psychiatry* 16: 67.

Serovich, J. M., Craft, S. M., Toviessi, P., Gangamma, R., McDowell, T. and Grafsky, E. L. (2008). A systematic review of the research base on sexual reorientation therapies. *Journal of Marital and Family Therapy*, 34 (2): 227-238.

Shackley, F. (1914). The role of homosexuality in the genesis of paranoid conditions. *Psychoanalytic Review*, 1: 431-438.

Shannon-Baker, P. (2016). Making paradigms meaningful in mixed methods research. *Journal of Mixed Methods Research*, 10 (4): 319-334.

Shelby, R. D. (2002). About cruising and being cruised. *Annual of Psychoanalysis*, 30: 191-208.

Shidlo, A. and Schroeder, M. (2002). Changing sexual orientation: a consumers' report. *Professional Psychology: Research and Practice*, 33: 249-259.

Siegel, E. (1988). *Female Homosexuality: Choice without Volition*. Hillsdale, NJ: Analytic Press.

Simpson, S. H. (2015). Creating a data analysis plan: what to consider when choosing statistics for a study. *Canadian Journal of Hospital Pharmacy*, 68 (4): 311-317.

Singer, J. (1976). *Androgyny: Toward a New Theory of Sexuality*. Garden City, NY: Anchor Press/Doubleday.

Smith, G., Bartlett, A. and King, M. (2004). Treatments of homosexuality in Britain since the 1950s – an oral history: the experience of professionals. *BMJ (clinical research ed.)*, 328 (7437): 427.

Smith, H. (2002). On psychic bisexuality. *Psychoanalytic Quarterly*, 71: 549-558.

Smith, J. A., Flowers, P. and Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage Publications.

Smith, J. and Firth, J. (2011). Qualitative data analysis: the framework approach. *Nurse Researcher*, 18 (2): 52-62.

Snyder, D. K. and Whisman, M. A. (2004). Treating distressed couples with coexisting mental health and physical disorders: direction for clinical training and practice. *Journal of Marital and Family Therapy,* 30 (1): 1-12.

Socarides, C. W. (1968). *The Overt Homosexual*. New York: Grune and Stratton.

Socarides, C. W. (1978). *Homosexuality.* New York: Aronson.

Srivastava, A. and Thomson, S. B. (2009). Framework analysis: a qualitative methodology for applied policy research. *Journal of Administration and Governance*, 4 (2): 73-79.

Stein, R. (1998). The poignant, the excessive and the enigmatic in sexuality. *International Journal of Psychoanalysis*, 79: 254-268.

Stein, R. (2008). The otherness of sexuality: excess. *Journal of American Psychoanalytic Association*, 56: 43-71.

Stekel, W. (1922). *Bisexual Love*. New York: Emerson Books.

Stoller, R. (1968). The sense of femaleness. *Psychoanalytic Quarterly*, 37: 42-55.

Stoller, R. (1976). Primary femininity. *Journal of the American Psychoanalytic Association*, 24 (S): 59-78.

Storr, M. (1999). *Bisexuality: A Critical Reader*. London: Routledge.

Suchet, M. (1995). 'Having it both ways': rethinking female sexuality. In: J. M. Glassgold and S. Iasenza (eds.), *Lesbians and Psychoanalysis: Revolutions in Theory and Practice*. New York: Free Press, pp. 39-61.

Sullivan, N. (2003). *A Critical Introduction to Queer Theory*. New York: New York University Press.

Swaab, D. F. (2008). Sexual orientation and its basis in brain structure and function. *Proceedings of the National Academy of Sciences of the United States of America,* 105 (30): 10273-10274.

Swallow, V., Newton, J. and Van Lottum, C. (2003). Research in brief: how to manage and display qualitative data using 'Framework' and 'Microsoft Excel'. *Journal of Clinical Nursing*, 12: 610-612.

Swift, J. K., Callahan, J. L., Cooper, M., and Parkin, S. R. (2018). The impact of accommodating client preference in psychotherapy: a meta-analysis. *Journal of Clinical Psycholo*gy; 74: 1924-1937.

Target, M. (2007). Is our sexuality our own? A developmental model of sexuality based on early affect mirroring. *British Journal of Psychotherapy*, 23 (4): 517-530.

Target, M. (2015). A developmental model of sexual excitement, desire and alienation. In: A. Lemma and P. E. Lynch (eds.), *Sexualities: Contemporary Analytic Perspectives*. London: Routledge, pp. 43-62.

Thorner, H. A. (1949). Notes on a case of male homosexuality. *International Journal of Psychoanalysis*, 30: 31-35.

Tiggemann, M., Martins, Y. and Kirkbride, A. (2007). Oh to be lean and muscular: body image ideals in gay men and heterosexual men. *Psychology of Men and Masculinity*, 8 (1): 15-24.

Tong, A., Sainsbury, P. and Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19 (6): 349-557.

Twomey, D. (2003). British psychoanalytic attitudes towards homosexuality. *Journal of Gay and Lesbian Psychotherapy*, 7 (1-2): 7-22.

Udis-Kessler, A. (1992). Appendix: notes on the Kinsey scale and other measures of sexuality. In: E. R. Weise (ed.), *Closer to Home: Bisexuality and Feminism*. Seattle: Seal Press, pp. 311-318.

Vanderlaan, D. P., Blanchard, R., Wood, H. and Zucker, K. J. (2014). Birth order and sibling sex ratio of children and adolescents referred to a gender identity service. *PloS One*, 9 (3): e90257.

Vaughan, S. C. (1998). Psychoanalytic and biological perspectives on lesbian patients: why developmental themes are more important in psychotherapy. *Harvard Review of Psychiatry*, 6: 160-164.

Verhaeghe, P (1999). *Does the Woman Exist? From Freud's Hysteric to Lacan's Feminine.* New York: Other Press.

Warner, J., McKeown, E., Griffin, M., Johnson, K., Ramsey, A., Cort, C. and King, M. (2004). Rates and predictors of mental illness in gay men, lesbians and bisexual men and women. *British Journal of Psychiatry*, 185: 479-485.

Watson, R. J., Rose, H. A., Doull, M., Adjei, J. and Saewyc, E. (2019). Worsening perceptions of family connectedness and parent support for lesbian, gay, and bisexual adolescents. *Journal of Child and Family Studies,* 28: 3121-3131.

Werner, S., Praxedes, M. and Kim, H. G. (2007). The reporting of nonresponse analyses in survey research. *Organizational Research Methods*, 10 (2): 287-295.

Whisman, M. A. and Uebelacker, L. A. (2003). Comorbidity of relationship distress and mental and physical health problems. In: D. K. Snyder and M. A. Whisman (eds.), *Treating Difficult Couples: Helping Clients with Co-existing Mental and Relationship disorders*. New York: Guilford Press, pp. 3-26.

Winnicott, D. (1971). *Playing and Reality*. London: Penguin Books.

Wolff-Berstein, J. (2012). Jacques Lacan. In: G. O. Gabbard, B. E. Litowitz and P. Williams (eds.), *Textbook of Psychoanalysis* (2nd edn.). Washington, DC: American Psychiatric Publishing, pp. 225-237.

Wood, H. (2003). Psychoanalytic theories of perversion reformulated. *Reformulation*, Summer: 26-31.

Wood, H. (2015). Working with problems of perversion. In: A. Lemma and P. E. Lynch (eds.), *Sexualities: Contemporary Analytic Perspectives,* London: Routledge, pp. 219-234.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*. 15: 215-228.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In: J. A. Smith (ed.), *Qualitative Psychology: A Practical Guide to Methods* (2nd edn.). London: Sage Publications, pp. 235-251.

Yin, R. (2016). *Qualitative Research from Start to Finish* (2nd edn.). London and New York: The Guildford Press.

Young-Bruehl, E. (2001). Are human beings 'by nature' bisexual? *Studies in Gender and Sexuality*, 2 (3): 179-213.

Zohrabi, M. (2013). Mixed method research: instruments, validity, reliability and reporting findings. *Theory and Practice in Language Studies*, 3 (2): 254-262.

Appendix A: Literature Search Strategy

The literature search consisted of both informal and formal methods. The informal method involved consulting existing sources of literature with which I was already familiar. These sources included: (1) several LGB-specific bibliographies published by the American Association of LGBTQ Psychiatrists (ALGP), the American Psychoanalytic Association (APsaA) and the American Psychological Association (APA); (2) available reading lists on sexual orientation compiled by individual psychodynamic training programmes in the UK and US; and (3) papers recommended by my supervisors.

The formal component involved conducting a wider, systematic literature search. For the purposes of my search strategy, the research questions were reduced to two broad concepts: (1) psychoanalysis; and (2) sexual orientation. For each concept, I created a list of search terms.[85] Using Booleans operators (AND, OR, NOT),[86] I entered various combinations of these keywords into the search engines of two main databases: Psychoanalytic Electronic Publishing (PEP) and PsychInfo. Hundreds of articles were returned. In order to identify the most relevant papers, I compared the titles of all the returned articles against the titles listed in the bibliographies and reading lists mentioned above (see informal method) and then screened abstracts to assess which papers were most pertinent to my research questions. Appropriate grey literature was also reviewed (e.g., the APA's 2012 Guidelines for Psychological Practice with Lesbian Gay and Bisexual Clients).

As the PhD progressed and my knowledge deepened, the need to include multidisciplinary perspectives became apparent. I subsequently returned to my literature review and expanded my search to identify papers from relevant non-analytic disciplines (e.g., queer theory; genetics). I used the bibliographic software tool, Mendeley, to manage the literature review. Mendeley allowed me to annotate papers, search for key concepts across papers (e.g., 'transference'; 'Oedipal' etc), add citations and compile bibliographic information. As I became acquainted with the literature, recurring trends, patterns and controversies began to emerge

[85] For 'psychoanalysis', the main search terms included: 'psychoanalysis'; 'psychoanalytic psychotherapy'; 'psychodynamic psychotherapy'; 'Jungian analysis'; 'analytic psychology'; 'psychotherapy'; 'therapy' etc. For 'sexual orientation', the main search terms included: 'sexual orientation'; 'same-sex sexual orientation'; 'same-gender sexual orientation'; 'homosexuality'; 'male homosexuality'; 'female homosexuality'; 'bisexuality'; 'lesbianism'; 'LGBT' etc.

[86] 'AND' narrows the search by only identifying articles where all the terms appear. 'OR' broadens the search by identifying articles where any of the terms appear. 'NOT' narrows the search by eliminating a term from my search.

Appendix B: Final Version of the Questionnaire

BPC Clinical Attitudes Questionnaire
Perspectives on Same-Sex Sexualities

Thank you for your interest in this questionnaire. Please read the information below before you decide to participate.

What is the questionnaire about?
The questionnaire aims to identify the views and experiences of psychoanalysts, psychoanalytic psychotherapists and psychodynamic psychotherapists working with Lesbian, Gay and Bisexual (LGB) clients. Since the focus of the questionnaire is on issues of sexual orientation and not gender (although there are obvious overlaps between sexuality and gender), we have opted to use the acronym LGB rather than the more commonly accepted LGBT.

Why is the questionnaire being conducted?
The questionnaire is one component of a wider University College London (UCL) PhD project and is fully supported by the BPC. The findings will inform the work of the BPC Sexual and Gender Diversity Task Group and ensure that any future BPC development work related to this issue reflects the concerns and needs of the profession.

What can I expect from the questionnaire?
Most questions require you to tick boxes. However, there are open-ended questions allowing you to reflect on the issues and respond in your own way. While the BPC acknowledges that a questionnaire cannot do justice to the complexity of this issue, the BPC would encourage you to respond as accurately and as honestly as you can.

How long will it take me to complete?
An earlier pilot of the questionnaire indicates that it will take you on average 20 minutes to complete.

Do I have to participate?
No. Participation is optional. However, the BPC would encourage all registrants and trainees to participate.

If I start to participate but change my mind, can I withdraw?
Yes. You can stop participation at any point during the questionnaire.

Has the questionnaire received ethical approval?
Yes. The questionnaire has been approved by the UCL Research Ethics Committee (REC) (Project ID Number 6566/001). The research is being supervised by: Professor Mary Target, Professor of Psychoanalysis at UCL and Professor Michael King, Professor of Primary Care Psychiatry.

Is the questionnaire compliant with data protection?
Yes. The questionnaire has received approval from the UCL Data Protection Officer stating that the questionnaire is compliant with the Data Protection Act 1998 (Registration Number is Z6364106/2015/01/56). This means that completion of the questionnaire is completely anonymous, and no identifying data will be collected other than what you are prepared to state in the 'About You' section at the end of the questionnaire.

What will happen to my data?

Your responses will be treated confidentially and joined with the responses of other respondents. Analysis of responses, including your answers to open-ended questions, will be reported in the PhD student's thesis, journal articles and BPC policy and research reports.

When must I complete my response?
Closing date for responses is December 30th 2015. You can save your responses as you go along and return to the questions at a time more convenient for you.

What if I have questions?
Please contact the BPC at leanne@bpc.org.uk.

Part 1: Consent

1. **Do you agree and give consent to participate in this questionnaire?**

Yes ☐

Part 2: Professional Characteristics

2. **What is your current status?**

In training ☐ Qualified ☐

3. **Roughly speaking, how much of your time is spent in private practice, working within the NHS or other settings?** *Please state numerically in %.*

Private	NHS	Other Settings
[Insert response]	[Insert response]	[Insert response

4. **To which BPC training organisation do you belong?** *Please tick all options that apply.*

Association for Psychodynamic Practice and Counselling in Organisational Settings ☐	North of England Association of Psychoanalytic Psychotherapists ☐
Association of Jungian Analysts ☐	Northern Ireland Association for the Study of Psychoanalysis ☐
Association of Medical Psychodynamic Psychotherapists ☐	Scottish Association of Psychoanalytical Psychotherapists ☐
Association of Psychodynamic Counsellors ☐	Severnside Institute for Psychotherapy ☐
British Psychoanalytical Society and the Institute of Psychoanalysis ☐	Society of Analytical Psychology ☐
British Psychotherapy Foundation ☐	Tavistock Society of Psychotherapists Tavistock and Portman NHS Foundation Trust ☐
British Society of Couple Psychotherapists and Counsellors ☐	Wessex Counselling ☐
Forensic Psychotherapy Society ☐	Would rather not say ☐
Foundation for Psychotherapy and Counselling/WPF Therapy ☐	Other ☐

If Other, please specify: [Insert response]

5. **Which BPC 'Category of Registrant' applies to you?** *Please tick all options that apply.*

Jungian Analyst (Analytical Psychologist) ☐	Psychodynamic Group Therapist ☐
Medical Psychodynamic Psychotherapist ☐	Psychodynamic Practitioner in Mental Health and/or Forensic Settings ☐
Psychoanalyst ☐	Psychodynamic Psychotherapist ☐
Psychoanalytic Couples Psychotherapist ☐	Psychodynamic Psychotherapist in time-limited work with adolescents ☐
Psychoanalytic Psychotherapist ☐	Would rather not say ☐
Psychodynamic Counsellor ☐	Other ☐
Psychodynamic Couples Psychotherapist ☐	

If Other, please specify: [Insert response]

6. **What is your theoretical affiliation?** *Please tick all options that apply.*

Freudian, Contemporary Freudian ☐	Self-psychological ☐
Kleinian, Contemporary Kleinian, Bionion ☐	Interpersonal ☐
British Independent ☐	Existential ☐
Jungian, Post-Jungian ☐	Attachment-led ☐
Lacanian ☐	Non-aligned ☐
Relational ☐	Pluralistic ☐
Intersubjective ☐	Other ☐

If Other, please specify: [Insert response]

Part 3: About Your Work with Lesbian, Gay and Bisexual (LGB) Clients

7. **Roughly speaking, how many clients have you seen over your career who would describe themselves as LGB?**

0 ☐ 1 - 25 ☐ 25+ ☐

8. **Roughly speaking, how many clients are you currently treating who would describe themselves as LGB?**

0 ☐ 6 - 10 ☐

1 - 5 ☐ 10+ ☐

9. **From your experience, what are the more common reasons your LGB clients have given for seeking therapy?** *You can select a MAXIMUM of 10 options from the list below.*

Anxiety ☐	Faith, Spirituality, Religion ☐	Gender identity issues ☐
Depression ☐	Terminal illness ☐	LGB parenting issues ☐
Lack of meaning in life ☐	Addiction and/or alcohol and/or substance abuse ☐	Living with HIV/AIDS ☐
Work-related issues ☐	Body image dissatisfaction ☐	Self-harm ☐
Family-related issues ☐	Bullying ☐	Sexual practices (e.g., kink, BDSM) ☐
Relationship difficulties ☐	Ageing or intergenerational issues ☐	Intersectional difficulties (e.g., being LGB and black, or LGB and Muslim) ☐
Sexual difficulties ☐	Child sexual abuse ☐	Discrimination linked to sexual orientation ☐
Shame about sexuality ☐	Coming out ☐	Discrimination not linked to sexual orientation (e.g., racism, ageism) ☐
Bereavement ☐	Domestic abuse and violence ☐	Other issues ☐

If Other, please specify: [Insert response]

10. **Based on your answer to question 9, are there any reasons your LGB clients are more likely to give for seeking therapy compared with your non-LGB clients?** *Please share your thoughts on this in the open-text box below.*

11. **From your experience, what mental and/or physical health issues do you observe most frequently amongst your LGB clients?** *You can select a MAXIMUM of 10 options from the list below.*

Anxiety ☐	Obsessive Compulsive Disorder ☐	Fatigue ☐
Depression ☐	Internalised homophobia ☐	Problems with memory and/or concentration ☐
Narcissistic Personality Disorder ☐	Self-harm ☐	Sleep disturbance ☐
Borderline Personality Disorder ☐	Addiction ☐	Worry about physical health ☐
Gender Identity Disorder ☐	Sexual perversion ☐	Non-health related worry ☐
Body Dysmorphic Disorder ☐	Suicidality ☐	Low self-esteem ☐
Eating disorder ☐	Post-Traumatic Stress Disorder ☐	Phobia ☐
Sexual dysfunction ☐	Schizophrenia ☐	Panic attacks ☐
Somatisation or psychosomatic illness. ☐	Paranoia ☐	Other ☐

If Other, please specify: [Insert response]

12. **Based on your answer to question 11, are there any symptoms or conditions your LGB clients are more likely to present in therapy compared with your non-LGB clients?** *Please share your thoughts on this in the open-text box below.*

13. **How often is sexual orientation central to the difficulties facing your LGB clients?** *Please tick the statement that comes closest to your views.*

Sexual orientation is always central to the difficulties facing my LGB clients ☐

Sexual orientation is frequently central to the difficulties facing my LGB clients ☐

Sexual orientation is occasionally central to the difficulties facing my LGB clients ☐

Sexual orientation is seldom central to the difficulties facing my LGB clients ☐

Sexual orientation is never central to the difficulties facing my LGB clients ☐

14. **Please state your level of agreement with the following theoretical statements.** *Please tick the appropriate option for each statement.*

Theoretical Statement	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly disagree
Sexual orientation can be changed or redirected through therapeutic means	☐	☐	☐	☐	☐
Sexual orientation is shaped by an inborn or genetic component	☐	☐	☐	☐	☐
Sexual orientation is shaped by disturbances in early attachment relationships	☐	☐	☐	☐	☐
Sexual orientation is shaped by unresolved Oedipal conflicts	☐	☐	☐	☐	☐
Sexual orientation is shaped by early trauma	☐	☐	☐	☐	☐
Sexual orientation is shaped by a mixture of nature and nurture	☐	☐	☐	☐	☐
Sexual orientation is multiply determined	☐	☐	☐	☐	☐

15. **Roughly speaking, how many of your LGB clients have seen a reduction in their original symptoms (e.g., anxiety, depression)?**

All ☐ Most ☐ Some ☐ Few ☐ None ☐

16. **Roughly speaking, how many of your LGB clients have seen an improvement in their day-to-day functioning (e.g., increase in self-esteem)?**

All ☐ Most ☐ Some ☐ Few ☐ None ☐

17. **How would you manage a LGB client who requests or seeks help in changing or redirecting their sexual orientation?** *Please select the statement that comes closest to your approach.*

Work with them to explore underlying reasons for wanting to change their sexual orientation ☐

Assist them to accept their sexual orientation ☐

Treat them to change their sexual orientation ☐

Refer them to another colleague who has more experience of assisting men and women to accept themselves ☐

Refer them to a colleague who may help them their homosexual or lesbian feelings ☐

None of these options ☐

If none of these options, what would you do?

18. How would you describe your level of satisfaction with therapeutic work with LGB clients compared to your non-LGB clients?

More satisfied ☐ The same ☐ Less satisfied ☐

19. If you answered 'more satisfied' or 'less satisfied' to question 18, please describe why you feel this way.

20. In your opinion, how does the average length of treatment for LGB clients differ compared with your non-LGB clients?

Tends to be shorter ☐ The same. ☐ Tends to be longer ☐

21. If you answered 'tends to be shorter' or 'tends to be longer' to question 20, please explain why you think this might be the case.

22. Do you think it is appropriate for a therapist who is LGB and who is open about their sexuality in their social and professional life to disclose their sexual orientation to their LGB clients?

Yes ☐ No ☐ Don't Know ☐

23. If you answered 'yes' or 'no' to question 22, why do you give that answer?

24. Should LGB clients have a right to access a psychotherapist who is also LGB?

Yes ☐ Don't Know ☐

No ☐ Prefer not to say ☐

25. **If you answered 'yes' or 'no' to question 24, could you please explain your answer?**

26. **Do you notice a difference working in the transference and countertransference with your LGB clients compared to your non-LGB clients?** *Please share your thoughts on this.*

27. **Are there any other thoughts you would like to share about your clinical work with LGB clients?**

Part 4: About Your Training Organisation

28. **Did you receive any formal teaching on sexual orientation during your training?**

Yes ☐ No ☐ Cannot recall ☐

29. **If yes, what did the teaching cover?** *Please describe.*

30. **How effective did you find the teaching for preparing you for clinical work with LGB clients?**

Very effective	Effective	Neither effective nor ineffective	Only slightly effective	Not at all effective
☐	☐	☐	☐	☐

31. **Do you think your current theoretical and clinical understanding of sexual orientation is in need of updating?**

Yes ☐ No ☐ Don't know ☐

32. **If yes, in what ways do you think your current theoretical and clinical understanding of sexual orientation is in need of updating?**

33. **Please indicate your impression of the situation in your own training organisation by stating your level of agreement with the following statements.** *Please tick the appropriate option for each statement.*

Statements on Training Organisation	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly disagree
Colleagues within my training organisation treat LGB and non-LGB colleagues the same	☐	☐	☐	☐	☐
Colleagues within my training organisation are less willing to supervise LGB candidates than non-LGB candidates	☐	☐	☐	☐	☐
My training organisation does not assess the aptitude for psychoanalytic work on the basis on sexual orientation	☐	☐	☐	☐	☐
My training organisation promotes LGB and non-LGB colleagues equally to senior positions within the organisation	☐	☐	☐	☐	☐

Part 5: About the British Psychoanalytic Council (BPC)

34. **Are you aware that, in 2011, the BPC published a Position Statement opposing discrimination against trainees on the basis on sexual orientation?**

Yes ☐ No ☐

35. **In your opinion, how active a role should the BPC play in fostering a more inclusive psychotherapy profession for LGB trainees and therapists?**

Much more active	More active	Fine as it is	Less active	Much less active
☐	☐	☐	☐	☐

36. How important do you consider the following BPC initiatives for helping to foster a more inclusive psychotherapy profession for LGB trainees and therapists? *Please tick the appropriate option for each statement.*

Statements on BPC Initiatives	Important	Somewhat important	Neither important nor unimportant	Not too important	Not at all important
Support training organisations in revising training entry requirements including how LGB applicants are discussed and selected	☐	☐	☐	☐	☐
Assist training organisations in revising their current curricula on sexual orientation	☐	☐	☐	☐	☐
Assist training organisations in delivering CPD events on sexual orientation for teaching and supervision staff	☐	☐	☐	☐	☐
Provide better information, advice and guidance on LGB-specific issues	☐	☐	☐	☐	☐
Develop partnerships with organisations working with the LGB community such as Pink Therapy	☐	☐	☐	☐	☐
Establish a network for LGB members across all BPC training organisations	☐	☐	☐	☐	☐
Ensure LGB issues are addressed by the BPC Ethics Committee	☐	☐	☐	☐	☐

Part 6: About You

We are interested to see if there are patterns between your views, experiences and ways of working with LGB clients and your personal demographics. We would be grateful if you could complete this section of the questionnaire.

37. What is your gender?

Female ☐ Male ☐ Other ☐

If Other, please specify: [Insert response]

38. What is your age?

20 - 29 ☐ 50 - 59 ☐

30 - 39 ☐ 60 - 69 ☐

40 - 49 ☐ 70+ ☐

39. What is your sexual orientation?

Lesbian	☐	Heterosexual	☐
Gay	☐	Rather not say	☐
Bisexual	☐	Other	☐

If Other, please specify: [Insert response]

40. If you describe yourself as LGB, were you open about your sexual orientation at the time of entering and undergoing training?

Yes	☐	Prefer not to say	☐
No	☐	Not applicable	☐

41. If you answered 'yes' or 'no' to question 40, why did you make that decision?

Part 7: Final thoughts

42. Are there any additional comments you would like to make about your experience of working with LGB clients and/or your training organisation's attitudes towards LGB colleagues and trainees that are not covered by this questionnaire? *Please share your thoughts with us.*

Part 8: Closing remarks

Thank you very much for taking the time to respond to this questionnaire. Results from the questionnaire will be shared with BPC members later in the year. Results will be used to inform future BPC

Appendix C: Final Interview Topic Guide

Interview Topic Guide

Project Title: Same-sex Sexualities: an empirical study of the clinical attitudes of British psychoanalytic psychotherapists towards Lesbian, Gay and Bisexual (LGB) clients

Supervisors: Professor Mary Target and Professor Michael King

Researcher: Wayne Full

Project ID Number: 6566/002

Preamble:

- Introduce yourself and your background.
- Thank the participant for their time.
- Explain the overall research project.
- Explain the interview process (e.g., aims of research; how the findings will be used and reported).
- Run through the Participant Information Sheet.
- Run through Consent Form (e.g., permission to record; right to withdraw from interview)
- Provide indication of the number of questions and the expected duration of the interview (approx. 45 mins).
- Explain that the participant has the right to withdraw from the interview process at any time. They have the option of continuing at a later date and/or of withdrawing their involvement altogether. If the latter option, the recording of their interview will be deleted in their presence (if this is what the participant would like to happen).
- As the interviewees will be discussing real-life LGB clients, explain the need for client confidentiality and ask interviewees to disguise the identities of their clients (e.g., by changing their name, gender, age).
- Explain that the interviewee can review and validate their transcripts should they wish to ensure client confidentiality.
- Before starting the interview, ask the interviewee if he or she has any questions or needs anything.

Warm-up Questions:

- When did you qualify as a psychoanalyst/psychotherapist?

- Where did you train?
- What is your preferred theoretical affiliation(s) (e.g., Jungian, Freudian)?
- What setting do you work in? (e.g., Private; NHS; Social Work)?

Main Interview Questions:

Unless specifically stated, use the following prompts for all questions:

- *Could you go into a bit more detail on that?*
- *Why do you say that?*
- *Can you tell me more about that?*

No.	Questions
1	Can you briefly tell me your reasons for choosing to take part in this interview? **Prompt:** Would you say you have an interest in the area of same-sex sexualities? If so, how did this interest develop?
2	Have you conducted a lot of work with clients who identify as Lesbian, Gay or Bisexual (LGB)? Could you give me a rough indication of how many LGB clients you have seen over your career?
3	Could you describe which theories (psychoanalytic and non-psychoanalytic) you find useful for understanding and explaining same-sex sexualities? **Prompt:** Could you explain why you find these theories useful?
4	Could you describe your clinical work with clients with same-sex sexual orientation(s)? **Prompt:** Could you outline any technical considerations you think are useful when exploring same-sex sexualities in the clinical setting? **Prompt:** Are there any clinical issues that are unique or specific to the LGB community? **Prompt:** What similarities and/or differences do you see in your clinical work between lesbians, gay men and bisexual clients? **Prompt:** Could we think a bit about how your clinical work with LGB clients compares with your clinical work with non-LGB clients?
5.	There is a lot of discussion at the moment about revising analytic theory and teaching on same-sex sexualities to reflect changing societal attitudes and evidence from other research. What are your thoughts on this? **Prompt:** In what ways do you think the training at your Member Institution (MI) helped prepare you for clinical work dealing with same-sex sexualities?
6	There is a lot of talk about making the profession more inclusive to Lesbian, Gay and Bisexual (LGB) trainees and clients? Can you describe the approach your own Member Institution (MI) takes to this matter?
7	How do you go about developing your own thinking and practice in the area of same-sex sexualities? **Prompts:** Do you attend conferences? Read widely? CPD? Group discussions? Own efforts?
8	Is there anything else you think relevant or important to discuss that we haven't covered so far?

Appendix D: Overview of Other Empirical Attitudes Studies

During the literature search, I identified 11 relevant clinical attitudes studies. I have summarised the results of these studies in the table below. These 11 studies were either conducted in the UK (n=4), the USA (n=5) or Italy (n=2). I did not identify any other relevant attitudes research from any other countries

Method(s) Used	Sampling frame and/or response rate	Key findings and/or discussion points	Limitations
UK STUDIES (n=4)			
STUDY 1: Ciclitira, K. and Foster, N. (2012). Attention to culture and diversity in psychoanalytic trainings			
Mixed method: Open-ended postal questionnaire and face-to-face interviews N.B. Only interview findings reported in this article	24 members of the British Association of Psychotherapists (BAP)[87] interviewed	Many of the therapists' accounts indicate that same-sex sexual orientation is 'even more difficult to discuss openly [within BAP] than other issues of difference such as culture, gender and ethnicity' (Ciclitira and Foster 2012, p. 366) Some participants describe the BAP training experience as particularly challenging for LGB trainees: pathologising attitudes are reported to be common within the organisation	Access to interview findings only Due to limited resources, only 24 BAP members interviewed out of a potential pool of 105 volunteers Of participants selected, individuals from diverse backgrounds prioritised (17 out of the 24 identifying as an ethnic minority) The views of non-minority BAP members underrepresented, leading to a partial and/or biased set of findings
STUDY 2: Bartlett, A., Smith, G. and King, M. (2009). The response of mental health professionals to clients seeking help to change or redirect same-sex sexual orientation			
Mono method: Postal questionnaire	1848 professionals contacted across four UK leading mental health membership organisations 1328 valid questionnaire responses returned, a 71% response rate	A significant minority of respondents (n=55, 4%) would, if requested, attempt to change a client's sexual orientation Furthermore, 17% of respondents (n=222) admit having supported at least one client to change their same-sex sexual orientation at some point during their career While respondents cite client distress and autonomy as reasons for intervening in this way, the researchers emphasise the evidence that such interventions are likely to be harmful to LGB clients	Research participants drawn from varied therapeutic backgrounds (respondents included psychologists, psychiatrists, counsellors and psychotherapists) Participants likely to have adopted very different treatment approaches (e.g., cognitive behavioral, psychodynamic, integrative)

[87] The BAP ceased operating under this name in 2013 and became amalgamated (along with several other psychotherapy organisations) under the umbrella of the British Psychotherapy Foundation (BPF).

Method(s) Used	Sampling frame and/or response rate	Key findings and/or discussion points	Limitations
STUDY 3A: Bartlett, A., King, M. and Phillips, P. (2001). Straight talking: an investigation of the attitudes and practice of psychoanalysts and psychotherapist in relation to gays and lesbians			
Mixed method: Postal questionnaire and semi-structured interviews N.B. Only questionnaire results reported in this article (See Study 3B for the interview results)	Random sample of psychotherapy practitioners registered with the British Confederation of Psychotherapists (BCP)[88] Data received from 274 (69%) of 395 questionnaires	Of the 218 practitioners who **fully** completed the questionnaire, almost one-third (n=70) think that gay and lesbian clients have a right to access a gay or lesbian therapist Of the 82% (n=179) who provided written comments, the majority indicate that the sexual orientation of gay and lesbian clients is (to varying degrees) a relevant factor in these clients' initial presentations in therapy and their subsequent treatments	Semantic differences in the use of terminology (i.e., the researchers' use of the terms 'gay' and 'lesbian' versus therapists' use of the term 'homosexual'), leading to potential misunderstandings Difficulty balancing the use of structured questions with pre-defined options (to ease response) and offering sufficient space for therapists to describe their clinical work in their own words
STUDY 3B: Phillips, P., Bartlett, A. and King, M. (2001). Psychotherapists' approaches to gay and lesbian patients/clients: a qualitative study			
Same study as above but this article reports the qualitative data from the interviews	15 therapists from the BCP interviewed	On the whole, interviewees are reported to be reluctant in fully accepting same-sex sexual orientation as a natural variant of human sexuality Interviewees think self-disclosure of a therapist's sexual orientation is unhelpful and/or unacceptable analytic practice Interviewees acknowledge that gay and lesbian individuals wanting to train as psychotherapists face significant discrimination on grounds of their sexual orientation, which the majority condemn	15 interviews cannot be considered representative The researchers openly acknowledge that the demographic profiles, professional characteristics, training backgrounds and geographic locations of the 15 interviewees are not particularly varied or diverse Limited focus: only attitudes data on lesbians and gay men collected (attitudes data on bisexuals not included)
STUDY 4: Ellis., M. L. (1994). Lesbians, gay men and psychoanalytic training			
Mixed method: Face-to-face interviews and questionnaire	Three senior members interviewed from three training organisations. Questionnaires sent to lesbian and gay training	Ellis describes the avoidant and evasive attitudes of three senior members towards same-sex sexual orientation Theoretical dogmatism within these institutions (i.e., a resolved Oedipus complex = a healthy, heterosexual orientation) strongly shapes the decision-making process about the suitability of lesbian and gay	The reporting does not meet adequate standards for empirical research: it does not use the IMRaD format and there is no systematic discussion of the methods, sampling frame and/or limitations of approach taken

[88] The British Confederation of Psychotherapists (BCP) now operates as the British Psychoanalytic Council (BPC).

Method(s) Used	Sampling frame and/or response rate	Key findings and/or discussion points	Limitations
	candidates (numbers not stated)	individuals for psychoanalytic training. Lesbian and gay training candidates reveal that they have been told explicitly by training committee members that same-sex sexual orientation is incompatible with training as a psychoanalyst	
USA STUDIES (n=5)			
STUDY 5: Kilgore et al (2005). Psychologists' attitudes and therapeutic approaches toward gay, lesbian and bisexual issues continue to improve			
Mono method: A 15-item closed-ended questionnaire	1000 questionnaires distributed to members of the American Psychological Association (APA) 437 responses returned (female: n=237, 54.2%; male: n=200, 45.8%) Response rate of 43.7%	92.4% of respondents consider an active LGB lifestyle as 'acceptable' 81% of respondents consider LGB identity as 'not a disorder at all' Female psychologists are significantly more likely than their male counterparts to view LGB clients more favourably and to adopt LGB-affirmative therapeutic approaches Comparing their own results with those of a 1995 study by Jordan and Deluty (which uses the same 15-item questionnaire – see Study 7, below), Kilgore et al (2005) conclude that, overall, psychologists' attitudes towards LGB clients have improved over the decade	Limited sampling frame: questionnaire randomly distributed to *doctoral-level licensed* psychologists only (500 female, 500 male) Since the perspectives of APA members *without doctorates* are excluded, these findings lack generalisability to the APA population as a whole
STUDY 6: Friedman, R.C. and Lilling, A. A. (1996). An empirical study of the beliefs of psychoanalysts about scientific and clinical dimensions of male homosexuality			
Mono-method: Theoretical Beliefs Questionnaire (TBQ)[89]	900 psychoanalysts randomly contacted from five US psychoanalytic training institutions 82 responses were returned (response rate of 9.11%)	The mean score for all 82 respondents is 428.4 (with a Standard Deviation of 56.4 and a range of 304 to 581), indicating that the majority of respondents largely hold the belief that male homosexuality is non-pathological	The low response rate is a significant limitation to this study, so the results cannot be considered representative It is very likely that non-respondents might hold very different theoretical perspectives Limited focus: only tested attitudes towards gay men

[89] Drawn from an extensive review of the psychotherapeutic literature, the TBQ consists of 88 theoretical statements: 46 statements (53%) represent male homosexuality as pathological and 42 statements (47%) represent male homosexuality as non-pathological. Respondents are asked to rate their level of agreement or disagreement with each statement on a seven-point Lickert scale. For pathological statements, 1 indicates strong agreement and 7 strong disagreement; for non-pathological statements, 1 indicates strong disagreement and 7 strong agreement. Respondents' scores for all statements are added together to provide a final score: a final score of 88 represents the highest level of agreement with the belief that male homosexuality is pathological; a final score of 616 (88 x 7) represents the highest level of agreement with the belief that male homosexuality is non-pathological; and a final score of 352 (the mid-point of the scale) represents a neutral perspective.

Method(s) Used	Sampling frame and/or response rate	Key findings and/or discussion points	Limitations
STUDY 7: Jordan, D. and Deluty, R. H. (1995). Clinical interventions by psychologists with lesbians and gay men			
Mono-method: Uses the same 15-item questionnaire as Kilgore et al (2005) (see Study 5, above)	Questionnaire sent to chief psychologists at randomly selected psychiatric hospitals and mental health clinics. Chief psychologists asked to distribute questionnaire to doctoral-level staff psychologists Of the 338 questionnaires distributed, 139 responses returned. Response rate of 41%	While the study reports that none of the 139 participants use aversion therapies to change the sexual orientation of their gay and lesbian clients, 5.8% do endorse the use of aversion therapies Furthermore, 11% of respondents indicate that they use psychodynamic techniques in order to redirect same-sex sexual orientation A univariate regression analysis predicts that respondents who view lesbian and gay lifestyles as 'unacceptable' are more likely to endorse the use of both aversion and alternative therapies to modify same-sex sexual orientation	59% non-response rate: the views of professionals using aversion therapies are likely under-represented Limited focus on *doctoral-level* licensed psychologists only 5% of clinics have 0% response rate (chief psychologists may not have forwarded the questionnaire) Psychologists with disinterest in the topic may not have responded Focus on lesbians and gay only (bisexuals not included)
STUDY 8: Macintosh, H. (1994). Attitudes and experiences of psychoanalysts in analysing homosexual patients			
Mono-method: Treatment attitudes questionnaire	422 psychoanalysts working across the USA, of which 285 responded Response rate of 67.5%	Virtually all respondents (n=278, 97.6%) disagree with the statement that 'a homosexual patient can and should change to heterosexuality' Over a third (n=98), however, believe that most of their colleagues are likely to agree with this statement 17% admit to having altered their own thinking on this statement over the last 10 years	Potential oversampling of practitioners from the Washington DC and Maryland areas. 39% (n=164) of the sampling frame is from this geographical area while the remainder of the sampling frame (n=258, 61%) is divided into four fairly similar sized groups drawn from across other US regions Not clear whether 'homosexual patients' refers to gay men only or includes lesbians and/or bisexual
STUDY 9: Garnets et al (1991). Issues in psychotherapy with lesbians and gay men: a survey of psychologists			
Mono-method: Clinical attitudes questionnaire to American psychologists to identify whether their clinical practices with lesbian and gay clients are harmful or beneficial	Of the 6,580 questionnaires distributed, 2,544 valid responses returned Of these 2544, only 1481 respondents (58.2%) indicate that they have knowledge and/or direct experience of psychotherapy with lesbian or gay clients	Thematic analysis of the 'critical incident material' identifies: 17 themes representing harmful practices (e.g., 'a therapist focuses on sexual orientation as a therapeutic issue when it is not relevant') 14 themes representing beneficial practices (e.g., 'a therapist uses an understanding of societal prejudice and discrimination experienced by lesbians and gay men to guide the therapy and to help gay male and lesbian clients overcome negative ideas about homosexuality')	The researchers themselves acknowledge that the sample is not representative of the APA Furthermore, the study does not indicate the frequency of the most common types of clinical intervention (whether harmful or beneficial) used by psychologists but rather provides a broad range of possible therapeutic approaches Focus on lesbians and gay only (bisexuals not included)

Method(s) Used	Sampling frame and/or response rate	Key findings and/or discussion points	Limitations
ITALIAN STUDIES (n=2)			
STUDY 10: Lingiardi, V., Nardelli, N. and Tripodi, E. (2015). Reparative attitudes of Italian psychologists towards lesbian and gay clients: theoretical, clinical and social implications			
Mono-method: An online clinical attitudes questionnaire	A convenience sampling frame of 28,477 members of the Italian Psychological Association with 3,135 respondents (11% response rate)	Of the 3,135 respondents, three-quarters state that they consider same-sex sexual orientation to be a natural variant of human sexuality. However, in contradiction to this, the study also finds that 58% of these same respondents hold some form of reparative attitude Regression analysis significantly predicts that reparative attitudes are more common amongst respondents who are heterosexual, older, politically conservative and/or religious.	Convenience sampling frame – and therefore its lack of generalisability to the whole population (n=93,118) of the Italian Psychological Association) Low 11% response rate Focus on lesbians and gay only (bisexuals not included)
STUDY 11: Lingiardi, V. and Capozzi, P. (2004). Psychoanalytic attitudes towards homosexuality: an empirical research			
Mono-method: A 13-statement clinical attitudes questionnaire Respondents asked to state categorically (i.e., yes or no) whether they agree with each of the statements	600 randomly selected psychoanalysts across the five main Italian psychoanalytic associations 206 responses returned (34% response rate)	Cultural and theoretical considerations are more likely to inform clinical attitudes towards LGB clients than gender and/or age Respondents with a medical degree are more likely to hold pathologising views about same-sex sexual orientation Respondents' clinical practice (i.e., disagreement that therapists should assist LGB clients to change sexual orientation) contradicts their theoretical models (i.e., agreement that same-sex sexual orientation is an indicator of psychopathology) Compared to their psychoanalytically trained counterparts, Jungian-trained therapists are not only less pathologising in their theoretical outlook but also less discriminatory towards LGB colleagues	Moderate response rate (34%) Researchers attribute low response rate to ambivalent attitudes to the subject matter and/or distrust of research Focus on lesbians and gay only (bisexuals not included)

Appendix E: Pilot Questionnaire Feedback Form

BPC Practitioner Clinical Attitudes Questionnaire on Same-Sex Sexualities

Pilot Feedback Form

Thank you for agreeing to participate in the pilot questionnaire. You are asked to read this Feedback Form in advance of completing the pilot questionnaire and to keep these questions in mind as you progress through the survey. It might be helpful to jot down any problems or concerns you have with the questions as you go through the questionnaire to help you complete this Feedback Form later.

1. How long did the questionnaire take you to complete?

2a. From the questionnaire introduction, did you understand the aims and objectives of the questionnaire? *Tick the appropriate box.*

The aims and objectives were clear ☐

The aims and objectives were unclear ☐

2b. If the questionnaire introduction was unclear, what do you think should be included to make the aims and objectives of the questionnaire clearer? *Please describe in the open-text box below.*

3a. Did you feel comfortable answering the questions?

Yes ☐ No ☐

3b. If no, what questions did you find particularly objectionable, and why? *Please describe in the open-text box below.*

4a. Is the wording of the questions clear?

Yes ☐ No ☐

4b. If no, which questions did you find particularly unclear, and why? *Please describe in the open-text box below.*

5a. Are the answer choices compatible with your experience of the subject matter?

Yes ☐ No ☐

5b. If no, which answer responses would you like to see included and in relation to which questions? *Please describe in the open-text box below.*

6a. Do any of the questions require you to think too long or too hard before responding?

Yes ☐ No ☐

6b. If so, which ones? *Please describe in the open-text box below.*

7. Which questions (if any) produced irritation, embarrassment and/or confusion and could you explain why? *Please describe in the open-text box below.*

8a. Do any of the questions encourage you towards a 'politically correct' answer? If so, which ones? *Please describe in the open-text box below.*

8b. Do you have any suggestions on how these 'politically correct' questions might be better worded? *Please describe in the open-text box below.*

9a. In your opinion, are there any questions missing?

Yes ☐ No ☐

9b. If so, what type of questions do you think should be included? *Please describe in the open-text box below.*

10). Is there enough diversity in the type of questions posed in the questionnaire?

Yes ☐ No ☐

10b. If not, what type of questions do you think need to be included to increase the range of questions? *Please describe in the open-text box below.*

11. Is the survey too long?

Yes ☐ No ☐

12. Are there any other important issues that you think have been overlooked? *Please describe in the open-text box below.*

END OF FEEDBACK FORM

Appendix F: Questionnaire Data Analysis Plan

To support the questionnaire data analysis, I created a data analysis plan (Simpson 2015). The plan provided a template for how I would organise and analyse the questionnaire data in order to effectively answer my research questions.

Research Questions:
The main research questions are:

1. How do UK psychodynamic psychotherapists understand and conceptualise same-sex sexual orientation both theoretically and clinically?
2. In what ways has psychodynamic training on sexual orientation shaped the views and practice of UK psychodynamic psychotherapists working with lesbian, gay and bisexual (LGB) clients?

Research sub-questions	Relevant questionnaire questions	Using questionnaire questions to answer research sub-questions
1. How representative is the sample of the BPC membership? 2. What does the questionnaire sample look like (e.g., demographics)?	Overall response rate Q37: Respondent's gender Q38: Respondent's age Q40: Respondent's sexual orientation	**Response rate:** • Questionnaire sent to all 1403 BPC members. • 399 responses stored in *Survey Monkey*. 287 suitable for analysis. Response rate of 20%. • 267 complete submissions (90% of fields answered) and are fully analysable. • 132 incomplete submissions of which 20 have enough data to be included in the analysis. • 112 have little or no data – only the first six questions on professional characteristics were answered before questionnaire was abandoned. No topic-specific questions answered. Exclude from main analysis but maybe use to explore partial response and non-response bias? **Analysis to be undertaken:** • For each of the demographic items in the questionnaire (Q37, Q38 and Q40), explore the frequencies and percentages of responses. This first tells me the demographic profile of those who returned the survey.

Research sub-questions	Relevant questionnaire questions	Using questionnaire questions to answer research sub-questions
		Demographic data at a glance suggests: • Majority of respondents (80%) over 50 years of age. Sadly, no continuous data was collected. I made the mistake of reducing the age category from a ratio-level variable (measured in years) to an ordinal variable (e.g., 20-29, 30-39 etc). Unable to measure mean, median or mode. • Majority of respondents (70%) were female. • 14% of respondents were LGB. This suggests a response bias if general population is considered. The national average for the LGB population in the UK is 2% (ONS 2017). • Not possible to compare my sample with the demographics of the overall BPC membership as the BPC does not collect demographic data. **How to present data:** • Pie chart or simple table might be most simple and effective way to present the data.
3. What are the professional characteristics of the sample?	Q2: Respondent's current training status (e.g., in training or qualified) Q3: % of respondent's time spent in private practice, NHS or other settings Q4: Respondent's training organisation Q5: Respondent's BPC Category of Registrant (modality) Q6: Respondent's theoretical affiliation	**Analysis to be undertaken:** • For each of these questions, look at the frequencies and percentages of respondents who checked each answer option. **Issues at glance:** • *Clinical settings.* While the survey provides data on the percentage of time respondents spend in private, NHS and other settings, it does not (due to the wording of the question) automatically collate data on the total number of respondents working in private, NHS, other settings and/or a combination of these three. Explore non-response bias: compare sample with non-responders (the 112 respondents who only answered the questions on professional demographics before abandoning questionnaire). • *Training organisation*. Highest percentage of responders were BPF (39%), FPC/WPF (20%), BPAS (13%) and Tavistock (13%). Other organisations identified by respondents (14 in total) amounted to less than 6%. In order to make categories meaningful for analysis, maybe group the two Jungian organisations together (approx. 8%)? Maybe group the regional organisations together e.g., North England, Scotland, Northern Ireland, South West (approx. 10%)? Should I then group the remaining options as 'Other' as there is no obvious way of grouping them together? Many respondents are members of multiple organisations and this might be worth adding to the analysis also? Explore

Research sub-questions	Relevant questionnaire questions	Using questionnaire questions to answer research sub-questions
		non-response bias: BPC does collect data on which training institution members belong – compare sample with official BPC data? • *BPC Category of Registrants.* Highest responders were Psychoanalytic Psychotherapists (54%), Psychodynamic Psychotherapists (33%), Psychoanalysts (17%) and Jungian Analysts (14%). The remaining categories (9 in total) amounted to less than 5%. Maybe group these remaining 9 categories together, so they are more meaningful for analysis? Again, many respondents fall under multiple BPC categories of registrant and this might be worth adding to the analysis? Explore non-response bias: compare sample with non-responders (the 112 respondents who only answered the questions on professional demographics before abandoning questionnaire). • *Theoretical affiliation.* Highest responders were Kleinian (46%), British Independent (43%), Post-Classical (29%) Freudian (25%), Jungian (19%), Attachment-led (13%), Pluralistic (10%) and Non-aligned (10%). The remaining options (six in all) were all 6% and below. Maybe combine with larger categories and/or add to 'Other' if it makes sense to do so. Identify the percentage of respondents identifying with multiple theoretical positions? Explore non-response bias: compare sample with non-responders (the 112 respondents who only answered the questions on professional demographics before abandoning questionnaire). **How to present data:** • Given that respondents could tick multiple options and counts will exceed sample of 287 and exceed 100%, might be best to present as a table.
4. What experience do respondents have of working with LGB clients?	Q7: Number of LGB clients treated by the respondent over career Q8: Number of LGB clients treated by respondent today	**Analysis to be undertaken:** • For both questions, look at the frequencies and percentage of responses. • Majority of respondents (83%) have seen between 1 – 25 LGB patients over their careers. • Majority of respondents (68%) are currently treating between 1 – 5 LGB clients. **Issues at a glance:**

Research sub-questions	Relevant questionnaire questions	Using questionnaire questions to answer research sub-questions
		• Sadly, no continuous data was collected. I made the mistake of creating categories rather than asking respondents to state a number. No mean, median or mode can be calculated. • Did not ask respondents about the size of their general caseload so no way of knowing what proportion of LGB clients make up their full caseload. • Just over one-quarter of respondents (29%) are currently not treating LGB clients, which I think is sizeable enough to warrant further investigation. • Would be interesting to see, for example, how many of these 29% also said they are in training (11% reported being in training, see Q2) and therefore just starting out and perhaps have not treated many LGB clients yet? • Similarly, it would be interesting to see what theories on sexual orientation these 29% hold, especially given that they are not currently working with LGB clients. Does their lack of exposure to LGB clients mean they hold particular views on this client group? Is there a pattern in the theories these 29% hold? **How to present data:** • As the responses to these questions can be presented as 100%, a pie chart might be most simple and effective way to present the data.
5. What are the respondent's theoretical assumptions about same-sex sexual orientation?	Q14: Respondent's views on theories of sexual orientation	**Analysis to be undertaken:** • Look at the frequencies and percentages of responses. • Where appropriate and depending on the distribution, recode some of the responses into new categories (for example, add the 'strongly agree' and 'agree' responses together if it makes sense to do so). • It would be interesting to see how respondents' demographics (e.g., gender; age; sexual orientation) or professional characteristics (e.g., theoretical affiliation; therapeutic modality) influence their responses. Since most of my data is categorical, I will need to recode relevant categories into binaries, create simple cross tabulations and conduct chi-squared (χ^2) tests to identify associations. If associations are found, check phi co-efficient (φ) to assess strength of association. **How to present data:** • Tables might be most effective way to present this data.
6. What does a respondent's typical LGB caseload look like?	Q9: Respondent's views on common reasons LGB clients seek therapy	**Analysis to be undertaken:** • Keep descriptive.

Research sub-questions	Relevant questionnaire questions	Using questionnaire questions to answer research sub-questions
	Q10: Respondent's views on whether there are any reasons LGB clients are more likely to give for seeking therapy compared to non-LGB clients [Open-ended] Q11: Respondent's view on typical mental and/or physical health issues presented by LGB clients Q12: Respondent's views on whether there are any mental and/or physical health issues LGB clients are more likely to present compared to non-LGB clients [Open-ended] Q13: Respondent's views on how central sexual orientation is to the difficulties facing LGB clients	• For Q9 and Q11, look at the frequencies and percentage of respondents who checked each answer option. Rank them from high to low. Prioritise the top ten options selected for both questions. There were 27 options offered but focus on the top ones selected. • The relative frequency with which each item is checked will indicate whether respondents consider LGB clients to present certain symptoms or issues. • Open-ended questions (Q10 and Q12) will be thematically analysed. • For Q13, look at the frequencies and percentages of responses. **Issues at a glance:** • Qualitative responses will require a lot of analysis and organising. • Themes will need review and double-checking. **How to present data:** • Q9 and Q11 – present as bar charts. • Select most exemplary quotations from open-ended responses to illustrate respondents' views.
7. How does the respondent approach their therapeutic work with LGB clients?	Q17: Respondent's views on LGB clients who request to re-direct their same sex attraction Q22: Respondent's views on whether LGB therapists' should self-disclosure their sexuality to LGB clients Q23: Respondent's explanation for self-disclosure (or not) [Open-ended]	**Analysis to be undertaken:** • Q23, Q25, Q26 and Q27 are all open-ended and some very detailed responses were given. These will be thematically analysed. • For Q17, Q22 and Q24, look at the frequencies and percentages of responses. • It would be interesting to see how respondents' demographics (e.g., gender; age; sexual orientation) or professional characteristics (e.g., theoretical affiliation; therapeutic modality) influence their responses to some of these questions (e.g., LGB therapists' self-disclosure (of sexual orientation); LGB clients' rights to access LGB therapists). Since most of my data is categorical, I will need to recode relevant categories into binaries, create simple cross tabulations and conduct chi-squared (χ^2) tests to identify associations. If associations found, check phi co-efficient (φ) to assess the strength of the association.

Research sub-questions	Relevant questionnaire questions	Using questionnaire questions to answer research sub-questions
	Q24: Respondent's view on whether LGB clients have a right access a therapist who is also LGB Q25: Respondent's explanation of their answer to Q24 [Open-ended] Q26: Respondent's views on the transference and countertransference in the work with LGB clients [Open-ended] Q27: Respondent's views on any other clinical issues with LGB clients [Open-ended]	**Issues at a glance:** • While most respondents (65%) do not think a therapist should disclose their sexual orientation, are these likely to be classically informed therapists rather than those who draw on relational theories etc? • 25% are undecided on the issue of self-disclosure. I think this is a high enough proportion to warrant further analysis. • 9% of respondents think it is appropriate to disclose their sexual orientation, it would be interesting to know if this 9% is mostly made up of LGB respondents? Or those drawing on contemporary schools of thought (e.g., relational)? • Mixed response on whether LGB clients have a right to LGB therapists: 38% yes, 32% don't know, 27% no. Again, it would be interesting to see if there is any pattern in the type of respondent who says 'yes' or 'don't know' or 'no'. Does the sexual orientation of respondents influence responses? • The majority of respondents would not redirect LGB clients' sexual orientation if requested. 89% would work with the client to explore underlying reasons for wanting to change their sexual orientation or work with them to accept it). So, have things moved on? Only 9% of respondents didn't choose any of the 6 options provided, so I would approach such a request in a different way. It would be interesting to see how else they would approach this work (will need to analyse 'other' options thematically). • Only one respondent would attempt to change a client's sexual orientation. I find this suspicious. Of all the responses, only one respondent is willing to say they would change the LGB client's sexual orientation. Have other responses been influenced by social desirability? Or are those with conservative views the least likely to have responded to the survey? **How to present data:** • Tables might be most effective way to present this data. • Select most exemplary quotations from open-ended responses to illustrate respondents' views.
8. What are the respondent's views on the outcome of their work with LGB clients?	Q15: Respondent's view on reduction of symptoms in LGB clients	**Analysis to be undertaken** • Keep descriptive. • For Q15 and 16, look at the frequencies and percentages of responses. • For Q18 and Q20 look at the frequencies and percentages of responses.

Research sub-questions	Relevant questionnaire questions	Using questionnaire questions to answer research sub-questions
	Q16: Respondent's view on general improvement in their LGB clients Q18: Respondent's level of satisfaction with therapeutic work with LGB clients Q19: Compared with non-LGB clients [Open-ended] Q20: Respondent's views on the average length of a treatment with LGB clients Q21: Compared with non-LGB clients [Open-ended]	• Q19 and Q21 are open-ended and some very detailed responses were given. These will be thematically analysed. **Issues at a glance:** None identified at present. **How to present data:** • Mixture of bar charts and tables might be most effective way to present this data.
9. In what ways might a respondent's training influence their work with LGB clients?	Q28: Respondent's exposure to formal training on issues relevant to LGB clients Q29: Respondent's view on topics and modules covered in their training linked to sexual orientation [Open-ended] Q30: Respondent's views on effectiveness of training in preparing them for work with LGB clients	**Analysis to be undertaken:** • For Q28, Q30 and Q31, look at the frequencies and percentage of respondents. • It would be interesting to see how respondents' demographics (e.g., gender; age; sexual orientation) or professional characteristics (e.g., theoretical affiliation; therapeutic modality) influence their responses to some of these questions. Since most of my data is categorical, I will need to recode relevant categories into binaries, create simple cross tabulations and conduct chi-squared (χ^2) tests to identify associations. If associations found, check phi co-efficient (φ) to assess strength of association. **Issues at a glance:** None identified at present. Due to agreement with BPC, I will not be able to publicly report the link between a particular training organisation and its members views on its teaching programme. Maybe I could say how many member institutes were progressive in these terms and how many were not?

Research sub-questions	Relevant questionnaire questions	Using questionnaire questions to answer research sub-questions
	Q31: Respondent's view on whether their theoretical and clinical models need updating Q32: Respondent's views on what topics and modules need updating [Open-ended]	**How to present data:** • Tables likely to be most effective way to present the data.
10. In what ways does the respondent's Member Institute (MI) support LGB colleagues?	Q33. Respondent's impression of their MIs attitudes towards LGB colleagues Q41: Respondent's view (if LGB) on how open they could be about their sexual orientation while training	**Analysis to be undertaken:** • Look at the frequencies and percentage of responses. • The relative frequency with which each item is checked will tell me whether respondents training organisations were supportive and inclusive. • See how a respondents' demographics (e.g., gender; age; sex orientation) or professional characteristics (e.g., theoretical affiliation; therapeutic modality) influence their responses to some of these questions. Since most of my data is categorical, I will need to recode relevant categories into binaries, create simple cross tabulations and conduct chi-squared (χ^2) tests to identify associations. If associations found, check phi co-efficient (φ) to assess strength of association. **Issues at a glance:** None identified at present. Due to agreement with BPC, I will not be able to publicly report the link between a particular training organisation and its members' attitudes towards LGB colleagues. **How to present data:** • Tables likely to be most effective way to present the data.
11. In what ways might the BPC support a more LGB friendly profession?	Q34: Respondent's awareness of the BPC Position Statement on same-sex attraction Q35: Respondent's view on the role of the BPC in fostering a more inclusive profession	**Analysis to be undertaken:** • Look at the frequencies and percentage of responses. • The relative frequency with which each item is checked will tell me whether respondents are keen to see more BPC initiatives fostering inclusivity (and which initiatives in particular they favour). **Issues at a glance:** None identified at present. Due to confidentiality, I will not be able to publicly report the link between a particular training organisation and its members' views on the BPC's role.

Research sub-questions	Relevant questionnaire questions	Using questionnaire questions to answer research sub-questions
	Q36: Respondent's views on activities the BPC should develop to foster a more inclusive profession	**How to present data:** • Tables likely to be most effective way to present the data on BPC initiatives. • Bar chart might be best way to present question 35.

Appendix G: Codebook for SPSS Data Entry

In line with Pallant (2013), a codebook was created to simplify and standardise the questionnaire data for analytical purposes within SPSS. Using the codebook, the data were re-coded, which involved re-defining each of the questionnaire variables by assigning a number to each response (e.g., replacing 'female' by 1, 'male' by 2 and so on).

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
1	Respondent's permission to use their data	Agreement to use data	Agree	Nominal	1 = yes
2(1)	Respondent's clinical background - in training	In training	In training	Nominal	0 = no 1 = yes
2(2)	Respondent's clinical background - certified to practice	Certified	Certified	Nominal	0 = no 1 = yes
3(1)	Respondent's clinical background	% time spent working in private practice	Private	Ratio	Enter % stated
3(2)	Respondent's clinical background	% time spent working in the NHS	NHS	Ratio	Enter % stated
3(3)	Respondent's clinical background	% time spent working in other settings	Other Settings	Ratio	Enter % stated
4(1)	Respondent's Member Institution	Association for Psychodynamic Practice and Counselling in Organisational Settings	APPCIOS	Nominal	0 = no 1 = yes
4(2)	Respondent's Member Institution	Association of Jungian Analysts	AJA	Nominal	0 = no 1 = yes
4(3)	Respondent's Member Institution	Association of Medical Psychodynamic Psychotherapists	AMPP	Nominal	0 = no 1 = yes
4(4)	Respondent's Member Institution	Association of Psychodynamic Counsellors	APC	Nominal	0 = no 1 = yes

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
4(5)	Respondent's Member Institution	British Psychoanalytical Society and the Institute of Psychoanalysis	BPAS	Nominal	0 = no 1= yes
4(6)	Respondent's Member Institution	British Psychotherapy Foundation	BPF	Nominal	0 = no 1 = yes
4(7)	Respondent's Member Institution	British Society of Couple Psychotherapists and Counsellors	BSCPC	Nominal	0 = no 1 = yes
4(8)	Respondent's Member Institution	Forensic Psychotherapy Society	FPS	Nominal	0 = no 1 = yes
4(9)	Respondent's Member Institution	Foundation for Psychotherapy and Counselling/WPF Therapy	FPC_WPF	Nominal	0 = no 1 = yes
4(10)	Respondent's Member Institution	North of England Association of Psychoanalytic Psychotherapists	NEAPP	Nominal	0 = no 1 = yes
4(11)	Respondent's Member Institution	Northern Ireland Association for the Study of Psychoanalysis	NIASP	Nominal	0 = no 1 =yes
4(12)	Respondent's Member Institution	Scottish Association of Psychoanalytical Psychotherapists	SAPP	Nominal	0 = no 1 = yes
4(13)	Respondent's Member Institution	Severnside Institute for Psychotherapy	SIP	Nominal	0 = no 1 = yes
4(14)	Respondent's Member Institution	Society of Analytical Psychology	SAP	Nominal	0 = no 1 = yes
4(15)	Respondent's Member Institution	Tavistock Society of Psychotherapists/Tavistock and Portman NHS Foundation Trust	TSP	Nominal	0 = no 1 = yes

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
4(16)	Respondent's Member Institution	Wessex Counselling	Wessex	Nominal	0 = no 1 = yes
4(17)	Respondent's Member Institution	Would rather not state	NotState_Q4	Nominal	0 = no 1 = yes
4(18)	Respondent's Member Institution	Other_Q4	Other_Q4	Nominal	0 = no 1 = yes
5(1)	Respondent's BPC Category of Registrant	Jungian Analyst (Analytical Psychologist)	JA	Nominal	0 = no 1 = yes
5(2)	Respondent's BPC Category of Registrant	Medical Psychodynamic Psychotherapist	MPP	Nominal	0 = no 1 = yes
5(3)	Respondent's BPC Category of Registrant	Psychoanalyst	PA	Nominal	0 = no 1 = yes
5(4)	Respondent's BPC Category of Registrant	Psychoanalytic Couples Therapist	PACT	Nominal	0 = no 1 = yes
5(5)	Respondent's BPC Category of Registrant	Psychoanalytic Psychotherapist	PAP	Nominal	0 = no 1 = yes
5(6)	Respondent's BPC Category of Registrant	Psychodynamic Counsellor	PDC	Nominal	0 = no 1 = yes
5(7)	Respondent's BPC Category of Registrant	Psychodynamic Couples Psychotherapist	PDCP	Nominal	0 = no 1 = yes
5(8)	Respondent's BPC Category of Registrant	Psychodynamic Group Therapist	PDGP	Nominal	0 = no 1 = yes
5(9)	Respondent's BPC Category of Registrant	Psychodynamic Practitioner in Mental Health and/or Forensic Settings	PDPMHFS	Nominal	0 = no 1 = yes
5(10)	Respondent's BPC Category of Registrant	Psychodynamic Psychotherapist	PDP	Nominal	0 = no 1 = yes
5(11)	Respondent's BPC Category of Registrant	Psychodynamic Psychotherapist in time-limited work with adolescents	PDPAdol	Nominal	0 = no 1 = yes

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
5(12)	Respondent's BPC Category of Registrant	Would rather not state	NotState_Q5	Nominal	0 = no 1 = yes
5(13)	Respondent's BPC Category of Registrant	Other_Q5	Other_Q5	Nominal	0 = no 1 = yes
6(1)	Respondent's theoretical affiliation	Freudian/Contemporary Freudian	Freud	Nominal	0 = no 1 = yes
6(2)	Respondent's theoretical affiliation	Kleinian/Post-Kleinian/Bionian	Klein	Nominal	0 = no 1 = yes
6(3)	Respondent's theoretical affiliation	British Independent	Independ	Nominal	0 = no 1 = yes
6(4)	Respondent's theoretical affiliation	Jungian/Post-Jungian	Jung	Nominal	0 = no 1 = yes
6(5)	Respondent's theoretical affiliation	Lacanian	Lacan	Nominal	0 = no 1 = yes
6(6)	Respondent's theoretical affiliation	Relational	Relate	Nominal	0 = no 1 = yes
6(7)	Respondent's theoretical affiliation	Intersubjective	InterSub	Nominal	0 = no 1 = yes
6(8)	Respondent's theoretical affiliation	Self-psychological	SelfPsych	Nominal	0 = no 1 = yes
6(9)	Respondent's theoretical affiliation	Interpersonal	InterPers	Nominal	0 = no 1 = yes
6(10)	Respondent's theoretical affiliation	Existential	Exist	Nominal	0 = no 1 = yes
6(11)	Respondent's theoretical affiliation	Attachment-led	Attach	Nominal	0 = no 1 = yes

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
6(12)	Respondent's theoretical affiliation	Non-aligned	NonAlign	Nominal	0 = no 1 = yes
6(13)	Respondent's theoretical affiliation	Pluralistic	Plural	Nominal	0 = no 1 = yes
6(14)	Respondent's theoretical affiliation	Other_Q6	Other_Q6	Nominal	0 = no 1 = yes
7	Number LGB clients treated by respondent over career	Number of LGB clients over career	LGBCareer	Ordinal	1 = 0 2 = 1 - 25 3 = 25+
8	Number of LGB clients treated by respondent today	Number of current LGB clients	LGBCurrent	Ordinal	1 = 0 2 = 1 - 5 3 = 6-10 4 = 10+
9(1)	Respondent's views on common reasons LGB clients seek therapy	Anxiety	Anxiety_Q9	Nominal	0 = no 1 = yes
9(2)	Respondent's views on common reasons LGB clients seek therapy	Depression	Depression_Q9	Nominal	0 = no 1= yes
9(3)	Respondent's views on common reasons LGB clients seek therapy	Lack of meaning in life	Meaning	Nominal	0 = no 1 = yes
9(4)	Respondent's views on common reasons LGB clients seek therapy	Work-related issues	Work	Nominal	0 = no 1 =yes
9(5)	Respondent's views on common reasons LGB clients seek therapy	Family-related issues	Family	Nominal	0 = no 1 = yes
9(6)	Respondent's views on common reasons LGB clients seek therapy	Relationship difficulties	Relationship	Nominal	0 = no 1 = yes
9(7)	Respondent's views on common reasons LGB clients seek therapy	Sexual difficulties	Sexual	Nominal	0 = no 1 = yes
9(8)	Respondent's views on common reasons LGB clients seek therapy	Shame about sexuality	Shame	Nominal	0 = no 1 = yes

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
9(9)	Respondent's views on common reasons LGB clients seek therapy	Bereavement	Bereavement	Nominal	0 = no 1 = yes
9(10)	Respondent's views on common reasons LGB clients seek therapy	Faith/religion/spirituality	Religion	Nominal	0 = no 1 = yes
9(11)	Respondent's views on common reasons LGB clients seek therapy	Terminal illness	Illness	Nominal	0 = no 1 = yes
9(12)	Respondent's views on common reasons LGB clients seek therapy	Addiction/alcohol or substance abuse	Addiction_Q9	Nominal	0 = no 1 = yes
9(13)	Respondent's views on common reasons LGB clients seek therapy	Body image dissatisfaction	BodyImage	Nominal	0 = no 1 = yes
9(14)	Respondent's views on common reasons LGB clients seek therapy	Bullying	Bullying	Nominal	0 = no 1 = yes
9(15)	Respondent's views on common reasons LGB clients seek therapy	Ageing/intergenerational	Ageing	Nominal	0 = no 1 = yes
9(16)	Respondent's views on common reasons LGB clients seek therapy	Child sexual abuse	Abuse	Nominal	0 = no 1 =yes
9(17)	Respondent's views on common reasons LGB clients seek therapy	Coming out	ComingOut	Nominal	0 = no 1 = yes
9(18)	Respondent's views on common reasons LGB clients seek therapy	Domestic violence and abuse	Domestic	Nominal	0 = no 1 = yes
9(19)	Respondent's views on common reasons LGB clients seek therapy	Gender identity issues	Gender	Nominal	0 = no 1 = yes
9(20)	Respondent's views on common reasons LGB clients seek therapy	LGBT parenting issues	Parenting	Nominal	0 = no 1 = yes
9(21)	Respondent's views on common reasons LGB clients seek therapy	Living with HIV	HIV	Nominal	0 = no 1 = yes

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
9(22)	Respondent's views on common reasons LGB clients seek therapy	Self-harm	SelfHarm_Q9	Nominal	0 = no 1 = yes
9(23)	Respondent's views on common reasons LGB clients seek therapy	Sexual practices (e.g., BDSM)	BDSM	Nominal	0 = no 1 = yes
9(24)	Respondent's views on common reasons LGB clients seek therapy	Intersectional difficulties	Intersectional	Nominal	0 = no 1 = yes
9(25)	Respondent's views on common reasons LGB clients seek therapy	Discrimination/stigma linked to sexual orientation	StigmaSO	Nominal	0 = no 1 = yes
9(26)	Respondent's views on common reasons LGB clients seek therapy	Discrimination/stigma not linked to sexual orientation	StigmaNotSO	Nominal	0 = no 1 = yes
9 (27)	Respondent's views on common reasons LGB clients seek therapy	Other_Q9	Other_Q9	Nominal	0 = no 1 = yes
10 = Open-ended question. Analyse thematically.					
11(1)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Anxiety_Q11	Anxiety_Q11	Nominal	0 = no 1 = yes
11(2)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Depression_Q11	Depression_Q11	Nominal	0 = no 1 = yes
11(3)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Narcissistic Personality Disorder	NPD	Nominal	0 = no 1 = yes
11(4)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Borderline Personality Disorder	BPD	Nominal	0 = no 1= yes
11(5)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Gender Identity Disorder	GID	Nominal	0 = no 1 = yes
11(6)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Body Dysmorphic Disorder	BDD	Nominal	0 = no 1 =yes
11(7)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Eating Disorder	Eating	Nominal	0 = no 1 = yes
11(8)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Sexual dysfunction	Dysfunction	Nominal	0 = no 1 = yes

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
11(9)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Somatisation/psychosomatic illness	Psychosomatic	Nominal	0 = no 1 = yes
11(10)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Obsessive Compulsive Disorder	OCD	Nominal	0 = no 1 = yes
11(11)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Internalised homophobia	Homophobia	Nominal	0 = no 1 = yes
11(12)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Self-harm	SelfHarm_Q11	Nominal	0 = no 1 = yes
11(13)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Addiction	Addiction_Q11	Nominal	0 = no 1 = yes
11(14)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Sexual perversion	Perversion	Nominal	0 = no 1 = yes
11(15)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Suicidal tendencies	Suicidal	Nominal	0 = no 1 = yes
11(16)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Post-Traumatic Stress Disorder	PTSD	Nominal	0 = no 1 = yes
11(17)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Schizophrenia	Schizophrenia	Nominal	0 = no 1 = yes
11(18)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Paranoia	Paranoia	Nominal	0 = no 1 =yes
11(19)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Fatigue	Fatigue	Nominal	0 = no 1 = yes
11(20)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Problems with memory and/or concentration	Memory	Nominal	0 = no 1 = yes
11(21)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Sleep disturbance	Sleep	Nominal	0 = no 1 = yes

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
11(22)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Worry about physical health	Health	Nominal	0 = no 1 = yes
11(23)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Non-health related worry	Worry	Nominal	0 = no 1 = yes
11(24)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Low self-esteem	SelfEsteem	Nominal	0 = no 1 = yes
11(25)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Phobia	Phobia	Nominal	0 = no 1 = yes
11(26)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Panic attacks	Panic	Nominal	0 = no 1 = yes
11(27)	Respondent's view on typical mental and/or physical health issues presented by LGB clients	Other_Q11	Other_Q11	Nominal	0 = no 1 = yes
12 = Open-ended question. Analyse thematically.					
13	Centrality of sexual orientation to LGB clients' problems	Centrality of Sexual Orientation	Central	Ordinal	1 = always 2 = frequently 3 = occasionally 4 = seldom 5 = never
14(1)	Respondent's views on possible aetiological cause of same-sex attraction	Can be re-directed	Redirect	Ordinal	1 = strongly agree 2 = agree 3 = neither agree nor disagree 4 = disagree 5 = strongly disagree
14(2)	Respondent's views on possible aetiological cause of same-sex attraction	Genetic	Genetic	Ordinal	1 = strongly agree 2 = agree 3 = neither agree nor disagree 4 = disagree 5 = strongly disagree

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
14(3)	Respondent's views on possible aetiological cause of same-sex attraction	Early attachment relationship	Attachment	Ordinal	1 = strongly agree 2 = agree 3 = neither agree nor disagree 4 = disagree 5 = strongly disagree
14(4)	Respondent's views on possible aetiological cause of same-sex attraction	Unresolved Oedipal conflicts	Oedipal	Ordinal	1 = strongly agree 2 = agree 3 = neither agree nor disagree 4 = disagree 5 = strongly disagree
14(5)	Respondent's views on possible aetiological cause of same-sex attraction	Early trauma	Trauma	Ordinal	1 = strongly agree 2 = agree 3 = neither agree nor disagree 4 = disagree 5 = strongly disagree
14(6)	Respondent's views on possible aetiological cause of same-sex attraction	Nature/Nurture	NatNur	Ordinal	1 = strongly agree 2 = agree 3 = neither agree nor disagree 4 = disagree 5 = strongly disagree
14(7)	Respondent's views on possible aetiological cause of same-sex attraction	Multiply determined	Multiple	Ordinal	1 = strongly agree 2 = agree 3 = neither agree nor disagree 4 = disagree 5 = strongly disagree

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
15	Respondent's view on symptom reduction in LGB clients	Symptom reduction in LGB clients	Reduce	Ordinal	1 = all 2 = most 3 = some 4 = few 5 = none
16	Respondent's view on general improvement in LGB clients	General improvement in LGB clients	Improve	Ordinal	1 = all 2 = most 3 = some 4 = few 5 = none
17	Respondent's view on LGB clients who request to re-direct same-sex attraction	Conversion	Convert	Ordinal	1 = work with client to explore underlying reasons 2 = assist to accept sexual orientation 3 = treat to change sexual orientation 4 = refer to another colleague with experience in helping clients accept their sexual orientation 5 = refer to another colleague with experience in helping clients change their sexual orientation 6 = other
18	Respondent's level of satisfaction with therapeutic work LGB clients	Level of satisfaction	Satisfy	Ordinal	1 = more satisfied 2 = the same 3 = less satisfied
19 = Open-ended. Analyse thematically.					
20	Respondent's average length of treatment with LGB clients	Average length of treatment	Length	Ordinal	1 = tends to be shorter 2 = much the same 3 = tends to be longer

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
21 = Open-ended. Analyse thematically.					
22	Respondent's views on self-disclosure of therapist's sexual orientation	Self-disclosure	SelfDisclose	Nominal	1 = yes 2 = no 3 = don't know
23 = Open-ended. Analyse thematically.					
24	Respondent's views on LGB clients' right to a LGB therapists	Right to LGB therapist	Right	Nominal	1 = yes 2 = no 3 = don't know 4 = prefer not to say
26 = Open-ended. Analyse thematically.					
27 = Open-ended. Analyse thematically.					
28	Respondent received formal training on sexual orientation	Formal training	Train	Nominal	1 = yes 2 = no 3 = cannot recall
29 = Open-ended. Analyse thematically.					
30	Respondent received effective teaching on sexual orientations	Effective teaching	Teach	Ordinal	1 = very effective 2 = quite effective 3 = neither effective nor ineffective 4 = only slightly effective 5 = not at all effective

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
31	Respondent needs to update theories and models of same-sex attraction	Updated theories/models	Update	Nominal	1 = yes 2 = no 3 = don't know
32 = Open-ended. Analyse thematically.					
33(1)	Respondent's impression of their Member Institution	MI treats LGB and non-LGB colleagues the same	Treat	Ordinal	1 = strongly agree 2 = agree 3 = neither agree nor disagree 4 = disagree 5 = strongly disagree
33(2)	Respondent's impression of their Member Institution	MI willingness to supervise LGB colleagues	Supervise	Ordinal	1 = strongly agree 2 = agree 3 = neither agree nor disagree 4 = disagree 5 = strongly disagree
33(3)	Respondent's impression of their Member Institution	MI recruits trainees based on aptitude, not sexual orientation	Aptitude	Ordinal	1 = strongly agree 2 = agree 3 = neither agree nor disagree 4 = disagree 5 = strongly disagree
33(4)	Respondent's impression of their Member Institution	MI promotes LGB and non-LGB colleagues equally	Promote	Ordinal	1 = strongly agree 2 = agree 3 = neither agree nor disagree 4 = disagree 5 = strongly disagree

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
34	Respondent's awareness of BPC Position Statement	Awareness of BPC Position Statement	Aware	Nominal	1 = yes 2 = no
35	Respondent's view on BPC role in fostering inclusive profession	BPC role in fostering inclusive profession	BPCRole	Ordinal	1 = much more active 2 = more active 3 = fine as it is 4 = less active 5 = much less active
36(1)	Respondent's view on BPC role in fostering inclusive profession	Revise entry requirements for LGB trainees	Entry	Ordinal	1 = important 2 = somewhat important 3 = neither important nor unimportant 4 = not too important 5 = not at all important
36(2)	Respondent's view on BPC role in fostering inclusive profession	Revise teaching curricula on LGB issues	Curricula	Ordinal	1 = important 2 = somewhat important 3 = neither important nor unimportant 4 = not too important 5 = not at all important
36(3)	Respondent's view on BPC role in fostering inclusive profession	Deliver CPD events for clinicians	CPD	Ordinal	1 = important 2 = somewhat important 3 = neither important nor unimportant 4 = not too important 5 = not at all important
36(4)	Respondent's view on BPC role in fostering inclusive profession	Better information, advice and guidance (IAG) on LGB issues	IAG	Ordinal	1 = important 2 = somewhat important 3 = neither important nor unimportant 4 = not too important 5 = not at all important

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
36(5)	Respondent's view on BPC role in fostering inclusive profession	Build partnerships with other LGB-specific psychotherapy organisations	Partners	Ordinal	1 = important 2 = somewhat important 3 = neither important nor unimportant 4 = not too important 5 = not at all important
36(6)	Respondent's view on BPC role in fostering inclusive profession	Network for LGB members of BPC	Network	Ordinal	1 = important 2 = somewhat important 3 = neither important nor unimportant 4 = not too important 5 = not at all important
36(7)	Respondent's view on BPC role in fostering inclusive profession	Ethics committee review of LGB issues/complaints	Ethics	Ordinal	1 = important 2 = somewhat important 3 = neither important nor unimportant 4 = not too important 5 = not at all important
37	Respondent's gender	Respondent's gender	Gender	Nominal	1 = female 2 = male 3 = other
38	Respondent's age	Respondent's age	Age	Ordinal	1 = 20-29 2 = 30-39 3 = 40-49 4 = 50-59 5 = 60-69 6 = 70+
39	Respondent's sexual orientation	Respondent's sexual orientation	Orientation	Nominal	1 = bisexual 2 = gay 3 = lesbian 4 = heterosexual 5 = none of these options 6 = other

Question No.	Questionnaire Item	Description of Variable	SPSS Variable Name	Measure	Coding Instructions
40	Respondent's openness about sexual orientation during training	Respondent's openness about sexual orientation during training	Openness	Nominal	1 = yes 2 = no 3 = prefer not to say 4 = not applicable
41 = Open-ended. Analyse thematically.					
42 = Open-ended. Analyse thematically.					

Appendix H: Analysis of An Open-Ended Question (Questionnaire)

Qualitative data from the questionnaire's open-ended responses were entered into Excel sheets (18 in total). The data for each worksheet were read, re-read and summarised. Patterns of responses were identified and grouped together into themes. Here is an example for the following question:

- Do you think it is appropriate for a therapist who is LGB and who is open about their sexuality in their personal and professional lives to disclose their sexual orientation to their LGB clients? YES/NO. Why did you give that answer?

Thematic Summary for the question 23 (LGB therapist self-disclosure)

Nb. Some responses are more detailed and nuanced than others, sometimes with several themes overlapping.

- Self-disclosure affects the transference and/or disrupts client's phantasies x 77. A number of words are used to describe the ways in which disclosure denudes the transference: 'intrusion'; 'restricts'; 'interferes'; 'obstructs'; 'plays havoc'; 'affects'; 'inhibits'; 'biases'; 'impedes'; 'disturbs'; 'complicates'; 'curtails'; 'damages'; 'unhelpful effect'; 'impairs'; 'closes down'; 'forecloses'; 'gets in the way'; 'robs'; 'compromises'; 'detracts'; 'disadvantages'; 'cuts across'; 'takes away'; 'hampers'.

- Self-disclosure is not consistent with therapist's personal practice/training/values x 65. Disclosure is against their ethical framework, the fundamental rule of psychoanalysis and/or theoretical training but these respondents do not mention explicitly transference (although this is sometimes implied).

- It depends on the individual circumstances and/or would need to be reviewed case-by-case x 35. Therapist would need to consider self-disclosure very carefully. Self-disclosure would need to be thoroughly explored with clients before revealing.

- Analyst recognises potential benefits of self-disclosure x 16. Benefits include: feeling understood; helps move therapy forward; assist clients fearing homophobia and/or discrimination; honest encounter; authenticity; affirming; validates LGB experience; helps not shame the client; reassuring; models self-acceptance; good use can be made of self-disclosure in the transference; facilitating; nurtures empathy; allows identification; respectful.

- Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure x19. Therapist sexual orientation many be known via: online profile; Pink therapy and/or other LGB referral systems; clues around therapist's home; unconscious cues.

- Analyst must be neutral, impartial or anonymous x 13.

- Self-disclosure crosses boundaries x 7.

- Analyst doesn't need to disguise or deny sexual orientation x 4. Could be anti-therapeutic if denied.

- Sexuality not always primary x 1 (therefore self-disclosure not necessary).

- Profession is not educated enough on these matters x 1.

SPSSID	Why do you give that answer?	Initial themes/codes
1	Although I personally never felt the need to access a LGB therapist, my issues weren't especially to do with my sexuality. That said, I can completely understand why a person would want to see a LGB therapist. There are nuances a person wouldn't need to explain, and that's incredibly important. Also, a lot of therapists were trained by reading papers on homosexuality alongside papers on perversion and haven't done anywhere near enough to educate themselves better.	• Sexuality not always primary • Analyst recognises potential benefits (of disclosure) • Profession is not educated enough on matters of sexual orientation
2	I answered no because disclosure might get in the way of the transference/countertransference and exploration of fantasies about the therapist. This could also get in the way of allowing a relationship based on trust to develop naturally and therapeutically, leading towards developing acceptance of self, and of self in society outside of the LGB community.	• It affects the transference and/or disrupts client's phantasies
3	I generally think that disclosure (e.g., about sexual orientation, whether or not you have children etc.) interferes with exploring the patient's phantasy.	• It affects the transference and/or disrupts client's phantasies
4	Because sometimes it is important for the client to know whether the therapist is LGB and I don't see why you shouldn't tell them.	• Analyst recognises potential benefits (of disclosure)
5	I would not disclose routinely but would carefully consider if I felt this was appropriate case by case; in addition, some patients will find me through a LGB referral system where my sexual orientation is stated.	• It depends on the individual circumstances and/or would review case-by-case • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
6	As with any disclosure, it robs the patient of any helpful fantasies about the analyst.	• It affects the transference and/or disrupts client's phantasies
7	It would not be consistent with my practice. I would not normally disclose information about myself.	• It is not consistent with therapist's personal practice/training/values
8	It depends on the patient and whether disclosing or not disclosing would help the patient understand and resolve his/her problems better.	• It depends on the individual circumstances and/or would review case-by-case • Analyst recognises potential benefits (of disclosure)
9	I don't think self-disclosure necessarily helps the patient.	• It is not consistent with therapist's personal practice/training/values

SPSSID	Why do you give that answer?	Initial themes/codes
10	Because the anonymity of the therapist applies whatever the sexual orientation of the patient. It is important to hold the space for the patient's fantasies and transference issues and disclosure would not allow that.	• Analyst must be neutral, impartial or anonymous • It affects the transference and/or disrupts client's phantasies
11	In certain situations, I would not see it as inappropriate to disclose information about myself to any patient regardless of their sexual orientation if that disclosure was helpful for moving the therapy forward.	• It depends on the individual circumstances and/or would review case-by-case • Analyst recognises potential benefits (of disclosure)
13	I think it is generally unhelpful to make personal disclosures. My perspective is from private practice. I appreciate that there are other settings where it may be thought about quite differently e.g., Pink Therapy.	• It is not consistent with therapist's personal practice/training/values • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
14	I would want to explore the patient's fantasies about my sexual orientation first in order to allow working in the transference. If after we had explored their reasons for wanting to know it remained an important question for the patient, I would then disclose.	• It affects the transference and/or disrupts client's phantasies • It depends on the individual circumstances and/or would review case-by-case
15	Because the sexual orientation of the therapist is also a subject of the patient's fantasy that should be explored without knowing for certain.	• It affects the transference and/or disrupts client's phantasies
16	Some patients might want a gay practitioner so should be allowed to choose that I think if the practitioner wishes to disclose it.	• It depends on the individual circumstances and/or would review case-by-case
17	By 'don't know' I mean - it depends on the situation ...	• It depends on the individual circumstances and/or would review case-by-case
19	I generally don't think it's a good idea to disclose personal details of any kind to patients. It doesn't help the treatment.	• It is not consistent with therapist's personal practice/training/value
20	If asked, why not say "Yes". Some LGB patients may only want to see a LGB therapist. Also, it may be easy enough to discover via shared social networks, so why hide it.	• Analyst recognises potential benefits (of disclosure) • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
21	I would not foreclose the fantasies in that way.	• It affects the transference and/or disrupts client's phantasies

SPSSID	Why do you give that answer?	Initial themes/codes
23	For the same reasons that one does not disclose other personal information to one's patients.	• It is not consistent with therapist's personal practice/training/values
25	I wouldn't disclose my sexuality, my faith, my marital status, my parental status, my age etc. Why close down the work?	• It is not consistent with therapist's personal practice/training/values
26	This is tricky as my first instinct is to avoid closing down room to explore fantasies about why a patient may think the therapist is of a certain orientation. However, I would also balance this with the need for authenticity and honesty which, by denying a central part of a therapist's identity, may be brought into question.	• It affects the transference and/or disrupts client's phantasies • Analyst recognises potential benefits (of disclosure)
27	I do not think that self-disclosure is helpful.	• It is not consistent with therapist's personal practice/training/value
30	I don't feel that a therapist's sexual orientation belongs in the therapy room. It is entirely private and should remain so. The work is in the transference that arises from not knowing and all the fantasies that are held in the patient.	• Analyst must be neutral, impartial or anonymous • It affects the transference and/or disrupts client's phantasies
31	I think it is not appropriate for a therapist to disclose their sexuality whether heterosexual or homosexual.	• It is not consistent with therapist's personal practice/training/value
33	I think that this would or might put pressure on the patient to respond in an affirming way. I would want to leave it the patient.	• It affects the transference and/or disrupts client's phantasies
34	Ordinarily, I'd say no disclosure, but if it is important to the patient at the start of therapy to know the therapist's sexuality then it's OK because at the moment there could well be distrust of psychoanalysis among LGB people.	• Analyst recognises potential benefits (of disclosure) • It depends on the individual circumstances and/or would review case-by-case
35	You need to be able to retain your own stuff to enable you to be able to listen to your patient.	• It is not consistent with therapist's personal practice/training/values
36	It would close down exploration in the transference.	• It affects the transference and/or disrupts client's phantasies
37	I believe the less the therapist discloses to the patient, the better it is.	• It is not consistent with therapist's personal practice/training/values

SPSSID	Why do you give that answer?	Initial themes/codes
38	Not sure that this would be helpful any more than other disclosures. I am straight but have been considered gay by a patient which was very important when using transference.	• It is not consistent with therapist's personal practice/training/values • It affects the transference and/or disturbs client's phantasies
40	If the therapist him/herself chose to do so, then that's his/her decision. I have nothing to say about it, although they would need to reflect on why they wanted to disclose it to the particular patients.	• It depends on the individual circumstances and/or would review case-by-case
41	I would prefer to say, "not necessarily". I do not think it is necessary nor always helpful for the work but in some circumstances, it may be appropriate - so case by case approach. I do not think it is necessarily WRONG to do so but I would not normally expect to do so any more than to disclose other personal details about myself.	• It depends on the individual circumstances and/or would review case-by-case
42	It might be an appropriate disclosure in a specific case but generally speaking the answer is no because it would interfere with working in the transference or inhibit it.	• It depends on the individual circumstances and/or would review case-by-case • It affects the transference and/or disrupts client's phantasies
43	Non-disclosure of personal material is my norm.	• It is not consistent with therapist's personal practice/training/values
44	It would intrude the therapist too much into the work.	• It affects the transference and/or disrupts client's phantasies
45	Declaring sexual orientation to any patient does not seem relevant.	• It is not consistent with therapist's personal practice/training/values
46	In general, I would avoid self-disclosure of any kind. I can see the benefit of having therapists whose sexual orientation is public - so that someone wanting, for example, a gay therapist would be able to find one. I would be more questioning of someone who disclosed their sexuality in the course of working with a patient.	• It is not consistent with therapist's personal practice/training/values • Analyst recognises potential benefits (of disclosure)
48	I am not sure it is necessarily helpful to privilege the disclosure of that personal information over any other personal information about the therapist's life.	• It is not consistent with therapist's personal practice/training/values
51	It compromises their frame and may invite their patients to think too much about why they needed their sexuality to be known.	• It affects the transference and/or disrupts client's phantasies
54	The less a patient knows, the more they can use the therapist.	• It affects the transference and/or disrupts client's phantasies

SPSSID	Why do you give that answer?	Initial themes/codes
55	I don't agree that one should disclose sexual orientation in general.	• It is not consistent with therapist's personal practice/training/values
57	I don't disclose personal information about myself to patients.	• It is not consistent with therapist's personal practice/training/values
58	Because it detracts from the patients' opportunities for exploring their fantasies about the therapist and his/her life (and therefore for exploring the transference).	• It affects the transference and/or disrupts client's phantasies
60	Because I wouldn't disclose this to non-LGB patients.	• It is not consistent with therapist's personal practice/training/values
61	The therapist, regardless of sexual orientation, should not disclose their preferences as the focus is the patient, not the therapist.	• It is not consistent with therapist's personal practice/training/values
62	Because it is private.	• It is not consistent with therapist's personal practice/training/values
65	Because none of the analyst's personal issues and in particular the issue of sexuality and its complexities should get mixed up with the patient's anxieties.	• It affects the transference and/or disrupts client's phantasies
71	I would question and be cautious about any personal disclosure to any patient, as it compromises the analytic work.	• It affects the transference and/or disrupts client's phantasies
74	My model is not one of self-disclosure - so I do not talk about myself, but respond to the patient's thoughts, assumptions, fantasies about me as revealed in the session material.	• It is not consistent with therapist's personal practice/training/values • It affects the transference and/or disturbs client's phantasies
75	I would see it as part of the normal refraining from self-disclosure which is part of a psychoanalytic approach which is more interested in exploring fantasies of patients about the analyst. I hope to be thoughtful with the patient if there is an assumption of my heterosexuality.	• It is not consistent with therapist's personal practice/training/values • It affects the transference and/or disrupts client's phantasies
76	The therapist, regardless of sexual orientation, should not disclose their preferences as the focus is the patient, not the therapist.	• It is not consistent with therapist's personal practice/training/values

SPSSID	Why do you give that answer?	Initial themes/codes
77	The way psychoanalytic therapy works is that the therapist keeps as much of himself out of the consulting room so that the patient can make him whatever object they need to. I think talking about one's own sexual preferences is a serious boundary violation because it can be experienced as seductive.	• It affects the transference and/or disrupts client's phantasies • It is not consistent with therapist's personal practice/training/values • It crosses boundaries
78	I think it is important to be as neutral as possible about oneself.	• Analyst must be neutral, impartial or anonymous
79	I would not expect any therapist working psychoanalytically to self-disclose in any way, regardless of their sexual orientation, as self-disclosure apart from any other objection, impedes working with fantasy and transference.	• It affects the transference and/or disrupts client's phantasies
81	It is very affirming. It is not something to keep quiet. The key part of the question is if they are 'open about their sexuality in their social and professional life'. Many LGB therapists are not open, particularly if they work in the psychoanalytical field.	• Analyst recognises potential benefits (of disclosure)
82	Because I haven't done so directly myself. My training was very clear on non-disclosure of personal matters. However, I think it is probable that my LGB patients will imagine I am a lesbian.	• It is not consistent with therapist's personal practice/training/values • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
84	But if challenged by the patient, I need to work very carefully with the patient's transference. My position is that unconsciously the patient probably knows.	• It affects the transference and/or disrupts client's phantasies • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
85	I do not think it is appropriate to give patients social or professional details of their therapist's lives.	• It is not consistent with therapist's personal practice/training/values
87	While I would not think it appropriate in every case, I believe it should be an option that is open to a psychotherapist treating a LGB patient.	• It depends on the individual circumstances and/or would review case-by-case
88	I don't believe it is consonant with my role as a therapist to make common cause with my patient. There is an implication that shared experience and similarity to the patient is what is important rather than training and experience.	• It is not consistent with therapist's personal practice/training/values

SPSSID	Why do you give that answer?	Initial themes/codes
90	Therapists should be able to treat people of different sexual orientation and be open minded to what the patient needs them to understand, without disclosing their own sexuality. I think the latter approach would be over-intrusive to the analytic work and development of the transference and would thus disadvantage the patient.	• It is not consistent with therapist's personal practice/training/values • It affects the transference and/or disturbs client's phantasies
92	I believe that a therapist should not disclose anything personal so that we can work with the positive and negative transference.	• It affects the transference and/or disrupts client's phantasies
93	I didn't tick 'yes' or 'no' because I think this would depend on the circumstances. Patients may guess or somehow find out in some other way, then it would depend on the circumstances/the patient etc. Supervision or discussion with colleagues might be indicated.	• It depends on the individual circumstances and/or would review case-by-case • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
97	It forecloses the value of fantasy. It will depend on the needs of the patient.	• It affects the transference and/or disrupts client's phantasies • It depends on individual circumstances
101	I try to work with their fantasies about my orientation.	• It affects the transference and/or disrupts client's phantasies
105	For my orientation, I'd say no but this is because self-disclosure does not occur in general. There are many other roads to Rome, and I cannot speak for other orientations.	• It is not consistent with therapist's personal practice/training/values
107	We are not there as therapists to disclose anything. If asked we work with it and might find it useful to the patient to say who we are.	• It is not consistent with therapist's personal practice/training/values
109	Generally, no: better to explore the transference.	• It affects the transference and/or disrupts client's phantasies
110	For me personally it would cross a professional boundary, like marital status or children etc. but this may not be the case for other therapists.	• It is not consistent with therapist's personal practice/training/values • It crosses boundaries
111	I think that the therapist should not disclose personal information of any kind to the patient. Equally I do not think the therapist should change the way they present themselves or seek to "disguise" their orientation.	• It is not consistent with therapist's personal practice/training/values • Analyst doesn’t need to disguise or deny sexual orientation

SPSSID	Why do you give that answer?	Initial themes/codes
112	Would not share sexual orientation as any other personal info with my patient.	• It is not consistent with therapist's personal practice/training/values
113	I wouldn't disclose other personal information, so why this?	• It is not consistent with therapist's personal practice/training/values
114	I think the disclosure may interfere with the transference and the freedom of the patient to have phantasies about their therapist.	• It affects the transference and/or disrupts client's phantasies
115	Not sure if someone would receive parity of treatment.	• It is not consistent with therapist's personal practice/training/values
116	I think the therapist needs to be open to explore every aspect of their/the patient's erotic transference and fantasy life and "declaring" sexuality restricts this capacity for full exploration. Inevitably we all give off signals which categorise us, size of house, accent etc. but nevertheless, the less said the more room for fantasies. I don't think the therapist should deny their sexual orientation and as is the same for any therapist the patient will probably come to know us as facts of our lives seep through.	• It affects the transference and/or disrupts client's phantasies • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure • Analyst doesn't need to disguise or deny sexual orientation
117	Yes, but in a way, which is worked through in the therapist's mind and puts their patient's needs first i.e., bears in mind the burden on one's patients of self-disclosure. It is not right with every patient and needs great care and thought.	• It depends on the individual circumstances and/or would review case-by-case
118	I would imagine this depends on the patient's position in therapy and the therapist's position vis-a-vis disclosure.	• It depends on the individual circumstances and/or would review case-by-case
119	Only if there is a good reason for it. Not as a norm.	• It depends on the individual circumstances and/or would review case-by-case
120	I work with a classical conception of transference and believe that the patient should be free to project on to the therapist without being side-tracked by reality information.	• It affects the transference and/or disrupts client's phantasies
121	Patients do not know about the therapist's private life and sexuality is also a private matter.	• It is not consistent with therapist's personal practice/training/values
122	I am very sceptical about all disclosure; however, I would expect to confirm a patient's intuitions if that seemed appropriate or if not doing so seemed inappropriate.	• It depends on the individual circumstances and/or would review case-by-case

SPSSID	Why do you give that answer?	Initial themes/codes
123	I believe in the blank screen approach.	• Analyst must be neutral, impartial or anonymous
124	I do not think it appropriate for therapists to disclose their sexual orientation or other aspects of their life within the therapeutic relationship.	• It is not consistent with therapist's personal practice/training/values
125	Disclosing personal details is not part of my practice.	• It is not consistent with therapist's personal practice/training/values
126	The patient comes to present his/her issues and looks for the therapist to listen and use their therapeutic skills. To overwhelm the patient with one's own stuff is never sound policy.	• It is not consistent with therapist's personal practice/training/values • It crosses boundaries
130	The sexual orientation of the therapist should be of little significance to the work.	• It is not consistent with therapist's personal practice/training/values
131	On the whole, I think personal details from the therapist just get in the way of helping the patient.	• It is not consistent with therapist's personal practice/training/values
133	Interferes with transference.	• It affects the transference and/or disrupts client's phantasies
134	As a psychoanalytic therapist, I think the patient needs to be free to think of the therapist in all sorts of ways, and for things not to be foreclosed. It is an intrusion into the patient and self-indulgent to disclose such things. Probably a way of avoiding the negative transference and being too pally and nice.	• It affects the transference and/or disrupts client's phantasies
135	I think it is important for the patient to have the freedom in the transference to imagine whatever they need to about their therapist.	• It affects the transference and/or disrupts client's phantasies
136	In line with giving the patient as little personal information as possible.	• It is not consistent with therapist's personal practice/training/values
138	The word disclose feels too absolute - it has the potential to impose the therapist on the patient, rather than allowing space for the patient to wonder, explore.	• It affects the transference and/or disrupts client's phantasies
140	The therapist should be neutral allowing the patient the freedom to explore what they want to and to allow for any fantasies/phantasies.	• Analyst must be neutral, impartial or anonymous • It affects the transference and/or disrupts client's phantasies

SPSSID	Why do you give that answer?	Initial themes/codes
142	The same applies as in heterosexual work where declaring orientation could interfere with the patient's recourse to phantasy.	• It affects the transference and/or disrupts client's phantasies
143	It seems a bit affirmative. But I don't have strong feelings about it. I don't, for instance, tell my straight clients that I'm straight. But then I don't think it takes them long to work it out from my house.	• Analyst recognises potential benefits (of disclosure) • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
145	Why cut across the patient's fantasies about one's own sexual preferences, thereby shutting down the depth of exploration such intriguing curiosity can elicit.	• It affects the transference and/or disrupts client's phantasies
146	The work is not about the therapist and the transference needs to be allowed its freedom.	• It affects the transference and/or disrupts client's phantasies
147	Interference with transference.	• It affects the transference and/or disrupts client's phantasies
148	All self-disclosure needs to be carefully thought about before being acted upon, however I can see why a LGB therapist may choose to disclose in this way e.g., to model self-acceptance, or to more fully explore a homophobic transference, amongst others.	• Analyst recognises potential benefits (of disclosure)
150	I don't think that any disclosure of private issues can help patients. Sexual orientation is not different.	• It is not consistent with therapist's personal practice/training/value
151	Because it is part of my ethical framework not to disclose personal information. The fact that a patient may find out something personal about me from elsewhere and bring it into the therapy would be different. I would then work with what they bring in so far as its meaning would be relevant to them. If I were LGB, I still would not necessarily disclose it, any more than I would disclose not being LGB.	• It is not consistent with therapist's personal practice/training/values • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
152	I don't disclose anything about my private life.	• It is not consistent with therapist's personal practice/training/values
153	Because I also don't think it appropriate for a therapist who is heterosexual to disclose their sexual orientation to their heterosexual or LGB patients. However, I might decide to include that I work with LGB clients on my website.	• It is not consistent with therapist's personal practice/training/values
154	Because disclosure affects the development of the transference, and so restricts the field available for analytic exploration.	• It affects the transference and/or disrupts client's phantasies
155	I do not think it is normally helpful to discuss my personal life with any patients.	• It is not consistent with therapist's personal practice/training/value

SPSSID	Why do you give that answer?	Initial themes/codes
156	It would disturb the transference for the patient.	• It affects the transference and/or disrupts client's phantasies
160	It takes away the opportunity to work with transference material.	• It affects the transference and/or disrupts client's phantasies
161	Therapist abstinence is as applicable to sexuality as it is any other aspect of the therapist.	• Analyst must be neutral, impartial or anonymous
162	I wouldn't consider it appropriate to disclose or discuss any personal material to patients.	• It is not consistent with therapist's personal practice/training/values
163	It has to be a qualified 'yes', because it depends on circumstances. It may be that the therapeutic relationship needs to be built on a footing where the patient feels safe in not being pathologised (so I don't think it is inappropriate for a therapist to advertise services within say a 'pink' community website). On the other hand, good use can be made in the transference of assumptions made by the patient as to the orientation of his/her therapist.	• It depends on the individual circumstances and/or would review case-by-case • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure • Analyst recognises potential benefits (of disclosure)
164	If one would not reveal this to non-LGB patients, why do so with LGB patients? The reasons for wanting to reveal, or doing so, would need to be examined.	• It is not consistent with therapist's personal practice/training/values
165	It depends.	• It depends on the individual circumstances and/or would review case-by-case
166	I do not generally disclose myself, but I think this particular 'disclosure' may facilitate the work in some circumstances. Therefore, I think it can be appropriate.	• It depends on the individual circumstances and/or would review case-by-case • Analyst recognises potential benefits (of disclosure)
167	There is no blanket answer to this question. It depends on the individual circumstances of the transference relationship. Why only to their LGB patients - what's the therapist's fantasy? If a therapeutic relationship has been established, I cannot see the why the therapist should disclose their sexuality. Generally, the patient should have the freedom to develop their fantasies about the therapist; to avoid enactment and favour thinking instead; same reasons for self-disclosure as in other areas.	• It depends on the individual circumstances • It affects the transference and/or disrupts client's phantasies

SPSSID	Why do you give that answer?	Initial themes/codes
168	Yes, if appropriate, and could help the work but not necessary to do so.	• It depends on the individual circumstances and/or would review case-by-case
169	All patients have a right to expect unprejudiced therapy, empathy and a capacity to both homo- and hetero-sexual identification in their therapist. Therapist's concrete sexual identity irrelevant to this.	• It is against therapist's personal practice/training/values
170	These things need to be explored in the therapy. If you self-disclose, you foreclose that.	• It affects the transference and/or disrupts client's phantasies
171	It depends entirely on whether it would be helpful to the patient.	• It depends on the individual circumstances and/or would review case-by-case
173	My first reaction is that this seems to me to be an unwarranted step away from neutrality and anonymity and may impair the therapist's capacity to be the patient's required transference object. However, if it's requested by the patient, I think it would be unhelpful to deny what the patient may already know from e.g., your online profile. Certainly, I don't deny things about me that the patient knows or might reasonably have discovered. For instance, not answering 'are you Scottish?' seems to me rather futile when you speak with a discernible Scots accent.	• Analyst must be neutral, impartial or anonymous • Analyst doesn't need to disguise or deny sexual orientation • It affects the transference and/or disrupts client's phantasies • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
174	There may be occasions when it is appropriate and helpful but generally, I think it's best to stick to the same boundaries as with any patient.	• It depends on the individual circumstances and/or would review case-by-case • It crosses boundaries
175	It's irrelevant except in the sense that we bring ourselves in a deeply personal way into the work with patients, but in the knowledge that this is only as a private point of reference for us. Anything else intrudes upon the patient however much the patient may put pressure on the therapist to know. It's the patient's therapy, not the therapist even if learning something about one's self is a potential 'perk' of the job.	• It is against therapist's personal practice/training/values
177	Patients - whatever their sexual orientation - should be free to explore their fantasies about my sexual orientation. Revealing details of my sexual life (i.e., my sexual orientation) would curtail their free association and damage their analysis.	• It affects the transference and/or disrupts client's phantasies
178	The relative anonymity of the therapist helps patient and therapist explore the patient's unconscious projections and "sets up the scene" for the transference.	• Analyst must be neutral, impartial or anonymous

SPSSID	Why do you give that answer?	Initial themes/codes
		• It affects the transference and/or disrupts client's phantasies
179	Disclose within the bounds of therapeutic abstinence. It is not a secret but should not be disclosed without reason.	• Analyst must be neutral, impartial or anonymous
183	It depends on the individual situation.	• It depends on the individual circumstances and/or would review case-by-case
184	I think that would cross the boundaries. I would not disclose my sexual orientation to my heterosexual patients, why to my LGB patients?	• It is not consistent with therapist's practice/training/values • It crosses boundaries
185	I do not disclose any personal information - this is the same.	• It is not consistent with therapist's personal practice/training/values
186	As with anyone patient/issue, self-disclosure may not be helpful.	• It is not consistent with therapist's personal practice/training/values
190	It creates a false sense of being the same and having gone through the same difficulties.	• It affects the transference and/or disrupts client's phantasies
191	I would work with their fantasies and use this as rich material for further growth.	• It affects the transference and/or disrupts client's phantasies
192	Follow the general rule of non-disclosure with patients.	• It is not consistent with therapist's personal practice/training/values
193	In my way of practicing I do not disclose 'personal' facts about myself.	• It is not consistent with therapist's personal practice/training/values
194	Need to be mindful about all sorts of disclosure. I feel it can be better to leave most questions unanswered (at least for a time) so that the patients' feelings/fantasies can be opened and explored.	• It affects the transference and/or disrupts client's phantasies
195	I do not think it is appropriate to ALWAYS be open about this, certainly if not prompted by the client. In some cases, I think it is important to be genuine about one's identity if a client asks about it (after exploring the reasons for asking).	• It is not consistent with therapist's personal practice/training/values • It depends on the individual circumstances and/or would review case-by-case

SPSSID	Why do you give that answer?	Initial themes/codes
196	I don't give any patients any information about me other than professional information. They may get information from other sources. But, generally, information like this it inhibits the patient from being able to access their own feelings.	• It is not consistent with therapist's personal practice/training/values • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure • It affects the transference and/or disrupts client's phantasies
198	The work is not about the therapist but understanding the transference onto the therapist.	• It affects the transference and/or disrupts client's phantasies
199	The focus for treatment is the patient - it has to be patient-led.	• It is not consistent with therapist's personal practice/training/values
200	I do not disclose to enhance transference therapeutic gain for any patient.	• It affects the transference and/or disrupts client's phantasies
202	Disclosure of highly personal information, whatever it is, is not appropriate. Sexual orientation is no exception. If a patient wants to know the sexual orientation of their therapist this is more fruitfully explored rather than answered.	• It is not consistent with therapist's personal practice/training/values • It affects the transference and/or disrupts client's phantasies
203	It is never appropriate to disclose.	• It is not consistent with therapist's personal practice/training/values
204	I tend to think it is not appropriate to make explicit disclosures about any aspect of the therapist's life, although I recognise that we all make implicit disclosures all the time, and that these should be reflected on.	• It is not useful/appropriate to disclose anything personal • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
205	It would play havoc with the transference.	• It affects the transference and/or disrupts client's phantasies
206	It would be dependent on the therapeutic alliance and whether it was felt it could be helpful for the client.	• It depends on the individual circumstances and/or would review case-by-case • Analyst recognises potential benefits (of disclosure)
208	This is private and personal information. I wouldn't reveal it to other clients therefore why LGB ones? As a psychodynamic counsellor I would not reveal any of my personal info to my clients as it would affect the transference relationship.	• It is not consistent with therapist's personal practice/training/values

SPSSID	Why do you give that answer?	Initial themes/codes
		• It affects the transference and/or disrupts client's phantasies
209	I believe that it is helpful for the therapist to exhibit a neutral perspective so that the patient will not feel coerced, manipulated or encouraged to please the therapist.	• Analyst must be neutral, impartial and anonymous • It affects the transference and/or disrupts client's phantasies
210	I think the transference relationship should be allowed to develop unhindered by 'reality'.	• It affects the transference and/or disrupts client's phantasies
211	It is up to the therapist. I do not self-disclose usually but if I had explored the reasons for the patient's question and felt a concrete response was the only way to continue work, I would consider doing so - however this would be rarely the case and only after a lot of thought.	• It depends on the individual circumstances and/or would review case-by-case
213	Probably not, but it depends on a range of different factors e.g., whether the patient is likely to find out through other sources, what transpires in the therapy etc.	• It depends on the individual circumstances and/or would review case-by-case • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
214	It is important to explore patient's projections.	• It affects the transference and/or disrupts client's phantasies
216	It depends on the type of therapist. I tend to disclose as little as possible.	• It depends on the individual circumstances and/or would review case-by-case
218	Because I believe the patient is usually paying the therapist for the work of self-discovery. I would wonder how such a disclosure would affect/change the relationship. And if this was in the patient's best interest.	• It affects the transference and/or disrupts client's phantasies
223	The therapist must remain as anonymous as possible on such matters to allow the patient's phantasies about them to flourish.	• Analyst must be neutral, impartial or anonymous • It affects the transference and/or disrupts client's phantasies
226	Patients need to be able to explore their fantasies about what you might think or how you might be. As well as their accurate observations!	• It affects the transference and/or disrupts client's phantasies

SPSSID	Why do you give that answer?	Initial themes/codes
228	My opinion has changed over the years. I now think it is very appropriate that there are - for those who wish to be 'out' - identifiable 'Gay' therapists. Otherwise the unhelpful, (promoting institutional homophobia) assumption is that all therapists are heterosexual in their lifestyle.	• Analyst recognises potential benefits (of disclosure)
229	I am generally against self-disclosure by therapists but could imagine it might be helpful in some situations.	• It is not consistent with therapist's personal practice/training/values • It depends on the individual circumstances and/or would review case-by-case
230	Boundaries. Don't self-disclose.	• It crosses boundaries
232	Why would you disclose this as opposed to anything else about you? I find it more useful to work with the client's fantasy.	• It affects the transference and/or disrupts client's phantasies
233	This is a transference relationship.	• It affects the transference and/or disrupts client's phantasies
234	I believe the best position for an analytic therapist is that of not bringing one's own issues to therapy, and that disclosure would affect transference in an unhelpful way. Remaining opaque would allow the patient the possibility of exploring their feelings towards and phantasies about non-LGB people and their positions relative to each other, and a host of other important issues, where disclosure seems to me a simple and rather cheap way of 'winning friends' and suggesting to the patient that you will be particularly sympathetic and helpful.	• It affects the transference and/or disrupts client's phantasies • Analyst must be neutral, impartial or anonymous
235	Boundary violation.	• It crosses boundaries
236	Therapist needs to be more of a blank canvas for proper psychoanalytic work. Sensitivity and understanding about LG issues is what's important.	• Analyst must be neutral, impartial or anonymous
237	I would not like to generalise about this. It is quite possible this may be relevant to disclose but the method suggests we should take things through the transference. Symbolic meaning is central to psychoanalytic therapy. However, one of the changes taking place and perhaps a more honest approach is through a 'relational' style.	• Analyst recognises potential benefits (of disclosure) • It depends on the individual circumstances and/or would review case-by-case
238	Would a therapist disclose that they were straight??	• It is not consistent with therapist's personal practice/training/values
239	This is partly an artefact of the way this question is structured. I do not disclose information about myself though patients are free to find out whatever they find out about me, for example from Googling me. I have a clear theoretical underpinning for this position, but I do not believe others are bound by my theory-driven practice. Thus, I think disclosure is "wrong" but I do not think everyone does or should share my view.	• It is not consistent with therapist's personal practice/training/values • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure

SPSSID	Why do you give that answer?	Initial themes/codes
240	No more than disclosure of any other personal aspect of life as it can close down exploration of conflicts, fantasy and work in the transference. Some have found out about mine via mutual fluke contacts and then we work with it. It brings as many challenges and opportunities for shifts as other boundary breaches can. But this is different from a starting position of knowing or choosing.	• It affects the transference and/or disrupts client's phantasies • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
241	I do not think it is appropriate for a therapist to speak about their personal life/values etc and interfere with the process between therapist and patient.	• It is not consistent with therapist's personal practice/training/values • It affects the transference and/or disturbs client's phantasies
242	No: so that patient has space to talk about their fantasies about their therapist.	• It affects the transference and/or disrupts client's phantasies
244	Generally, no, because of the need for the patient to make me what they need to in the transference.	• It affects the transference and/or disrupts client's phantasies
249	I think it wrong to DISCLOSE the therapist's sexual orientation, whether gay or straight. (Cf. it would be wrong to disclose religious faith or lack of it). HOWEVER, if it is generally known, and the patient knows it, it could be anti-therapeutic to deny it. This would be a matter of clinical judgement.	• It is not consistent with therapist's personal practice/training/values • Analyst doesn't need to disguise or deny sexual orientation • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
250	The same reason as I don't disclose many other personal details.	• It affects the transference and/or disrupts client's phantasies
251	There remains considerable homophobia in the psychotherapy/psychoanalysis profession. This disclosure would be one way for a patient to ensure that they have a respectful therapist.	• It is not consistent with therapist's personal practice/training/values
252	Transference.	• It affects the transference and/or disrupts client's phantasies
253	For the same reason I would not disclose anything about myself because otherwise it would obstruct the transference.	• It affects the transference and/or disrupts client's phantasies

SPSSID	Why do you give that answer?	Initial themes/codes
256	I think it should remain about the patient, not the therapist.	• It is not consistent with therapist's personal practice/training/values
257	It's the same as me as a female therapist disclosing my heterosexuality, marital status etc. It hampers treatment by introducing expectation of identification.	• It affects the transference and/or disrupts client's phantasies
260	I would want to explore what is behind the question including fears and fantasies so that the subject is not closed off but would be open to the possibility of disclosure if I thought it necessary as a last resort.	• It affects the transference and/or disrupts client's phantasies • It depends on the individual circumstances and/or would review case-by-case
263	Certain things become obvious to patients, but it is not my job to disclose any facts about my own life or beliefs.	• Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure • It is not consistent with therapist's personal practice/training/values
266	It could bias the transference.	• It affects the transference and/or disturbs client's phantasies
268	In this and other aspects, I think the therapist's private self should be kept in the background to allow space for the patient.	• Analyst must be neutral, impartial or anonymous • It affects the transference and/or disturbs client's phantasies •
271	Could interfere with the transference.	• It affects the transference and/or disrupts client's phantasies
273	To the extent that personal disclosure is unhelpful I would say no. I am sure there are exceptional circumstances where I might choose to act differently. While it may provide some reassurance, I start from the assumption that it would have an unhelpful effect on transference issues.	• It depends on the individual circumstances and/or would review case-by-case • It affects the transference and/or disrupts client's phantasies
274	I suspect this may depend on the environment and the specific work. It seems it is up for the usual discussion within the therapeutic setting as much as anything else (e.g., childlessness etc).	• It depends on the individual circumstances and/or would review case-by-case
275	I don't feel it would merit a special mention above any form of self-disclosure.	• It is not consistent with therapist's personal practice/training/values

SPSSID	Why do you give that answer?	Initial themes/codes
276	Generally, I think that this level of disclosure is not appropriate to any patient in any circumstance.	• It is not consistent with therapist's personal practice/training/values
277	Because not to disclose, when appropriate, can be seen as shaming the client even further.	• Analyst recognises potential benefits (of disclosure)
280	Working analytically, I would assume the wish to tell had some meaning that should be understood and that it had a fair chance of trying (unconsciously perhaps) to avoid something.	• It affects the transference and/or disrupts client's phantasies
283	Self-disclosure is a tactic or a spontaneous occurrence that needs to be considered v carefully, whatever the content: this is not specific to LGB or any other category; so, as a rule, "no" but there are exceptions as with anything else.	• It depends on the individual circumstances and/or would review case-by-case
284	My answer is not specifically about LGB issues. Generally, therapist disclosure complicates the transference. There may be times, however, when disclosure might be very helpful. It is a clinical judgement in each case	• It affects the transference and/or disrupts client's phantasies • It depends on the individual circumstances and/or would review case-by-case
285	It's important for patients to explore unconscious phantasy. I think it's often known at some level. A friend of mine seeing a gay analyst would mention that when they talked about sexuality it often didn't seem to fit right and felt odd. A gay colleague talked about not feeling their heterosexual analyst could really engage with them around gay sexuality.	• It affects the transference and/or disrupts client's phantasies • Analyst's sexuality may already be known and/or recognition that there may be accidental and/or implicit/unconscious self-disclosure
287	NO disclosure whatsoever is a fundamental rule.	• It is not consistent with therapist's personal practice/training/values

Appendix I: Interview Participant Information Sheet

Interview Participant Information Sheet

Project Title: Same-sex sexualities: an empirical study of the clinical attitudes of British psychoanalytic psychotherapists towards Lesbian, Gay and Bisexual (LGB) clients

I am inviting you to participate in a research project being carried out by a PhD student Wayne Full (07817 452 437) under the supervision of:

Professor Mary Target (07966 807699) m.target@ucl.ac.uk
Professor of Psychoanalysis at UCL

Professor Michael King (020 7830 2397) michael.king@ucl.ac.uk
Professor of Primary Care Psychiatry Joint director of PRIMENT Clinical Trials Unit, and Joint lead on the UCL arm of the London Research Design Service.

The UCL Research Ethics Committee has approved the study (Project ID Number: 6566/002).

Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if anything is unclear or if you would like more information.

The research is exploring the theories and clinical models of same-sex sexual orientation held by psychoanalytic practitioners working with Lesbian, Gay and Bisexual (LGB) clients.

The one-off interview will last approximately 40-45 minutes. Wayne will be exploring your views, experiences and ways of working with LGB patients. He will be interviewing as broad a range of psychoanalytic practitioners as possible. All interviews will be in a suitable venue agreed with you, possibly your consulting room or an office at UCL. From the responses you provide, Wayne will identify key themes, which will inform his final thesis.

Wayne will record and transcribe all interviews. Wayne will ensure all recorded interviews and transcripts are stored securely and encrypted with an external hard disc back-up copy kept in Wayne's possession. None of the raw data will be shared with other parties. You will be offered a summary of the final thesis.

If you decide to participate in this study, your participation and any information collected from you will be strictly confidential, and only available to Wayne and, where necessary and anonymously, to his supervisors. **All data will be collected and stored in accordance with the Data Protection Act 1998.** If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form.

I would like to thank you very much, in advance, for your participation.

Professor Mary Target

Appendix J: Interview Consent Form

Interview Consent Form

Project Title: Same-sex Sexualities: an empirical study of the clinical attitudes of British psychoanalytic psychotherapists towards Lesbian, Gay and Bisexual (LGB) clients

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Thank you for your interest in taking part in this research. The UCL Research Ethics Committee has approved this study (Project ID Number: 6566/002).

Before you agree to take part, the person organising the research must explain the project to you.

If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Please read the following statements. If you consent to these statements, please print and sign your name in the spaces provided below, and date the form.

1. I confirm that I have read and understand the information sheet and understand what the research study involves.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I consent to the processing of my personal information for the purposes of this research study.

4. I agree to anonymised quotations being used in the final thesis, reports and other publications. I understand my confidentiality and anonymity will be maintained. It will not be possible to identify me from any publications.

5. I agree for a recording and transcription of the interview to be made.

6. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.

7. I agree to take part in this research study.

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Researcher	Date	Signature

All data will be stored securely.

Tick this box if you would like to receive a summary of the results by e-mail ☐

E-mail: _____

Researcher: Wayne Full (07817 452 437) wayne.full.12@ucl.ac.uk under the supervision of:

Professor Mary Target (07966 807 699) m.target@ucl.ac.uk
Professor of Psychoanalysis at UCL

Professor Michael King (0207 830 2397) michael.king@ucl.ac.uk
Professor of Primary Care Psychiatry; Joint director of PRIMENT Clinical Trials Unit; and Joint lead on the UCL arm of the London Research Design Service

Appendix K: Interview Demographics Form

Interviewee Personal and Professional Demographics Sheet

Thank you for taking part in the interview. I hope you will help me by completing this form about your personal and professional demographics. I am collecting this type of data to ensure the broadest range of participants for interview. By monitoring demographics, I hope to obtain a variety of perspectives on the topic of same-sex sexualities. However, please be aware that completing the form is entirely voluntary.

1. What is your gender? *Please place 'X' against the appropriate category.*

Female	
Male	
Other	

If 'Other', please specify here:

2. What is your age? *Please place 'X' against the appropriate category.*

20-29	
30-39	
40-49	
50-59	
60-69	
70+	

3. What is your sexual orientation? *Please place 'X' against the appropriate category.*

Asexual	
Bisexual	
Gay	
Heterosexual	
Lesbian	
Queer	
Other	
Would rather not say	

If 'Other', please specify here:

4. In your own terms, please describe your primary theoretical orientation?
Examples: Freudian/Contemporary Freudian; Kleinian/Post-Kleinian; Jungian; Interpersonal)
Please describe here:

5. At which institute(s) did you train?
Examples: British Psychoanalytical Society and Institute of Psychoanalysis; British Psychotherapy Foundation; Severnside Institute for Psychotherapy
Please specify here:

6. If different from where you trained, at which institute(s) are you a member now?
Please specify here:

7. **To which of the following activities do you contribute**? *Please place 'X' against all categories that apply.*

Clinical work in private practice	
Clinical work within the NHS	
Clinical work within the third/charity sector	
Specialist clinical work (e.g., HIV/AIDS; Sexual Offenders, Gender Identity)	
Research	
Theoretical development	
Teaching within academia and/or training institute	
Training therapist/supervisor	
National activity (e.g., lobbying government, informing policy)	
Committee membership(s)	
Journal editor/editorial work	
Author	
Conference speaker	
Any other activities	

If 'Other', please specify here:

Appendix L: Pilot Interview Feedback Form

Pilot Interview Feedback Form

Project Title: Same-sex sexualities: an empirical study of the clinical attitudes of British psychoanalytic psychotherapists towards Lesbian, Gay and Bisexual (LGB) clients

Supervisors: Professors as Mary Target and Michael King

Researcher: Wayne Full

Project Number: 6566/002

Thank you for agreeing to participate in a pilot interview for the above research project. We would now like you to provide some feedback on how the interview questions and how the interview was conducted. The responses you provide on this form will be used to refine the interview process and topic guide.

Part 1: Interview Protocols

State your level of agreement with each of the following statements by placing an X next to the box that best reflects your opinion.

1.1 The interviewer clearly introduced himself and his background.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

1.2 The interviewer clearly explained the overall research project and its aims.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

1.3 The Participant Information Sheet was written in simple non-technical language and I understood clearly what I was agreeing to.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

1.4 The Consent Form was written in simple non-technical language and I understood what I was consenting to.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

1.5 The interviewer asked my permission to digitally record the interview.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

1.6 The interviewer described my rights to withdraw from the interview at any time.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

1.7 The interviewer reassured me concerning issues of confidentiality and anonymity.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

1.8 The interviewer asked me if I had any questions before starting the interview.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

1.9 Are there any suggestions you would like to make on how research etiquette might have been improved? Please answer in the space below (box is expandable).

Part 2: Topic Guide

The interview guide is appended with this form. You will need to refer to it in order to answer some of the questions in this section.

State your level of agreement with each of the following statements by placing an X next to the box that best reflects your opinion.

2.1(a) The wording of the interview questions was clear and straightforward.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

2.1(b) If the wording of any of the questions was not clear and straightforward, could you indicate in the space below which questions and why you felt this way:

2.2(a) I was comfortable answering the interview questions.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

2.2(b) If you found any of the questions uncomfortable to answer, please indicate in the space below which questions and why you felt this way:

2.3(a) The interview questions were flexible and open, allowing me to think and answer the questions freely.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

2.3(b) If the wording of any of the questions was inflexible, could you indicate in the space provided which questions and why you felt this way:

2.4(a) The interview questions covered a diverse enough range of topics in relation to the subject matter.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

2.4(b) If there were not enough diverse coverage of topics, what type of questions did you think were missing and would like to have seen?

2.5(a) The wording of the interview questions was biased and/or leading.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

2.5(b) If you found any of the interview questions biased and/or leading, could you indicate in the space provided which questions and why you felt this way:

Part 3: Interview Conduct

3.1(a) The interviewer built and maintained a good rapport with me throughout the interview.

- Strongly Agree ☐.
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

3.1(b) In what ways did the interviewer establish a good rapport (or not) with you? Please answer in the space below (box is expandable).

3.2 The interviewer achieved a neutral position in the interview (i.e., I was not aware of the interviewer's conduct and/or views influencing my responses to questions).

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

3.2(b) In what ways did the interviewer achieve or fail to achieve a neutral standpoint/conduct in the interview? Please answer in the space below (box is expandable).

3.3(a) The interviewer allowed adequate breathing space for me to reflect on questions in my own way and in my own time.

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

3.3(b) In what ways did the interview allow or not allow adequate breathing space? Please answer in the space below (box is expandable).

3.4(a) The interviewer managed the interview process well (e.g., provided appropriate verbal feedback, the interview flowed well).

- Strongly Agree ☐
- Agree ☐
- Neither Agree Nor Disagree ☐
- Disagree ☐
- Strongly Disagree ☐

3.4(b) In what ways might the interviewer have improved how the interview was managed? Please answer in the space below (box is expandable).

Appendix M: Interview Work Mapped against Consolidated Criteria for Reporting Qualitative Research (COREQ)

In order to ensure my qualitative reporting was robust and met academic standards, I was advised to map my interview work against the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist and guidelines (Tong, Sainsbury and Craig 2007). COREQ is a 32-item checklist for explicit and comprehensive reporting of qualitative studies such as in-depth interviews and focus groups.

No. Item	Guide questions/description	PhD Interviews mapped against COREQ Items
DOMAIN 1: RESEARCH TEAM AND REFLEXIVITY		
Personal Characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	The student conducted all 36 interviews.
2. Credentials	What were the researcher's credentials? E.g., PhD, MD	The student has a Master's in Theoretical Psychoanalytic Studies (2012–13) and has taught psychoanalytic theory to MSc students at the Anna Freud Centre (2017–18). The student is also a member of the BPC Task Group on Sexual and Gender Diversity (2013–present). For many years, the student worked as a freelance researcher for the creative industries, which included conducting both quantitative and qualitative projects, as well as evaluations. The student co-ordinates *Psychotherapy Today*, the British Psychotherapy Foundation's flagship introductory course (2018–19). He is also on the Review Panel for the *British Journal of Psychotherapy* (2018–19). Professors Mary Hepworth and Michael King, both well-known and well-respected experts in their fields, supervised the student.
3. Occupation	What was their occupation at the time of the study?	The researcher was a full-time PhD student but undertook occasional teaching and course co-ordination within the field during this time (see above) and some research consultancy in the creative industries.
4. Gender	Was the researcher male or female?	The student was male but, perhaps, of more importance for this study, the student identified as LGB. However, not all interview participants knew this. See **item six** on relationships established.

5. Experience and training	What experience or training did the researcher have?	Having worked as a freelance research consultant, the student had some experience of interviewing stakeholders and had been involved in qualitative research projects in the past. The student undertook further training in qualitative practice and methods as part of the UCL Doctoral Skills Programme. All credits attained from these qualitative courses were registered in the student's Research Log.
Relationship with Participants		
6. Relationship established	Was a relationship established prior to study commencement?	Before the study, the student had had professional contact and interactions with ten out of the 36 interviewees. These ten interviewees were, for the most part, specialists in the field of sexuality or gender. The student had either worked with these individuals on related projects or through the BPC Task Group on Sexual and Gender Diversity.
7. Participant knowledge of the interviewer	What did the participants know about the researcher? E.g., personal goals, reasons for doing the research	The ten participants above would have been aware not only of the student's sexual orientation but also personal motivation and interest in the topic area. Before conducting the interviews, most of the other 26 participants would not have been aware of the student's sexual orientation or personal interest in the topic. The other 26 participants would only have been provided with basic information about the study (via the Interviewee Information Sheet and Interview Consent Form). However, some interviewees did ask for more information about the student and the study on the day of the interview. Where appropriate, the student disclosed his sexual orientation and provided further contextual background or information about personal motivation. In some instances, due to the focus of the study, participants may have assumed the student was gay and therefore had a personal investment in the study.
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g., bias, assumptions, reasons and interests in the research topic	Participants were provided with a basic Interviewee Information Sheet, which only stated that the research was seeking to explore theoretical, clinical and institutional questions linked to the topic of same-sex sexual orientation. No information about the interviewee's background or assumptions was provided. The student only revealed his sexual orientation and/or reasons and interests in the research topic if asked directly by the participant on the day of the interview.

DOMAIN 2: STUDY DESIGN		
Thematic Analysis		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? E.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis	The student adopted a pragmatic philosophy. A Framework Analysis was selected to analyse the data. Framework Analysis is compatible with the student's pragmatic methodological approach. As an analytic tool, Framework Analysis is not aligned with specific epistemological, philosophical or theoretical perspectives. It is a practical approach, offering clear steps and procedures to follow. It is a rigorous, flexible and methodical approach, fostering transparency of the data analysis process.
Participant Selection		
10. Sampling	How were participants selected? E.g., purposive, convenience, consecutive, snowball	Thirty-six interviews were conducted as part the study. Participants were recruited via a combination of purposive and snowballing methods. Overall, 97 individuals were approached to participate. Sixty-one declined to take part (63% non-response rate). Eighty-seven individuals were sent direct invitations. These 87 invitees were either known specialists in the area of gender and/or sexuality or were in senior positions within the field (but who may not have been specialists in the topic area). By 'senior position', I mean individuals who were Training Analysts/Supervisors, members of high-profile committees and panels (e.g., BPC Executive Council) or Professors/Senior Lecturers at leading university departments. Most contact details were identified via the BPC Register. Individuals from across all 14 BPC membership organisations were invited. Twenty-six interviewees were recruited through this process. Ten individuals were recommended (snowballing element). I sent invitations to all these 10 individuals, all of whom accepted. Three interviews were not BPC members.
11. Method of approach	How were participants approached? E.g., face-to-face, telephone, mail, email	All invitations were sent via email with the Interviewee Information Sheet and Consent Form attached. Affirmative responses to the invitations were followed-

		up immediately and a mutually convenient location and time for interview were arranged.
12. Sample size	How many participants were in the study?	There were 36 participants overall.
13. Non-participation	How many people refused to participate or dropped out? Reasons?	Overall, 97 individuals were approached to be involved in the interviews. Thirty-six actually participated. Sixty-one refused to participate (63% non-participation rate).
Setting		
14. Setting of data collection	Where was the data collected? e.g., home, clinic, workplace	Thirteen people were interviewed at their private consulting rooms within their homes. Eleven were interviewed at their workplaces (e.g., at the hospital, clinic or university department where they worked). Seven were interviewed at their private consulting rooms at an external location (i.e., not at their homes). Five were interviewed at their homes, but not in their consulting rooms (i.e., kitchen, living room, lounge).
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	Only the student and the interviewee were present.
16. Description of sample	What are the important characteristics of the sample? E.g., demographic data, date	*Demographics include:* • *Gender:* Male (n=18); Female (n=17); Other (n=1). • *Age:* 60-69 (n=18); 50-59 (n=8); 70+ (n=6); 40 - 49 (n=4); no interviewees under 40. • *Sexual orientation:* Heterosexual (n=25); Lesbian (n=5); Gay (n=4); Queer (n=1); Would rather not say (n=1). • *Modality:* Psychoanalyst (n=13); Psychoanalytic Psychotherapist (n=8); Jungian Analyst (n=5); Psychodynamic Psychotherapist (n=2); Psychoanalyst & Psychoanalytic Psychotherapist (n=2); Couples Psychoanalytic Psychotherapist (n=2), Jungian analyst and child

		psychotherapist (n=1); Clinical Psychologist (n=1), Child Psychoanalyst & Psychoanalytic Psychotherapist (n=1) Child and Adult Psychoanalyst (n=1) • *Theoretical Perspectives:* Interviewees variously self-identified either exclusively or in combination as: Jungian; Attachment-led; Kleinian or contemporary Kleinian; Freudian or Contemporary Freudian; British Independent; Lacanian; Relational; Object Relational; Non-aligned; Dynamic Interpersonal; Pluralist Integrative; Humanistic; and Cognitive Behavioural. • *Training Organisation*: Interviewees were drawn from: WPF/FPC; BPAS/IoPA; SAP; BPF; Tavistock; and Other. Some interviewees were members of more than one institute. • *Professional Activities:* Private practice (n=32); Teaching within academia and/or training organisation (n=30); Conference speaker (n=30); Committee membership (n=30); Author (n=29) Training analyst (n=25); Research (n=18); Editorial/journal work (n=18); Theoretical development (n=15); National activity (n= 12); NHS (n=11); Third sector (n=11); Specialist clinical work e.g., GIDS, HIV/AIDS (n=5); other (n= 1) • *Ethnicity:* BAME (n=3).
Data Collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	The topic guide consisted of eight main questions with prompts. For the most part, the topic guide was not shared with interviewees in advance of the interview. Only two interviewees saw the topic guide in advance, but this was because they had specifically requested to see it. The topic guide was piloted with four participants (the pilot interviewees form part of the overall 36). The pilot interviewees were asked to complete feedback forms. The feedback form asked questions about the topic guide questions and interviewee conduct. Feedback data was used to refine the interview guide as well hone the researcher's interviewing skills.
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	Repeat interviews were not undertaken.
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	All interviews were audio recorded. Two devices were used, one for back up.

20. Field notes	Were field notes made during and/or after the interview or focus group?	Some field notes were taken. When field notes were taken, they tended to include my impressions about particularly difficult interviews and/or interviews that were moving and/or very personal.
21. Duration	What was the duration of the inter views or focus group?	All 36 interviews were conducted over a ten-month period, starting in July 2017 and ending in May 2018. Interview durations varied. The shortest interview was 28 minutes. The longest interview was 1 hour and 17 minutes. The average interview duration was 45 minutes. Overall, 28 hours of interviews were conducted.
22. Data saturation	Was data saturation discussed?	Participants were recruited until no new relevant knowledge was being obtained.
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	All 36 transcripts were returned to interviewees for comment/correction. Thirty-one out of 36 were reviewed by interviewees. Interviewees tended to make very minor amendments, usually in relation to clinical cases they had discussed during the interview and where they had concerns over patient confidentiality.
DOMAIN 3: ANALYSIS AND FINDINGS		
Data Analysis		
24. Number of data coders	How many data coders coded the data?	The student coded all 36 transcripts. Emerging findings were discussed and reviewed in supervision. Three transcripts were sent to Dr Karen Ciclitira to review independently and confirm my initial codes and/or identify gaps in analysis.
25. Description of the coding tree	Did authors provide a description of the coding tree?	Yes, see Appendix O.
26. Derivation of themes	Were themes identified in advance or derived from the data?	Both. Themes were drawn from a priori concerns (e.g., themes identified from the literature review, the clinical attitudes questionnaire and ongoing discussion with members of the BPC Task Group on Sexual Diversity). Emergent issues were also identified via the coding process (e.g., the issue of transgender was an unexpected focus).
27. Software	What software, if applicable, was used to manage the data?	All 36 manually coded transcripts have been uploaded to the software, NVivo, for indexing and charting.

28. Participant checking	Did participants provide feedback on the findings?	No. I will not be asking participants to offer feedback on findings. Supervisors have advised against this. However, interviewees were offered the opportunity to review their interview transcripts.
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g., participant number	Yes. All reporting has been backed up with supporting quotations. All quotations are accompanied with a respondent ID number and basic demographics (gender, age, sexual orientation). Quotations have been used to illustrate discussion points, deepen the reader's understanding, give interviewees a voice and enhance readability.
30. Data and findings consistent	Was there consistency between the data presented and the findings?	During the writing-up, I will provide supporting quotations from different participants to illustrate and add transparency to the findings.
31. Clarity of major themes	Were major themes clearly presented in the findings?	The final Analytical Framework for my interview data analysis consisted of 130 codes, clustered into to ten overarching themes. The reporting dedicates a section to each major theme.
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	There are several sub-themes under each of the ten over-arching themes identified above. Some of these sub-themes are more prominent than others; minor sub-themes were discussed when writing the thesis.

Appendix N: Example of an Annotated Transcript

Example of an Annotated Transcript

Interviewer: Can you briefly tell me your reasons for choosing to take part in this interview?

Participant: Primarily, I would say my interest in the area, the client group, related to my own sexual orientation and to the amount of experience I've had working particularly with gay men over a long period throughout pretty much all of my career as a therapist. Then, I think also the fact that it's an important area. For reasons linked to your research, I guess really. The fact that particularly in the psychoanalytic community, it's had a very difficult and vexed history. We're in the midst of an ongoing process of exploration and forward movement and I think with a long way to go but where I think research such as this and interviews with practitioners have a big part to play in helping the profession continue to move forward … I think, more personally, without knowing precisely the questions you might ask but my own interest in what I might find myself saying and how I might respond to the things that you ask me about.

Specialist interest in the client group

Therapist identifies as LGB so has a personal interest in the research

Has worked extensively with gay male clients

Considers research to be important

Acknowledges troubled historical context

Relevant and timely research
Research will assist profession in questioning its views

Curious about own response to the interview questions

Interviewer: Have you conducted a lot of work with clients who identify as lesbian, gay or bisexual? You mentioned work with gay men and I wondered about the other two categories that I'm looking at.

Participant: Yes, sure. Primarily with gay men and to a lesser extent, lesbian women and to a much, much lesser extent, I guess, people identifying as bisexual. Although, I think rarely, if ever, has someone presented formally, as it were, in terms of being bisexual. Though bisexuality, as one might understand it, would often or would sometimes feature as part of someone's presenting material. If I could say more about my history, as it were, in terms of the work, I would say it's not as big a feature of my work as it is used to be. I've been working about 30 years. Roughly the first 10 years of that were within the HIV field; [it was] in the 90s, when there was a very, very well funded set of services for people living with HIV and AIDS, or affected by, and I worked in the NHS and then an HIV voluntary organisation. Although there were other groups affected, and increasingly, as the decade passed, more African people, it was almost entirely gay men [who] were my clients during that period. There was a particular focus in terms of HIV but I was very much immersed as a gay man with working with gay men and in fact HIV prompted all kinds of reflections about every aspect of life for gay men. When I then started my main organizational job in another field and then started private work, initially that was very much with gay and LGB [individuals], I guess. I think a lot of my early referrals were from gay agencies back in those days. It was very much a specialism and one that had a great personal meaning for me. I think my own interest in the whole field of HIV and having been personally affected by it, to a degree, was all mixed-up together really. In a sense, my interest in training as a therapist came out of my interest in work I was really doing through some workshops and the co-counseling movement, and so forth, which was part of my way into becoming a therapist. Issues of gay sexuality and the training were very integrated really. I think, as time has passed, not with any conscious intention, as I developed my private work, the practice become wider and in some ways more generic in its identity. I do and I've always had an ongoing number of primarily gay men, and lesbian women to a degree, and that's the case at the moment. It's less of a specialism than it used to be, which I think … I feel a bit mixed about it. Partly, I enjoy having a wider range of identities, while also missing that greater specialism to a degree.

Wider clinical experience with LGB client group but work with gay males predominates

Bisexuality as a common feature of clinical work though not typically a formal part of clients' presentation

LGB specific work less of a feature now

30 years' experience in the field.
Specialist work with HIV and AIDS.

Clinical work has led to personal introspection and wider reflection on gay lives and issues

Sees LGB work as a specialism in the past

Personal meanings informing professional choices

Difficulty in separating personal and professional

Pre-analytic background in workshop delivery and co-counseling

Focus of clinical work diversifies over time

LGB-specific work remains a regular but modest feature of therapist's overall clinical caseload

Expresses mixed feelings about current make-up of caseload

Interviewer: Thank you. Could describe for me, which theories, psychoanalytic and non-psychoanalytic, that you find useful for understanding and explaining same-sex sexualities?

Participant: There's a question! (laughs). If I'm honest, I think it's something I think about a lot more than I used to. I think earlier on, I probably was developing my work with much less of a focus on a psychoanalytic perspective. I think ... Putting it briefly and in a way, a bit too superficially, I think I find it very helpful, in part, to stay attached to some original, classical thinking, in terms of Freud's *Three Essays*. Certainly, within the British Tradition, developing Post-Freud in the course of the 20th century, we've lost touch with that really. I think the British object relations tradition, and so much of what we're now trying to recover from within the BPC, took us away from a more open perspective on sexuality. It's not to say that Freud's thinking doesn't have severe limitations but I think there's a spirit of inquiry, that was, of course, incredibly innovative at the time and which somehow we were unable to develop in a way that was helpful. ... I think now, and particularly with a number of different influences, particularly from the States and including queer theory, but also some of the work of the gay American analysts, people like Blechner, Drescher, Isay and other people I know you're familiar with ... They're able to pick up on what's most helpful from Freud and pull it apart a bit and bring it up to date a bit and help us to not throw the baby out with the bathwater in a sense. I don't think this is a fully coordinated set of thoughts on my part. For example, in terms of early development, I find a broad thinking about what I would call Oedipal dynamics is very relevant and very helpful. It's evident that a very classic account of the Oedipus complex and its necessary resolution doesn't really fit for same-sex attraction. However, I think there are ways of making some sense of that, partly through the ideas Isay particularly developed around a gay version, as it were, of the Oedipus complex and the different attachments, particularly to the father for a gay boy. I find that it's quite convincing really as an argument ... I'm interested in ways of trying to retain ideas about the intricacies of sexuality that come from those very early psychoanalytic reflections ... At the same time, I think there's still a great ... we have a lot further to go in the sense, I think, of developing a more up-to-date and wider ranging theory of sexuality ...

Interest in theories about sexuality has increased over time

Less psychoanalytic focus when younger

Freud's classical theories of sexuality continue to be relevant

Specific allusion to Freud's classic paper, *Three Essays*

Critical of object relations theory – implies it has a less tolerant approach to sexuality?

Freud's limitations noted Acknowledges Freud's open-mindedness towards sexual matters

Post-Freud - psychoanalysis unable to build on the useful aspects of Freud's thinking on sexuality

Relational analysts in the US and queer theory - important for updating or reimagining classical thinking

Oedipal theory - if broadly conceived - useful for thinking about sexuality

Classical Oedipal theory outdated for thinking about same-gender sexual orientation

US relational revisions of Oedipal theory provide helpful framework

Isay - Son's attraction to father as 'positive' not 'negative' Oedipus complex

Wants to retain what is valuable from past theories

Keeps up-to-date with theoretical developments

Interviewer: Could you say more about relational and queer theory as you said that was an influence?

Participant: Yes, I'll try to. I don't feel I'm being wonderfully coherent which I think reflects that certain things are not clear enough or not sufficiently resolved in my own mind. I don't (coughs) I'm not as versed in queer theory as I think some of my colleagues probably are. I find Butler's ideas about gender particularly interesting ... I could talk about something quite specific. This is something I was talking about at the workshop I did recently on internalized homophobia, which does have some link with Butler's ideas about melancholia and gender. The idea of each individual needing to go through a process of mourning, in a sense similar to the dynamics that Freud talked about in *Mourning and Melancholia*, in terms of relinquishing the part of their potential sexuality that they are not going to express. If they don't do that, then what results is a version of the identification with the lost object that Freud talked about, originally. In the case of sexuality, it would turn into, for a gay person, an identification with heterosexuality, which will lead to an internalization of that homophobic and/or

Theoretical thinking never complete but a work-in-progress

Seems a bit unsure about extent of knowledge on queer theory

Specific reference to Judith Butler and gender theory

Role of internalized homophobia

Links between gender and melancholia

Butler's use of existing Freudian theories to create new ideas

Mourning for 'mainstream' sexual orientation that will not be experienced

Again, illustrates continued usefulness of some of Freud's initial contributions

Links between identification and internalized homophobia

heterosexist attitude. I find that way of thinking about earlier development in terms of the kind of society that we live in very helpful. There are all kinds of liberalities, gay marriage and so forth, but equally a great deal of homophobia that I think is still extremely current and indeed even more so, in certain ways, as the signs of gay liberation become much more visible through legislation, and so forth. So there's a consequence to that. There's rejection of that from parts of society. I think, if I'm honest, there's a lot, particularly in the area of queer theory, which I could pursue and develop in my own thinking that would interest me and would help my practice. That's an ongoing, I think, task for me.

Cultural and societal changes and liberalization

LGB more visible now

Homophobia persists despite advances

Always room for theoretical knowledge to be updated

Learning a life-long task

Interviewer: OK.

Participant: I'll leave you to think about the quality of my answers (laughs)

Interviewer: They've been very good so far, very coherent.

Participant: I'm giving a rather rambling account of my...

Interviewer: No, not at all. This is what I want in a sense. I want you just to allow whatever comes to mind rather than me be be too directive. This next question is very broad, so take your time. Can you describe your clinical work or approach with clients with same-sex sexuality?

Participant: OK ... I think, probably, these days this may have changed somewhat. I suspect longer ago, I was perhaps a bit more naive or certainly less experienced but, I think today I would aim to ... offer a space of ... I was going to say neutrality but I don't think that's really quite the right word. It's a positive, welcoming thinking space about sexual orientation ... I think not necessarily gay affirmative in the full sense of that term, in the way that I would understand it to be used in, say, more humanistic circles ... An example would be of ... I can think of a couple actually, a couple of current cases. One is of a man who is ... emerging very painfully from a marriage of many years with a family. His wife announces that having always known of his attraction to men, that the marriage is not sustainable from her point of view. By his account, as it were, he's been left to develop a gay lifestyle, which he is doing in terms of having a male partner and in terms of beginning to make huge changes to his life in middle age. He's very conflicted about this. I think what is really helpful for him is that I'm very sensitive to his own conflict about his sexual identity and equally to his sensitivity about terminology. For some other people, if a patient is coming and saying: "I used to identify as heterosexual and now I identify as gay", that's fine, and we can talk in those terms. With this man, this clearly isn't the case. He doesn't wish to use any terminology or to tick any particular box. That's a position that I respect. I think it's interesting for me, and perhaps when I was younger, I wouldn't have found this so easy to do. While, in a sense, I have always identified and been happy to do so as a gay man myself, I understand that people are approaching same-sex attraction, as it were, from a whole range of different backgrounds and with different influences on their development. In his case, we could say, and he might even think this himself deep down, "essentially, I'm gay and I'm having a relationship with a man but I'm struggling to use that terminology". I think my position is that I'm holding an interested empty space whereby the patient is at liberty to develop their own way of thinking and talking about themselves. We can see, in his case, terminology is important and sensitive, so we can actually talk about the kinds of words that we use ... I would be very careful about that, about language with any patient. I think a potential

Clinical experience has grown

Aims to create a supportive analytic space

Seems to suggest a therapeutic frame that is open to exploration and aims to be without judgement

Clinical vignette. Male client is coming to terms with aspects of his sexuality.

Previously in heterosexual marriage, now exploring his non-heterosexual side

Room left to explore conflict and anxieties around sexual identity

Shows sensitivity towards the client's conflicts

Labelling sexuality may close down exploration for this specific client

Acknowledges the value of one's clinical experiences and how this matures over time

One size does not fit all

Not allowing one's own worldview influence what you see

Sexual orientation influenced by cultural and social backgrounds – hinting at intersectional concerns?

Facilitating a reflective space for the client to self-determine what needs to be addressed

problem with what I'm thinking of as a more formally gay affirmative approach is that there is the danger of imposing a view through use of a certain language on someone. We're all using language all the time in particular ways. It's not always very conscious or intentional but it's quite a lesson, in a sense, working with this man, who's going through a very painful internal conflict. There is the need for me to be, I think, very respectful of his position while also being able to challenge his tendency to hold onto this position that he never wanted to separate from his wife and he's the victim, as it were, of her inability to tolerate something which they lived with for years because it was always known that this attraction was there. Another case would be with a younger guy I've started working with recently, who comes from a very particular cultural background, which would be fairly rife with homophobia. He's come to the UK partly to come out as well as to pursue study and work possibilities. In some ways, he is a more straightforwardly a gay man with a different developmental path to the other guy. He is also confused and conflicted, partly through being quite isolated in London and having, I think, arrived feeling that he needed to do certain things in order to become accepted into the gay community he was encountering in London. In his case, he found me, whereas the man I was talking about just now was referred through a colleague. As far as I'm aware, my sexual orientation hasn't arisen in our conversation. I'm not aware that he's aware of that. He may assume I'm heterosexual but it's early days. I think that's something that will develop. With the other guy, the younger guy, he found me on Pink Therapy so he was looking for somebody who's knowledgeable about psychoanalysis, he's interested in the approach, he was very interested in finding a gay psychoanalytically-oriented therapist, so there was quite a particular choice there. Immediately, I'm in a different position with the patient like

Therapist aware of how particular use of language may impose a worldview on clients

Balance needed between being respectful but also challenging & confronting client's defenses so change can occur

Another clinical vignette

Intersectional concerns - different cultural background

Role of homophobia

Client looking for acceptance and belonging within LGB community

Pink Therapy - client knows therapist's sexual orientation - this seems desirable in certain circumstances and with certain clients

Role of therapist's own sexual orientation and whether it is known by the client or not

that whereby there is something, as it were, more consciously known about me, but, of course, there is endless fantasy and unconscious components to that. I don't think my approach is different necessarily but obviously there are different opportunities, or we're starting from a different place.

Whether therapist's sexual orientation is known or not – different dynamics and therapeutic opportunities will present themselves

Interviewer: OK. I wondered whether you thought there were any clinical issues that were unique or specific to lesbian clients, gay men, bisexuals?

Participant: … I think, in many ways, I would say, no. I think it helpful for us to think about sexuality in a broader way and the various commonalities, particularly developmentally. However, I think something that is important is being part of a sexual minority. Where there's a history of significant and ongoing oppression and discrimination, inevitably [this] has a psychological impact. I think whatever the individual's path, say those two patients I've just mentioned as rather different examples, then there is a history that needs to be grappled with in some way and that the individual needs to explore, I think, in order to achieve a sufficient stability and peace of mind … I think that there is a particular psychological need, which a heterosexual person wouldn't experience in quite the same way. Something I was saying in this workshop is that we're all inevitably affected by our internalized homophobia. We all, in a sense, have that impulse inside us. I think that's true because of the nature of the society we live in. However, for a gay, lesbian or bisexual person, I think it's a different kind of experience than it is to someone identifying as heterosexual. I think broadly, it's largely about commonalities in terms of attachment and the development of stable objects and so forth. Some of the particularities would be about, realizing as one gets older, that one is

Broader conceptualization of sexuality needed.

Role of discrimination in LGB lives

History of discrimination and oppression looms large with all LGB clients.

Very different historical picture underpinning LGB experience compared to non-LGB.

Impact and influence of internalized homophobia in LGB lives

Importance of attachment and developmental issues

different to many of the people or most of the people around one, in terms of attraction to one's own sex rather than the opposite sex or to both sexes. I think, yes, I think that must make a difference. Of course, people can be fucked up, as it were, about sexuality or all kinds of ((inaudible)) regardless of sexual orientation, so I'm not suggesting, again, that it's easier, in a sense, for heterosexuals. I think, in some ways, there are certain things that are going to be different, \largely, I think, around the sense of oppression and the history of oppression and discrimination.

Recognition of one's difference in a heteronormative world

Sexuality is difficult for us all to manage regardless of stated sexual orientation

Re-iterates role of oppression and discrimination in LGB lives.

Interviewer: OK. We've looked at theories and clinical approaches. Currently, there's a lot of talk and discussion about revising analytic theory and teaching on same-sex sexuality to reflect changing societal attitudes and also evidence from other disciplines. I wondered what your thoughts were on this?

Participant: (laughs) I'm all for it. Yes. Yes, I think it's very important. I think it's essential and essential really for everyone. What we're advocating is something about addressing sexuality in a different way rather than the tendency [to deliver] ten seminars on diversity, which include looking at LGB issues but as something of an add-on and where inevitably stuff gets split-off and separated from, as it were, normal development. I think it's really important but actually difficult to do, partly because of the very well established trainings and the very particular curricula that are well established, even without there being resistance on the part those who are teaching. I imagine that resistance is there. I don't underestimate the magnitude of the task but I think it's essential to do and I think, in a way, it makes no sense in this day and age, for psychological training courses not to be more reflective of the world we live in, in terms of social values and legislation

Need for analytic theory to be revised

Diversity/same-sex desire - should be embedded across syllabus not separated

Resistance to change and alternative thinking within analytic circles

Analytic trainings not reflective of wider societal demographics

and ways of thinking about human identity that are very prevalent in society. I think that's part of the BPC statement on homosexuality, and everything that follows from that is, in a way, scrambling to make us catch up a bit with what's happening around us, in society ... Was there a secondary part, what did you ask me?

BPC Position Statement and wider political change

Psychoanalysis lagging behind ...

Interviewer: That was it really. The secondary part, which you've touched upon slightly, is: in what ways do you think the training at your own MI helped prepare you for clinical work with LGB patients?

Participant: That's a good question, probably not very much ... My own MI has developed and matured, shall we say, considerably since the days I was in training. I still think it's got a long way to go. I think, probably, these days, it's in practice one of the more enlightened trainings in terms of its attitudes and inclusions. I think that the big step, going back to what I was saying earlier, is addressing same-sex sexuality as moving from something that is a bit split-off, and thinking about it rather separately, to something that's much more integrated in terms of looking at the entire spectrum of human sexuality. I think that involves quite fundamental shifts in the approach of the MI, the approach of the teaching. I think my MI's [approach] was adequate. I was in and out of training through the 90s and until about 10 years ago, so I've had different bits of training in different organisations. My MI, my professional organisation, I would say these days, it is a good, fairly liberal organisation. For example, I was asked to run this extra CPD workshop on internalized homophobia. It was part of a series on sexuality that's run throughout the last year within my training body. That's one sign of something that's continuing to change and improve. I would say going back to when I started my training, in the 90s, I should think it would have been a

Institutional change: therapist's training organization as more inclusive than before

Same-gender sexuality now being addressed and integrated into teaching programme

Reiterates how training organization has improved over time re: sexual orientation

Therapist involved in teaching on sexuality and internalized homophobia

training, in the 90s, I should think it would have been a much more separate and split-off thinking about difference generally and certainly about sexuality. I think it wasn't so much a promotion of the more negative standpoint in relation to homosexuality. It was more a limitation or a lack of development that we've seen since then. I would say it was limited rather than being oppositional or negative in terms of same-sex attraction. I think it's come a long way since then in terms of opening its mind and views and integrating thinking much more.

Previously same-sex orientation would have been taught as something split-off

Therapist's organization has moved on - less oppositional now

Interviewer: OK. The next question is linked, because that was more around training and how it prepared you. There's also a lot of discussion about making the profession more generally inclusive to LGB trainees and LGB colleagues. I wondered again about what is the approach of your own MI towards LGB people training and LGB colleagues around selection and ...?

Participant: Yes, as far as I'm aware, I think it's pretty good these days ... certainly, in terms of thinking in a more superficial social level, thinking about events, conferences and so forth that I go to within the MI. There's plenty of social openness in terms of contact with colleagues, so men kissing each other, gay colleagues that I'm friendly with. I (and others) feel comfortable in doing that in the same way we would, I think, in other social settings. I think that's quite an important sign.

LGB visibility much better at therapist's training organization

Able to be out and show social affection between LGB colleagues

Interviewer: Yes. OK.

Participant: I'm trying to think and answer your questions in terms of training and so forth. I don't regularly teach there but I hear quite a lot about it and I do feel that things have improved and developed considerably over the years. I'd be surprised to hear of particular problems today of, say, applicants for training being open about sexual orientation. I have heard of stories, I'm thinking of a colleague a few years ago, a gay man talking about and remembering his interview for selection and feeling that the reference to his sexuality led to supplementary questions, that you would imagine that someone identifying as heterosexual wouldn't have been asked. We've all heard plenty of stories over the years. I think within my MI, I would be surprised, if that was happening now. However, it may be more about what might be happening in a much more subtle way, possibly. A more overt example would be, where as soon as somebody mentions being L, G or B, there would be an essentially pathologising response in terms of different questions that would be asked. I think, even if that isn't happening, there might be something within any of the institutions. It's of a much more subtle nature. This is the very thing we've been trying to address in terms of the training, that you keep on developing the staff, the MI staff. As far as I can judge, I would say there's a lot of openness and inclusivity and acceptance these days and plenty of 'out' gay men and lesbian women, as it were.

Selection interviews more open and friendly now to LGB but past pockets of discriminatory practice e.g. additional questions

If discrimination does continue today, might be less explicit and expressed more subtly

Overall, therapist feels training organization is open and inclusive to LGB candidates and colleagues

Interviewer: OK. Two questions to go you'll be happy to hear. How do you go about developing your own thinking and practice in the area of same-sex sexualities? You have mentioned conferences and events. Do you want to elaborate on how you yourself remain up to date?

Participant: I suspect in some ways I'm not doing as much as I might, perhaps with a bit of a semi-, maybe only semi-conscious sense of (laughs) "I know it all already". There's also something, I think, about being gay oneself, which can lead to a rather unhelpful sense of knowledge and/or superiority. Actually, I think ... I'm interested in CPD, I'll

Therapist admits complacency over keeping updated on LGB issues

Role and value of CPD

normally attend two or three events a year, across the board but sexuality would be one of the areas that I'd be interested in studying or attending an event on. At the same time, there's ... I'm in the position now where I might be more asked to go and run the event rather than attend it. I'm aware that I shouldn't neglect my own ongoing reflection and development. I get that, I suppose, in my own supervision but also in talking with colleagues, particularly with other gay and lesbian colleague. I've got certain fora for doing that; that has fulfilled some of the certain needs and interests in terms of developing my own thinking. What I'm saying may be a sign of there not always being enough around, or events that are necessarily of the most interest of people in my position with a certain level of experience. There's a lot CPD generally including in the areas of sexuality. Like the workshop I was running myself recently for people at an early stage of training, I think there's a lot of interest, there's a lot of keenness. People are interested in looking at these areas. Yes, I certainly remain interested in developing my own knowledge and thinking. I could probably do more.

Therapist is senior so more likely to teach than be taught

The value of on-going supervision with LGB colleagues

Insufficient CPD for senior therapists

General appetite for CPD in this area

Admits could be doing more to stay informed and up to date

Interviewer: OK, last question, a bit of a free for all. Is there anything else you think relevant or important to discuss that we haven't covered already in relation to this topic? ... That can be theoretical, clinical, institutional or whatever you wish, or nothing at all?

Participant: I don't know. I don't know whether there is anything particularly ... Just, as a reflection really, and more personal, I suppose. I was just thinking, partly because of my own situation ... partly perhaps thinking about ongoing training and CPD aspect as well. Just my own situation: being in a relationship with another gay male therapist. I'm not saying that in itself provides anything that's directly comparable to a training experience but there is something about it. It's a different background to the work that I do. I think that my wider social and relational life as a gay man provides an inevitable and important backdrop to the work that I do with LGB patients and I think on the whole feeds it very productively. There might be a rather different situation for people in different personal situations when they're working with LGB patients.

Being LGB might mean therapist feels more at ease and knowledgeable about same-gender sexual orientation and issues...

But could this lead to blind spots in knowledge and approach.?

Interviewer: OK. That's fine. End of interview.

Participant: Thank God for that. I'm sorry. I feel like I've been rambling all day.

Interviewer: Not at all. It's really fascinating for me. Thank you so much for taking the time out.

Participant: Not at all.

Appendix O: Final Analytic Framework (Interviews)

The final Analytical Framework for my interview data analysis consisted of 130 codes, clustered into to ten overarching themes.

Theme 1. 'There's a risk of throwing out the baby with the bathwater': The continuing value of Freud's theories of sexuality

1. Two Freuds: the Radical versus the Pathologiser
2. Freud's open-minded curiosity about sexuality
3. Freud's tolerance: same-sex sexual orientation not an illness and LGB individuals allowed to train
4. Retention of Freud's basic insights in *Three Essays* (e.g., libido; infantile sexuality)
5. The sexual drive: multiple aims and variable objects
6. Polymorphous perversity and component instincts
7. Multiple sexual developmental outcomes possible
8. Penis-in-vagina (PIV) intercourse as healthiest expression of sexuality
9. Conflation of gender identity with sexual orientation
10. Developmental arrest and psychopathology
11. Jungian theory: different conception of libido
12. Making Freud's theories of sexuality 'fit' observations

Theme 2. 'The best stab we've had at it really': The uses and abuses of Oedipal theory

13. Oedipal theory determines sexual orientation
14. Classical Oedipal theory still valuable (e.g., sexual difference; parental conflict; generational divide)
15. Oedipal theory applied too narrowly
16. Oedipal theory as universal developmental truth
17. Oedipal theory and Western heteronormative societies
18. Oedipal theory as phallocentric and sexist
19. Female versions of Oedipus complex: shift from patriarchy towards the maternal
20. Oedipal theory NOT a theory of causation/aetiology of non-heterosexuality
21. Oedipal theory and identifications: quality of identifications made more important than which sex parent is identified with
22. Oedipal theory and triangular relationship structures (e.g., exclusion, rivalry, competition, separation, boundaries, limits)
23. Freud's model is not the only one: alternative Oedipal models including Klein's and Lacan's models
24. US relational model: turning Oedipal theory on its head
25. Jungian model: archetypes and other myths (e.g., Senex-Puer; the double)

Theme 3. 'It's the kind of sex I don't like': Psychopathology, perversion and sexual practices

26. Spectre of Socarides: leading proponent of conversion therapy
27. Same-sex sexual orientation as psychopathology (e.g., paranoia, borderline)
28. Same-sex sexual orientation as narcissistic: a desire for sameness or could it represent mirroring and/or mutuality?
29. Same-sex sexual orientation as perversion: deviation from penis in vagina (PIV) intercourse and heterosexuality
30. Role of hatred and/or sexualised aggression underpinning perversions (Stoller)
31. Glasser's Core Complex: desire for closeness but fear of fusion
32. Sexualisation, de-humanisation and depersonalisation
33. Heterosexual sexual practices also deviate from pro-creative purposes (e.g., swinging, polyamory etc
34. Rejection of the term 'perversion': judgemental and pejorative term
35. Jungian concepts: the repressed 'shadow' elements
36. Fonagy's and Target's ideas about early desire
37. Clinical psychology versus psychoanalytic theorising of sexual practices: validation versus pathologisation
38. Therapist difficulties talking about sex and lack of knowledge about LGB sexual practices
39. Balancing concern for LGB clients' sexual health and analytic task

40. Specific sexual practices (e.g., anal sex, masturbation, cruising, snowballing, autogynephilia etc)

Theme 4. 'The issue is … can he bring love and sex together?': The desire for connectedness and relatedness

41. Relationships more important than psychosexuality and drives
42. Role of object relations: nature and quality of internalised relationships
43. Attachment theory: formative relationship with the mother or original caregiver (template for all future relating)
44. Dynamic interpersonal theories: focus on how one sees oneself in relation to others and effect on interpersonal functioning
45. No difference between LGB and non-LGB relationships: can be equally as intimate and share similar conflicts
46. Issues with intimacy and sustaining long-term commitment
47. Lesbian relationships (e.g., lack of sex; merger, fusion)
48. Gay relationships: can desire and love be separated? Open relationships comparatively common
49. Relationship structures: non-monogamy and open relationships: good gays versus bad gays
50. LGB families: gay male parents more visible and accepted; lesbians successful at combining parenting and relationships

Theme 5. 'Younger people … aren't just in some heteronormative strait jacket': Bisexuality, sexual fluidity and monosexuality

51. Difficulties discussing and making sense of bisexuality
52. Bisexuality as invisible, under researched and under theorised
53. Freud's constitutional bisexuality: useful but not a fully articulated theory
54. Jung's contrasexuality: male and female elements
55. Bisexuals as promiscuous and role of deception
56. Bisexuality as avoidance of gay or lesbian sexuality
57. Bisexuality and limit situations: omnipotence and best of both worlds?
58. Bisexuality as ego-dystonic to therapists who tend to be monosexual in outlook
59. Bisexuality as sexual orientation in its own right or a phase?
60. Bisexuality and sexual fluidity: moving away from monosexual outlook
61. Heterosexual men and same-sex fantasies

Theme 6. 'Transgender is the next big thing we have to really face psychoanalytically': The trials and tribulations of transgender

62. Surprise topic (was not a specific focus of the research)
63. Therapists express discomfort and anxiety over transgender
64. Trans as difficult to conceptualise theoretically
65. Trans as new homosexuality: are we repeating the same mistakes as with same-sex sexual orientation?
66. Trans as result of unresolved trauma
67. Trans as born in the wrong body
68. Can body and mind be separated? Mind/body dissociation
69. Trans and omnipotent thinking and denial of biological reality
70. Trans as unconscious homophobia or fear of accepting being gay or lesbian
71. Unable to think critically about trans or question the gender dysphoria: tyranny of political correctness and accusations of transphobia
72. Explosion of trans children and gender non-conformity: confirming young people too early in trans identity?
73. Value of clinical work with trans: challenging assumptions
74. Resistance to clinical work with trans clients; therapists' facing up to fears/prejudices

Theme 7. 'The painfulness of difference that we all experience': Coming out LGB and feeling different in a heteronormative world

75. Shared reality of discrimination and oppression amongst LGB people
76. Role of shame, self-loathing and guilt
77. Anti-LGB biases operating in society
78. Internalised homophobia: internalisation of negative parental and wider social or cultural prejudices

79. Internalised homophobia reinforced and consolidated across the lifespan
80. Internalised homophobia sometimes explicit in the therapy
81. Coming out in a heteronormative world that assumes everyone is heterosexual
82. Coming out is not a one-off occurrence
83. Maintaining an open and sensitive therapeutic attitude for LGB clients
84. Therapist may occupy privileged space if white, heterosexual and/or cisgender
85. Work with difference and respect for clients' alterity - essential part of psychoanalytic work
86. Intersectional difficulties: double discrimination
87. Psychoanalytic resistance to theorising diversity and difference
88. Conscious and unconscious 'Othering'

Theme 8. 'Am I Going to Reveal Myself or Something?': The Complexity of the Transference and Countertransference Relationship with LGB Clients

89. T/CT alerts therapist to own conflicts and prejudices
90. T/CT needs more active monitoring with LGB clients
91. Very little literature on T/CT with LGB clients
92. Negative, parental transferences: disapproving mother/father
93. Positive parental transferences: empathic and nurturing mother/father
94. Erotic transferences: straight male therapists and sexual excitement with lesbian clients
95. Fear of intimacy: straight male therapists working with gay male clients
96. Allowing oneself to be erotic object in the transference and working with one's psychic bisexuality
97. Erotic transference 'missing' or harder to identify if gender and sexuality of therapist and client is incongruent
98. Therapeutic relationship sexualized
99. Fears of homophobia, biphobia or transphobia in the CT/T
100. LGB therapists and homophobic transferences from heterosexual clients
101. LGB therapist meeting LGB clients outside therapy: intensification of erotic transference
102. The pre-transference: prejudices already formed before we work therapeutically with specific minority groups

Theme 9. 'It's like showing the fly the way out of the fly bottle': The ongoing anti-LGB biases within psychoanalytic training organisations

103. Continuing evidence of discriminatory recruitment and selection practices
104. Intrusive interviewing of LGB clients continues
105. LGB colleagues having to remain closeted within the training organisation
106. 'Don't ask, don't tell policies' and LGB colleagues having to 'pass'
107. Slow pace of change in UK: comparison with America
108. Attitudinal changes within institutions are cosmetic rather than deep
109. Psychodynamic profession needs to apologise to the LGB community
110. Generational divide in institutional attitudes
111. Institutions find it difficult to diversify and 'open up'
112. Need LGB staff in senior roles
113. Need LGB staff in teaching/supervisory roles
114. Not all LGB trainees have had negative experiences at training organisations
115. Some organisations welcoming and inclusive towards LGB trainees
116. Evidence of affectionate social contact between LGB and non-LGB colleagues

Theme10. 'Psychoanalysis has existed in splendid isolation': The diversification and modernisation of the sexual syllabus

117. Prejudicial teaching continues on some psychodynamic trainings
118. Some organisations getting better and are teaching diversity and difference
119. Need to integrate sexual orientation and diversity across the syllabus
120. Continue to teach historical papers but contextualize them
121. Psychodynamic courses not as rigorous as university courses: lack of critical thinking
122. Interdisciplinary exchange not easy: disciplines are too siloed
123. Need to update and revise psychodynamic theories: psychoanalysis working in isolation
124. Queer theory and gender theory: academic and political aspects and Judith Butler
125. Social constructionism: Foucault

126. Biological, genetics and environmental perspectives
127. Value of cultural and symbolic products (e.g., film, literature, art) in expanding viewpoints on sexuality
128. Cultural and critical theory and humanities: alternative ways of conceptualising sexuality
129. Role for qualitative research and social sciences
130. Psychoanalytic method unique and must not be diluted

Appendix P: Independent Thematic Review (Interviews)

Dr Karen Ciclitira agreed to independently review three of my transcripts in order to confirm or identify gaps in the analytical framework. Her themes, presented below, aligned closely with my own analysis, building confidence in the analytic framework I had developed.

Freud and sexuality - positives:

- History of thinking about homosexuality
- *Three Essays on Sexuality*
- Freud was open to thinking about sexuality in a different way
- Freud saw heterosexuality and homosexuality as something to understand
- Drive as opposed to instinct
- Importance of an unconscious mind
- Polymorphous perversity
- Infantile sexuality
- Bisexuality
- You can't be a psychoanalyst without being interested in sexuality
- Psychoanalysis takes the body seriously
- Offered different possibilities of pleasure
- Oedipal complex is an aid to thinking if used critically
- Now more fluid way of thinking about Oedipal trajectory

Freud and sexuality - negatives:

- Many thinking tools are steeped in prejudices
- Oedipal theory assumes a correct developmental path (heterosexuality)
- Oedipal complex sees homosexuality as a perversion and as a developmental arrest
- Too much emphasis on phallus, penis and not enough emphasis on mother
- Difficulties with paying attention to external world
- Problems with Freudian and Kleinian classical approach
- Socarides and link to psychoanalysis
- Psychoanalysis isolated from interdisciplinary exchange
- A gulf in theoretical thinking in psychoanalysis particularly in UK
- Heteronormativity
- Description can become prescription

Current times:

- Today interest in aggression/envy rather than sexuality
- Sexuality seen as superficial
- Sexuality coming back to the fore
- Different times - different culture
- Effects of digital age
- 'Me-too' movement - moving backwards

Clinical work:

- Clinical work should start from patient's experience not from theories about sexuality etc
- It is about the quality of identification (rather than gender of partner)
- Gender of partner is not the issue when thinking theoretically about a patient
- More interested in psychic economy than gender of partner
- Don't assume your own frameworks apply
- Internalised homophobia – therapists need to think about this

Theory being used and helpful other than Freud:

- Some contemporary theories - helpful - revaluates Oedipal theory
- Glasser's theory of Core Complex
- Fonagy's theory of early desire
- Sexual enactment vs. sexualisation theory
- Object relational framework - thinking about internalised object relationships for all patients regardless of their sexuality
- Role of attachment theory

- Queer Theory/poststructuralists - questions ‘natural’ and other assumptions

Trainings:

- Previous psychoanalytic training - uncritical thinking about sexuality - heteronormativity
- Although there are now seminars on diversity, the change is not deep
- LGB people afraid to express themselves now and before
- It is very difficult to talk about these issues now in trainings and meetings etc. due to political correctness, fear of being sued - which is unhelpful
- Older generation still see homosexuality as perverse
- Being a gay trainee - used to be hush hush - that has changed positively
- More work to be done on difference in transference and countertransference
- Difference between lesbian and homosexual patients?

Transgender:

- Focus of transgender has replaced focus on homosexuality
- Is it a displacement?
- Issues of difficulty and denial of reality and difference
- Trans sexuality - transgender becoming more plural and not rigid binary) (e.g., I want breasts and penis)

Appendix Q: Partnership Agreement with the British Psychoanalytic Council (BPC)

Partnership Agreement

This Partnership Agreement is effective as of March 1st 2015 and is made between:

- *University College London (UCL) PhD Researcher: Wayne Full, Flat 1, Rosslyn Road, St Margaret's,* Middlesex, TW1 2AR

and

- *The British Psychoanalytic Council (BPC), Suite 7, 19-23 Wedmore Street, London, N19 4RU*

1. Introduction

A University College London (UCL) PhD Researcher ("UCL Researcher") and the British Psychoanalytic Council ("BPC") have agreed to collaborate on a Practitioner Attitudes Questionnaire, investigating BPC members' views, experiences and ways of working with Lesbian, Gay and Bisexual (LGB) patients. This Partnership Agreement covers the following: Context and Background; Roles and Responsibilities; Timeline; Use of Research; Intellectual Property; Researcher's Right to Publish; Ethics; Public Engagement and Dissemination, and Partnership Guiding Principles.

2. Context and Background

Historically, psychological therapies have treated homosexuality as a form of psychopathology in need of cure. Although therapeutic attitudes are changing with several UK psychotherapy organisations signing a Memorandum of Understanding (MOU) on conversion therapy,[90] very little is known about the perspectives of psychodynamic practitioners on treatments to change sexual orientation, despite the fact that psychodynamic therapy is widely practiced in this country. This questionnaire will investigate this gap in knowledge and will identify the views and practices of BPC-registered psychoanalysts and psychodynamic practitioners, and whether their views and practices are related to their training and specific theoretical backgrounds.

3. Role and Responsibilities

UCL Researcher:

- Design and develop a questionnaire with relevant input from the BPC Task Group on Sexual Diversity, chaired by Juliet Newbigin.
- Ensure the questionnaire receives Ethics Approval from the UCL Research Ethics Committee (REC) and is compliant with the Data Protection Act 1998.
- Conduct an independent analysis of the findings from the questionnaire responses with minimal involvement from the BPC to ensure objectivity of findings.
- Share findings from the questionnaire and agree a process of dissemination with the BPC and its Task Group on Sexual and Gender Diversity.

[90] Department of Health. Memorandum of Understanding on Conversion Therapy in the UK. Retrieved from: http://www.core-issues.org/uploads/Conversion_Therapy_MoU%5B1%5D.pdf. Accessed 22.01.2015.

BPC:

- Pilot a version of the questionnaire with a small group of BPC members.
- Disseminate and launch the final version of the questionnaire to the whole BPC membership (1400 members approximately).
- Promote and market the questionnaire through the usual BPC channels: newsletter, email, social media and the quarterly magazine, *New Associations.*
- Work with BPC training organisations to encourage response rates.
- Disseminate findings to BPC membership and other relevant contacts.

4. Timelines

A broad timeline has been agreed for the all activities linked to the questionnaire. Both the UCL Researcher and the BPC acknowledge that slippages and delays occur, and these will be discussed and negotiated. However, the general timeline agreed runs as follows:

- Mar 16th 2015: Amend survey by March 16th (done).
- Mar 16th 2015: Secure sign-off on Partnership Agreement from Juliet Newbigin and Karen Ciclitira on behalf of the BPC Task Group on Sexual Diversity.
- Mar 20th 2015: Gary Fereday to sign Partnership Agreement and review final questionnaire.
- Mar 23rd 2015: Call out to BPC membership for participants to take part in questionnaire pilot.
- Mar 31st 2015: Include pilot call out in BPC e-newsletter.
- Apr 7th 2015: Call out for pilot closes.
- Apr 10th 2015: Send questionnaire and feedback form to pilot participant.
- Apr 20th 2015: Pilot participants submit responses to questionnaire.
- Apr 27th 2015: Responses to pilot reviewed and used to refine questionnaire.
- Apr 30th2015: Officially launch the questionnaire.
- May 29th 2015: Close questionnaire.
- Jun/Jul 2015: Analysis.
- Aug/Sep 2015: Write-up.
- Nov 2015: Dissemination and publication.

5. Use of questionnaire data

UCL Researcher:

Findings will be used to:

- Inform the UCL researcher's PhD thesis.
- Develop the subsequent stages of the research (which includes 20-30 semi-structured interviews with BPC-registered clinicians).
- Identify the predominant theoretical and clinical models used by psychoanalysts and psychodynamic practitioners working with LGB patients.
- Make an original contribution to theoretical and clinical knowledge by informing the researcher's PhD thesis.

BPC:

Findings will be used to:

- Develop policy on making the psychoanalytic profession more accessible to people with sexual orientations: both for patients and trainees.
- Improve services within training organisations which widen training opportunities for LGB trainees.
- Enhance training standards across the training organisations, reducing discrimination against trainees based on sexual orientation.
- Improve treatment services which widen treatment options for LGB patients (e.g., new clinical approaches).
- Encourage theoretical and clinical discussion on issues of sexuality and sexual orientation across the BPC membership.

- Bolster existing lobbying work on this issue e.g., Department of Health (DoH) Memorandum of Understanding (MoU) on Conversion Therapy.

6. Intellectual Property

As previously discussed and agreed with the BPC and its Task Group on Sexual and Gender Diversity, the UCL Researcher expects to own all intellectual property and to be able to build on the results of his own research in further research. This includes all information and results produced, generated or developed by the questionnaire. The UCL researcher shall have the right to use Intellectual Property for research, teaching and administrative purposes. The UCL Researcher will conduct the data analysis of the questionnaire and interpret the findings independently of the BPC to ensure objectivity of results.

7. Researcher's Right to Publish

The UCL Researcher expects to publish all the results of his research without delay or hindrance, as part of his PhD. The BPC, however, may wish to keep some findings confidential especially in relation to specific training organisations. The UCL Researcher will negotiate to protect the researchers' right to publish as much as possible, starting from the position that full publication, except for confidential information, is required with minimal review and delay. If the BPC has specific requirements (e.g., data relating to training organisation), the UCL Researcher will consider how far these are compatible with responsible publication and UCL's educational mission and will negotiate with the BPC so a reasonable solution is found.

8. Ethics

The UCL Research Ethics Committee (Project ID Number: 6566/001) has already approved the questionnaire. Copies of the Ethics Approval Application Form and the subsequent Approval Document have been forwarded to the Development Officer at the BPC. Approval was given for ethical issues concerning: Confidentiality and Anonymity; Informed Consent; Patient Confidentiality; Right to Withdraw; Data Protection; Intellectual Property (IP); Objectivity; and Researcher Bias.

The UCL Researcher has additionally obtained approval from the UCL Data Protection Officer stating that the research project is compliant with the Data Protection Act 1998. The Data Protection Registration Number is: Z6364106/2015/01/56.

9. Public Engagement and Dissemination

The UCL Researcher will package the findings into various formats, tailoring the content for specific audiences. Public engagement and dissemination will be achieved via:

- Publication of PhD thesis.
- Publication of papers in relevant peer reviewed journals.
- Presentations at Internal seminars at the UCL Psychoanalysis Unit.
- Presentations at External seminars at relevant universities with psychoanalytic or psychosocial departments such as Essex, Exeter and Birkbeck.
- Presentations at relevant conferences.

In collaboration with the BPC, additional public engagement and dissemination activities may be undertaken. The UCL Researcher and the BPC will work together on drafting all documents produced for dissemination purposes including:

- Special features/fact sheets uploaded to the website of the British Psychoanalytic Council (BPC).
- Headline findings shared via the BPC's social media channels (e.g., Twitter, Facebook);
- Dissemination sessions with the BPC training organisations.
- Specialist features in the monthly BPC newsletter and BPC quarterly magazine, *New Associations.*
- Policy briefings advocating policy change at different levels e.g., the UK Department of Health (DOH).
- Briefings and Executive Summaries shared with other UK psychotherapy bodies such as the UK Council of Psychotherapy (UKCP) and British Association of Counselling and Psychotherapy (BACP).

- Briefings and Executive Summaries shared with LGB-specific mental health organizations such as Pink Therapy, Albany Trust, Project for Advocacy, Counselling and Education (PACE).
- Special features within the LGB-specific press (e.g., Gay Times, Attitude, the Pink Paper) – specialist features could be written focusing on mental health issues and the LGB community.

10. Partnership Guiding Principles

As a partnership, we agree individually and collectively to adopt the following guiding principles which we believe will improve our services.

- *Openness and transparency*

We will adopt the principles of openness and transparency in all aspects of the partnership. This means that we will share information in a timely and accurate manner; that we will raise issues and problems as soon as possible and work creatively and constructively to find a resolution and that we will raise questions and queries promptly and share knowledge and expertise.

- *Sharing good and best practice*

We recognise that each of us has something to give to the partnership and that equally we have something to get from it. We will share learning through identifying good and best practice. Each partner will be encouraged to adopt best practice that they see elsewhere and to share examples widely within the partnership for the benefit of everyone.

- *Commitment to high standards and continuous quality improvement*

We are committed to delivering high quality partnership relationship. This means that we will set and expect high standards, which we will monitor. We will support each other to develop our collective standards.

- *Commitment to flexibility*

As a new partnership we acknowledge that we have much to learn from each other and that there may be times when things do not go according to plan or to expectation. We will therefore be flexible in terms of how we operate and be prepared to make changes, often at short notice.

11.Consent

[Signatures removed]

Appendix R: Complete Quantitative Dataset (Questionnaire)

I present three sets of data here. In section A, I present the descriptive frequency tables for the whole quantitative dataset. In section B, I present the comparisons between the final sample (n=287) and the partial responders (n=112)[91] in relation to respondents' professional characteristics. In section C, I present all chi-squared (χ^2) analyses undertaken.

Section A: Descriptive Frequency Tables

Respondents' gender

	Total Frequency (n=275)	Percent (%)
Female	195	70.9
Male	79	28.7
Other	1	0.4

Missing (n=12)

Respondents' age group

	Total Frequency (n=272)	Percent (%)%
30-39	15	5.5
40-49	36	13.2
50-59	77	28.3
60-69	108	39.7
70+	36	13.2

Missing (n=15)

Respondents' sexual orientation

	Total Frequency (n=272)	Percent (%)%
Heterosexual	211	77.6
Gay	16	5.9
Lesbian	12	4.4
Bisexual	11	4.0
Other	10	3.7
None of these options	12	4.4

Missing (n=15)

Respondents' current professional status

	Total Frequency (n= 274)	Percent (%)
Certified to practice psychotherapy	242	88.3
In training	32	11.7

Missing (n=13)

Respondents' time spent in private practice, NHS and/or other settings

	Total Frequency (n=284)	Percent (%)
Works in private practice	258	89.9
Works in the NHS	104	36.2
Works in other settings	88	30.7

Missing (n=3). Frequencies exceed 284 as more than one answer could be selected.

Percentages add up to more than 100% as more than one answer could be selected.

[91] These 112 respondents had not answered beyond the first six questions on professional characteristics[91] and so did not provide any data on the substantive questionnaire items. These 112 responses were excluded from the main analysis.

Respondents' training organisation

	Total Frequency (n=286)	Percent (%)
British Psychotherapy Foundation	113	39.4
Foundation for Psychotherapy and Counselling/WPF Therapy	57	19.9
Tavistock Society of Psychotherapists/Tavistock and Portman NHS Foundation Trust	37	12.9
British Psychoanalytical Society and the Institute of Psychoanalysis	36	12.5
Society of Analytical Psychology	20	7.0
British Society of Couple Psychotherapists and Counsellors	15	5.2
Severnside Institute for Psychotherapy	13	4.5
Other Member Institution (MI)	11	3.8
Scottish Association of Psychoanalytical Psychotherapists	7	2.4
Association of Jungian Analysts	5	1.7
Association of Psychodynamic Practice and Counselling in Organisational Settings	4	1.4
North of England Association of Psychoanalytic Psychotherapists	4	1.4
Would rather not state	4	1.4
Association of Psychodynamic Counsellors	3	1.0
Association of Medical Psychodynamic Psychotherapists	2	0.7
Forensic Psychotherapy Society	2	0.7
Northern Ireland Association for the Study of Psychoanalysis	2	0.7
Wessex Counselling	2	0.7

Missing (n=1). Frequencies exceed 286 as more than one answer could be selected.

Percentages add up to more than 100% as more than one answer could be selected.

Respondents' professional designation/licensure

	Total Frequency (n=286)	Percentage (%)
Psychoanalytic Psychotherapist	139	48.4
Psychodynamic Psychotherapist	67	23.3
Psychoanalyst	48	16.7
Jungian Analyst (Analytic Psychologist)	42	14.6
Psychoanalytic Couples Therapist	16	5.6
Medical Psychodynamic Psychotherapist	12	4.2
Other BPC Category of Registrant	11	3.8
Psychodynamic Counsellor	9	3.1
Psychodynamic Practitioner in Mental Health and/or Forensic Settings	4	1.4
Would rather not state	3	1.0
Psychodynamic Couples Psychotherapist	2	0.7
Psychodynamic Psychotherapist in time-limited work with adolescents	2	0.7

Missing (n=1). Frequencies exceed 286 as more than one answer could be selected.

Percentages add up to more than 100% as more than one answer could be selected.

No respondents ticked 'Psychodynamic Group Therapist'

Respondents' theoretical affiliation

	Total Frequency (n=286)	Percent (%)
Kleinian/Post-Kleinian/Bionian	132	46
British Independent	125	43.6
Freudian/Contemporary Freudian	71	24.7
Jungian/Post-Jungian	56	19.5
Relational	45	15.7
Attachment-led	38	13.2
Non-aligned	29	10.1
Pluralistic	28	9.8
Intersubjective	17	5.9
Interpersonal	14	4.9
Existential	5	1.7
Other theoretical affiliation	5	1.7
Lacanian	3	1.0
Self-psychological	3	1.0

Missing (n=1). Frequencies exceed 286 as more than one answer could be selected.

Percentages add up to more than 100% as more than one answer could be selected.

Number of LGB clients seen by respondents over career span

	Total Frequency (n=287)	Percent (%)
0	4	1.4
1-25	238	82.9
25+	45	15.7

Missing (n=0)

Number of LGB clients currently seen by respondents

	Total Frequency (n=286)	Percent (%)
0	82	28.7
1-5	193	67.5
6-10	10	3.5
10+	1	0.3

Missing (n=1)

Respondents' level of agreement with the statement that 'sexual orientation can be changed or re-directed through therapeutic means'

	Total Frequency (n=280)	Percent (%)
Strongly disagree	121	43.2
Disagree	88	31.4
Neither agree nor disagree	63	22.5
Agree	8	2.9

Missing (n=7). No respondent ticked 'strongly agree'

Respondents' level of agreement with the statement that 'sexual orientation is shaped by an inborn or genetic component'

	Total Frequency (n=280)	Percent (%)
Neither agree nor disagree	172	61.4
Disagree	45	16.1
Agree	42	15.0
Strongly disagree	13	4.6
Strongly agree	8	2.9

Missing (n=7)

Respondents' level of agreement with the statement that 'sexual orientation is shaped by disturbances in the early attachment relationship'

	Total Frequency (n=281)	Percent (%)
Agree	144	51.2
Neither agree nor disagree	88	31.3
Strongly agree	30	10.7
Disagree	15	5.3
Strongly disagree	4	1.4

Missing (n=6)

Respondents' level of agreement with the statement that 'sexual orientation is shaped by unresolved Oedipal conflicts'

	Total Frequency (n=282)	Percent (%)
Agree	117	41.5
Neither agree nor disagree	102	36.2
Disagree	33	11.7
Strongly agree	18	6.4
Strongly disagree	12	4.3

Missing (n=5)

Respondents' level of agreement with the statement that 'sexual orientation is shaped by early trauma'

	Total Frequency (n=281)	Percent (%)
Agree	133	47.3
Neither agree nor disagree	98	34.9
Strongly agree	24	8.5
Disagree	22	7.8
Strongly disagree	4	1.4

Missing (n=6)

Respondents' level of agreement with the statement that 'sexual orientation is shaped by a mixture of nature and nurture'

	Total Frequency (n=284)	Percent (%)
Agree	149	52.5
Strongly agree	57	20.1
Neither agree nor disagree	53	18.7
Disagree	17	6.0
Strongly disagree	8	2.8

Missing (n=3)

Respondents' level of agreement with the statement that 'sexual orientation is multiply determined'

	Total Frequency (n=283)	Percent (%)
Agree	141	49.8
Strongly agree	100	35.3
Neither agree nor disagree	30	10.6
Strongly disagree	7	2.5
Disagree	5	1.8

Missing (n=4)

Respondents' views on the most common reasons LGB clients seek therapy

	Total Frequency (n=287)	Percent (%)
Relationship difficulties	234	81.5
Anxiety	225	78.4
Depression	225	78.4
Family-related issues	147	51.2
Lack of meaning in life	77	26.8
Shame about sexuality	73	25.4
Work-related issues	66	23.0
Child sexual abuse	64	22.3
Sexual difficulties	63	22.0
Body image dissatisfaction	56	19.5
Self-harm	48	16.7
Addiction/alcohol or substance abuse	43	15.0
Coming out	43	15.0
Gender identity issues	42	14.6
Discrimination/stigma linked to sexual orientation	42	14.6
Other reasons	33	11.5
Bullying	31	10.8
Bereavement	30	10.5
Living with HIV	26	9.1
Sexual transgressive practices (e.g., BDSM)	24	8.4
Faith/religion/spirituality	21	7.3
LGBT parenting issues	17	5.9
Domestic violence and abuse	16	5.6
Intersectional difficulties	13	4.5
Ageing/intergenerational	12	4.2
Discrimination/stigma not linked to sexual orientation	6	2.1
Terminal illness	5	1.7

Missing (n=0)

Frequencies exceed 287 as a maximum of ten options could be selected.

Percentages add up to more than 100% as a maximum of ten options could be selected.

Respondents' views on the most common mental and/or physical health issues LGB clients present in therapy

	Total Frequency (n=287)	Percent (%)
Depression	223	77.7
Anxiety	210	73.2
Low self-esteem	132	46.0
Narcissistic Personality Disorder	84	29.3
Internalised homophobia	78	27.2
Suicidal tendencies	62	21.6
Borderline Personality Disorder	60	20.9
Panic attacks	52	18.1
Self-harm	51	17.8
Addiction	45	15.7
Eating Disorder	43	15.0
Post-traumatic stress disorder	42	14.6
Sleep disturbance	36	12.5
Worry about physical health	36	12.5
Sexual perversion	33	11.5
Somatisation/psychosomatic illness	32	11.1
Obsessive compulsive disorder	30	10.5
Paranoia	28	9.8
Gender Identity Disorder	27	9.4
Sexual dysfunction	26	9.1
Other symptoms	23	8.0
Body Dysmorphic Disorder	21	7.3
Non-health related worry	16	5.6
Fatigue	14	4.9
Problems with memory and/or concentration	11	3.8
Phobia	10	3.5
Schizophrenia	1	0.3

Missing (n=0)

Frequencies exceed 287 as a maximum of ten options could be selected.

Percentages add up to more than 100% as a maximum of ten options could be selected.

Respondents' views on the centrality of issues linked sexual orientation when working with LGB clients

	Total Frequency (n=277)	Percent (%)
Always	6	2.2
Frequently	75	27.1
Occasionally	143	51.6
Seldom	46	16.6
Never	7	2.5

Missing (n=10)

Respondents' clinical approach with LGB clients who request to re-direct their same sex attraction

	Total Frequency (n=281)	Percentage (%)
Work with client to explore underlying reasons for wanting to change	235	83.6
Other approach taken with client	27	9.6
Assist client to accept their sexual orientations	16	5.7
Treat client to change sexual orientation	1	0.4
Refer client to another colleague with experience of helping clients accept their sexual orientation	2	0.7

Missing (n=6)

Respondents' views on whether it is appropriate for therapists who are LGB and open about their sexuality in their social and professional life to disclosure their sexuality to their LGB clients

	Total Frequency (n=280)	Percent (%)
No	181	64.6
Don't know	72	25.7
Yes	27	9.6

Missing (n=7)

Respondents' views on whether LGB clients have a right access a therapist who is also LGB

	Total Frequency (n=277)	Percent (%)
Don't know	105	37.9
Yes	90	32.5
No	75	27.1
Prefer not to say	7	2.5

Missing (n=10)

Respondents' views on the reduction of symptoms in their LGB clients as a result of therapy

	Total Frequency (n=281)	Percent (%)
All	46	16.4
Most	160	56.9
Some	65	23.1
Few	9	3.2
None	1	0.4

Missing (n=6)

Respondents' views on the general day-to-day improvement of their LGB clients as a result of therapy

	Total Frequency (n=278)	Percent (%)
All	47	16.9
Most	157	56.5
Some	63	22.7
Few	10	3.6
None	1	0.4

Missing (n=9)

Respondents' level of satisfaction with therapeutic work with LGB clients compared with non-LGB clients

	Total Frequency (n=282)	Percent (%)
The same	256	90.8
Less satisfied	18	6.4
More satisfied	8	2.8

Missing (n=5)

Respondents' views on the average length of a treatment with LGB clients compared with non-LGB clients

	Total Frequency (n=278)	Percent (%)
Much the same	244	87.8
Tends to be shorter	20	7.2
Tends to be longer	14	5.0

Missing (n=9)

Respondents' views on whether they received formal training on issues of sexual orientation during their training

	Total Frequency (n=281)	Percent (%)
No	132	47.0
Yes	113	40.2
Cannot recall	36	12.8

Missing (n=6)

Respondents' views on effectiveness of sexual orientation training in preparing them for work with LGB clients

	Total Frequency (n=171)	Percent (%)
Neither effective nor ineffective	48	28.1
Effective	44	25.7
Not at all effective	40	23.4
Only slightly effective	30	17.5
Very effective	9	5.3

Missing (n=116) 40.4 % did not answer

Respondents' view on whether their current theories and models of sexual orientation need updating

	Total Frequency (n=271)	Percent (%)
Yes	129	47.6
No	74	27.3
Don't know	68	25.1

Missing (n=16)

Respondents' level of agreement with the statement that 'colleagues within my training organisation treat LGB colleagues the same as non-LGB colleagues'

	Total Frequency (n=271)	Percent (%)
Agree	110	40.6
Neither agree nor disagree	88	32.5
Strongly agree	41	15.1
Disagree	29	10.7
Strongly disagree	3	1.1

Missing (n=16)

Respondents' level of agreement with the statement that 'colleagues within my training organisation are less willing to supervise LGB candidates than non-LGB candidates'

	Total Frequency (n=268)	Percent (%)
Neither agree nor disagree	121	45.1
Disagree	86	32.1
Strongly disagree	52	19.4
Agree	9	3.4
Strongly agree	0	0

Missing (n=19)

Respondents' level of agreement with the statement that 'my training organisation does not assess the aptitude for psychoanalytic work on the basis of sexual orientation'

	Total Frequency (n=274)	Percent (%)
Agree	112	40.9
Neither agree nor disagree	78	28.5
Strongly agree	68	24.8
Disagree	13	4.7
Strongly disagree	3	1.1

Missing (n=13)

Respondents' level of agreement with the statement that 'my training organisation promotes LGB and non-LGB colleagues equally to senior positions within the organisation'

	Total Frequency (n=271)	Percent (%)
Neither agree nor disagree	119	43.9
Agree	88	32.5
Strongly agree	44	16.2
Disagree	16	5.9
Strongly disagree	4	1.5

Missing (n=16)

LGB respondents on whether they were open about their sexual orientation while training

	Total Frequency (n=119)	Percent (%)
Not applicable	73	61.3
Yes	28	23.5
No	13	10.9
Prefer not to say	5	4.2

Missing (n=168)

Respondents' awareness of the BPC Position Statement opposing discrimination against trainees on the basis of sexual orientation

	Total Frequency (n=276)	Percent (%)
Yes	243	88.0
No	33	12.0

Missing (n=11)

Respondents' views on how active a role the BPC should play in fostering a more inclusive profession for LGB clients and trainees

	Total Frequency (n=273)	Percent (%)
Much more active	51	18.7
More active	126	46.2
Fine as is	90	33.0
Less active	5	1.8
Much less active	1	0.4

Missing (n=14)

Respondents' views on the importance of the BPC in supporting training organisations in revising training entry requirements (including how LGB applicants are selected)

	Total Frequency (n=272)	Percent (%)
Important	135	49.6
Somewhat important	102	37.5
Neither important nor unimportant	26	9.6
Not too important	5	1.8
Not at all important	4	1.5

Missing (n=15)

Respondents' views on the importance of the BPC in assisting training organisations in revising their current curricula on sexual orientation

	Total Frequency (n=272)	Percent (%)
Important	144	52.9
Somewhat important	94	34.6
Neither important nor unimportant	26	9.6
Not too important	4	1.5
Not at all important	4	1.5

Missing (n=15)

Respondents' views on the importance of the BPC in assisting training organisations in delivering CPD events on sexual orientation for teaching and supervision staff

	Total Frequency (n=273)	Percent (%)
Important	139	50.9
Somewhat important	101	37.0
Neither important nor unimportant	22	8.1
Not too important	8	2.9
Not at all important	3	1.1

Missing (n=14)

Respondents' views on the importance of the BPC in providing better Information, Advice and Guidance (IAG) on LGB-specific issues

	Total Frequency (n=270)	Percent (%)
Important	109	40.4
Somewhat important	109	40.4
Neither important nor unimportant	42	15.6
Not too important	6	2.2
Not at all important	4	1.5

Missing (n=17)

Respondents' views on the importance of the BPC in developing partnerships with organisations working with the LGB community such as Pink Therapy

	Total Frequency (n=269)	Percent (%)
Somewhat important	102	37.9
Important	80	29.7
Neither important nor unimportant	54	20.1
Not too important	29	10.8
Not at all important	4	1.5

Missing (n=18)

Respondents' views on the importance of the BPC in establishing a network for LGB members across all training organisations

	Total Frequency (n=269)	Percent (%)
Neither important nor unimportant	100	37.2
Somewhat important	84	31.2
Important	45	16.7
Not too important	25	9.3
Not at all important	15	5.6

Missing (n=18)

Respondents' views on the importance of the BPC in ensuring that the BPC Ethics Committee addresses LGB issues

	Total Frequency (n=271)	Percent (%)
Important	130	48.0
Somewhat important	116	42.8
Neither important nor unimportant	19	7.0
Not too important	4	1.5
Not at all important	2	0.7

Missing (n=16)

Section B: Final Sample and Partial Responders Compared

Training Status: final sample and partial responders compared

Training status	Final sample (n=274)*	%	Partial responders (n=72)**	%
Qualified	242	88.3	53	73.6
In training	32	11.7	19	26.4

*Missing from final sample (n=13)

**Missing from partial responders (n=40)

Workplace setting: final sample and partial responders compared

Workplace setting	Final sample (n=284)*	%	Partial responders (n=72)**	%
Private	258	90.8	59	80.5
NHS	104	36.6	22	28.2
Other Settings	88	31.0	22	28.2

*Missing from final sample (n=3). Frequencies exceed 284 and percentages add to more than 100% because respondents could tick multiple options

**Missing from partial responders (n=40). Frequencies exceed 72 and percentages add to more than 100% because respondents could tick multiple options

Therapeutic modality: final sample and partial responders compared

Modality	Final sample (n=286)*	%	Partial responders (n=78)**	%
Psychoanalytic Therapist[92]	155	54.0	33	42.3
Psychodynamic Therapist[93]	96	33.4	36	46.2
Psychoanalyst	48	16.7	18	23.0
Jungian Analyst	42	14.6	5	6.4
Other[94] Therapist	11	3.8	8	10.3
Did not state	3	1.0	1	1.3

*Missing from final sample (n=1). Frequencies exceed 286 and percentages add to more than 100% because respondents could tick multiple options

**Missing from partial responders (n=34). Frequencies exceed 78 and percentages add up to more than 100% because respondents could tick multiple options

[92] Breakdown based on final sample: Psychoanalytic Psychotherapist (n=139, 48.4%); Psychoanalytic Couples Therapist (n=16, 5.6%). Breakdown based on partial responders: Psychoanalytic Psychotherapist (n=29, 37.2%); Psychoanalytic Couples Therapist (n=4, 5.1%).

[93] Breakdown based on final sample: Psychodynamic Psychotherapist (n=67; 23.3%); Medical Psychodynamic Psychotherapist (n=12, 4.2%); Psychodynamic Counsellor (n=9, 3.1%); Psychodynamic Practitioner in Mental Health and/or Forensic Settings (n=4, 1.4%); Psychodynamic Couples Psychotherapist; (n=2, 0.7%); Psychodynamic Psychotherapist in time-limited work with adolescents (n=2, 0.7%). Breakdown based on partial responders: Psychodynamic Psychotherapist (n=17; 21.8%); Medical Psychodynamic Psychotherapist (n=6, 7.7%); Psychodynamic Counsellor (n=4, 5.1%); Psychodynamic Practitioner in Mental Health and/or Forensic Settings (n=0, 0.0%); Psychodynamic Couples Psychotherapist (n=1, 1.3%); Psychodynamic Psychotherapist in time-limited work with adolescents (n=8, 10.3%).

[94] Under 'Other', respondents also included their work with children and adolescents as well specialist skills (e.g., Dream Matrix Facilitator; Dynamic Interpersonal Therapy (DIT) practitioner; and Rehabilitation Counsellor).

Theoretical affiliation: final sample and partial responders compared

Theoretical affiliation	Final sample (n=286)*	%	Partial responders (n=78)**	%
Kleinian/Contemporary Kleinian/Bionion	**132**	**46.0**	38	48.7
British Independent	**125**	**43.6**	28	35.6
Post-Classical***	**84**	**29.2**	11	14.1
Freudian/Contemporary Freudian	**71**	**24.7**	22	28.2
Jungian/Post-Jungian	**56**	**19.5**	8	10.3
Attachment-led	**38**	**13.2**	6	7.7
Non-aligned	**29**	**10.1**	6	7.7
Pluralistic	**28**	**9.8**	8	10.3
Other theoretical affiliation[95]	**8**	**2.7**	4	5.2

*Missing from final sample (n=1). Frequencies exceed 286 and percentages add to more than 100% because respondents could tick multiple options

** Missing from partial responders (n=34). Frequencies exceed 78 and percentages add to more than 100% because respondents could tick multiple options.

***Post-Classical includes relational, intersubjective, interpersonal, existential and self-psychological

Respondents by training organisation: final sample and BPC official data compared

Training Organisation	Final sample (n=286)*	%	BPC data (n=1403)	%
British Psychotherapy Foundation (BPF)	113	39.4	422	30.1
Foundation for Psychotherapy and Counselling (FPC)	57	19.9	220	15.7
Tavistock Society of Psychotherapists	37	12.9	180	12.8
British Psychoanalytical Society (BPAS)	36	12.5	283	20.2
Regional (outside of London)[96] training organisations	28	9.7	130	9.2
Jungian-based only training organisations[97]	25	8.7	133	9.5
Other training organisations[98]	26	9.0	35	2.4
British Society of Couple Psychotherapists & Counsellors	15	5.2	0	0

*Missing from final sample (n=1). Frequencies exceed 286 and percentages add to more than 100% because respondents could tick multiple options.

[95] Under 'Other', respondents included: mentalisation-based approaches; group analysis; social systems theory; Dynamic Interpersonal Therapy (DIT); schema therapy; and Lacanian psychoanalysis.

[96] Breakdown based on final sample: Severnside Institute for Psychotherapy (n=13, 4.5%); Scottish Association of Psychoanalytical Psychotherapists (n=7, 2.4%); North of England Association of Psychoanalytic Psychotherapists (n=4, 1.4%); Northern Ireland Association for the Study of Psychoanalysis (n=2, 0.7%); Wessex Counselling (n=2, 0.7%). Breakdown based on BPC data: Severnside Institute for Psychotherapy (n=61, 4.3%); Scottish Association of Psychoanalytical Psychotherapists (n=36, 2.6%); North of England Association of Psychoanalytic Psychotherapists (n=16, 1.1%); Northern Ireland Association for the Study of Psychoanalysis (n=8, 0.6%); Wessex Counselling (n=9, 0.6%).

[97] Breakdown based on final sample: Society of Analytical Psychology (n=20, 7.0%); Association of Jungian Analysts (n=5, 1.7%). Breakdown based on BPC data: Society of Analytical Psychology (n=121, 8.6%); Association of Jungian Analysts (n=12, 0.9%).

[98] Breakdown based on final sample: Association of Psychodynamic Practice and Counselling in Organisational Settings (n=4, 1.4%); Association of Psychodynamic Counsellors (n=3, 1.0%); Association of Medical Psychodynamic Psychotherapists (n=2, 0.7%); Forensic Psychotherapy Society (n=2, 0.7%); Would rather not state (n=4, 1.4%); 'Other' (n=11, 3.8%). Breakdown based on BPC data: Association of Psychodynamic Practice and Counselling in Organisational Settings (n=12, 0.9%); Association of Psychodynamic Counsellors (n=13, 0.9%); Association of Medical Psychodynamic Psychotherapists (n=9, 0.6%); Forensic Psychotherapy Society (n=1, 0.0%). Interestingly, there are no official BPC numbers recorded for the British Society of Couple Psychotherapists and Counsellors (BSCPC).

Section C: Chi Squared (χ^2) Analyses

Associations between respondents' attributes and theories of sexual orientation (χ^2 analysis)

Inborn or genetic component

Attribute	χ^2	P value
Gender	.505	.477
Sexual orientation	3.065	.080
Age	.703	.402
Therapeutic modality	1.368	.242
Theoretical affiliation	2.533	.112

Disturbed attachment relationships

Attribute	χ^2	P value
Gender	.113	.737
Sexual orientation	.641	.423
Age	.114	.735
Therapeutic modality	1.024	.311
Theoretical affiliation	.944	.331

Unresolved Oedipal conflicts

Attribute	χ^2	P value
Gender	.549	.459
Sexual orientation	.695	.405
Age	1.431	.232
Therapeutic modality	1.870	.172
Theoretical affiliation	1.889	.169

Early trauma

Attribute	χ^2	P value
Gender	.292	.589
Sexual orientation	.099	.753
Age	.939	.333
Therapeutic modality	1.187	.276
Theoretical affiliation	2.059	.151

Multiple determinants

Attribute	χ^2	P value
Gender	.005	.943
Sexual orientation	.054	.817
Age	.741	.389
Therapeutic modality	.015	.903
Theoretical affiliation	1.064	.302

Nature/Nurture

Attribute	χ^2	P value
Gender	.037	.848
Sexual orientation	.012	.914
Age	1.954	.162
Therapeutic modality	.349	.555
Theoretical affiliation	2.055	.152

All responses and categories of respondent were reduced to two categories each, so all comparisons have two degrees of freedom. The five-point Likert scale options for this question were recoded as 'agree' and 'disagree'. The 'agree' category combined the previous categories of 'strongly agree' and 'agree'. The 'disagree' category combined the previous categories of 'neither agree nor disagree', 'disagree' and 'strongly disagree'. 'Neither agree nor disagree' was assigned to 'not agree' to ensure the χ^2 test's requirements were met (i.e., expected frequencies in the cells should not be less than five). Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Theoretical modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' (i.e., that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories. I am aware that in conducting this analysis, I run the risk of multiple testing. However, all comparisons fell short of the most lenient level of significance at 0.05.

Associations between respondents' attributes and views on LGB therapist self-disclosure (χ^2 analysis)

Attribute	χ^2	P value
Gender	3.158	.076
Sexual orientation	10.909	.001
Age	1.984	.159
Therapeutic modality	1.100	.294
Theoretical affiliation	2.360	.124

Question responses were recoded as 'Yes' and 'No'. The category of 'Don't know' was assigned to the 'No' category. Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Theoretical modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' (that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.

Associations between respondents' attributes and views on LGB clients' rights to access LGB therapists (χ^2 analysis)

Attribute	χ^2	P value
Gender	3.910	.048
Sexual orientation	.031	.859
Age	.141	.708
Therapeutic modality	1.247	.264
Theoretical affiliation	3.445	.063

Question responses were recoded as 'Yes' and 'No'. The categories of 'Don't know' and 'Prefer not to say' were assigned to the 'No' category. Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Theoretical modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' (that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.

Associations between respondents' attributes and views on effectiveness of psychoanalytic teaching on sexual orientation (χ^2 analysis)

Attribute	χ^2	P value
Gender	1.462	.227
Sexual orientation	.684	.408
Age	2.335	.126
Therapeutic modality	1.531	.216
Theoretical affiliation	4.459	.035

The five-point Likert scale options were recoded as 'effective' and 'not effective'. The categories of 'very effective' and 'effective' were assigned to 'effective'. The categories of 'neither effective nor ineffective', 'only slightly effective' and 'not at all effective' were assigned to 'not effective'. Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Theoretical modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' (that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.

Associations between respondents' attributes and need to update theories of sexual orientation (χ^2 analysis)

Attribute	χ^2	P value
Gender	.998	.318
Sexual orientation	.000	.990
Age	3.318	.069
Therapeutic modality	5.096	.024
Theoretical affiliation	.144	.705

Question responses were recoded as 'Yes' and 'No'. The category of 'Don't know' was assigned to the 'No' category. Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Theoretical modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' (that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.

Associations between respondents' attributes and professional attitudes (χ^2 analysis)

Treat LGB colleagues the same as non-LGB colleagues		
Attribute	χ^2	P value
Gender	1.474	.225
Sexual orientation	5.937	.015
Age	2.259	.133
Therapeutic modality	1.704	.192
Theoretical affiliation	.102	.750

Does not assess aptitude for psychoanalytic work on the basis of sexual orientation		
Attribute	χ^2	P value
Gender	.708	.400
Sexual orientation	.000	.991
Age	1.055	.304
Therapeutic modality	1.307	.253
Theoretical affiliation	1.958	.163

LGB and non-LGB colleagues equally promoted to senior positions		
Attribute	χ^2	P value
Gender	.707	.401
Sexual orientation	.026	.873
Age	.912	.339
Therapeutic modality	13.314	.001
Theoretical affiliation	1.651	.199

χ^2tests could not be conducted on the statement 'colleagues within my training organisation are less willing to supervise LGB candidates than non-LGB candidates' as χ^2 test requirements were not met (i.e., expected frequencies in some cells were less than five).The five-point Likert scale for this question was recoded into two categories: 'agree' and 'disagree. The 'agree' category combined the previous categories of 'strongly agree' and 'agree'. The 'disagree' category combined the previous categories of 'neither agree nor disagree', 'disagree' and 'strongly disagree'. Gender was recoded into 'female' and 'male'. Sexual orientation was recoded into 'heterosexual' and 'not heterosexual'. Age was recoded into 'over 60' and 'under 60'. Theoretical modality was recoded as 'psychoanalytic' and 'non-psychoanalytic' (that is, Jungian or Other). Theoretical affiliation was recoded into 'traditional' and 'eclectic'. By 'traditional', I refer to respondents who exclusively use Freudian, Kleinian, Independent and Jungian theories. By 'eclectic', I refer to respondents who make use of more contemporary theories, such as self-psychological, relational etc, either exclusively or in combination with the traditional theories.