NHS TALKING THERAPIES FOR ANXIETY AND DEPRESSION: LGBTQ+ POSITIVE PRACTICE GUIDE (2024)

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Disclaimer: The terms, content, and resources used throughout this Positive Practice Guide were accurate at the time of writing, 13th March 2024

FOREWORD FROM NHS ENGLAND & LGBT FOUNDATION

The NHS Talking Therapies for anxiety and depression programme (formerly known as Improving Access to Psychological Therapies, IAPT), which started in 2008, has greatly increased the availability of NICE-recommended psychological therapies in the NHS. Substantial progress has been made in the 16 years since the programme started: 650,000 people a year are now provided with a course of treatment in NHS Talking Therapies services. Half of these make a full recovery, with many more improving through treatment.

Lesbian, gay, bisexual, trans, queer and other sexual minority (LGBTQ+) people on average experience higher levels of psychological difficulties than heterosexual people. The statistics in the 2018 National LGBT Survey: Research Report outlined in Section 1 make clear that more work needs to be done to improve the experience of LGBTQ+ people in the UK. This is the case also in NHS Talking Therapies services: evidence indicates that LGBTQ+ treatment outcomes within NHS Talking Therapies services are worse than the outcomes for heterosexuals, especially for bisexual people and sexual minority women.

This excellent Positive Practice Guide brims with helpful suggestions for how to achieve access and outcome equity for the LGBTQ+ community. It has been co-developed by NHS Talking Therapies clinicians and LGBTQ+ service users, and contains a comprehensive evidence review and has sections covering reducing barriers to access; data recording and monitoring; and inclusive practice. There is a large number of robust and helpful case studies and examples of best practice that will aid in developing therapeutic practice and improving care.

NHS Talking Therapies for anxiety and depression services are for people from all sections of the community.
The recommendations outlined in this Guide will help us all in our work to ensure that LGBTQ+ people have the best chance to benefit from psychological therapy.

Dr Adrian Whittington (He/Him)
National Clinical Lead for Psychological Professions — NHS England

Since 1975, LGBT Foundation have been transforming the lives of LGBTQ+ people across the UK. The same spirit that fuelled our beginnings still drives us today. We are committed to championing the unique voices, experiences and cultures of LGBTQ+ people across the UK.

We provide services and activities that give a lifeline to those in need, offering hope and support on their journey towards achieving their aspirations. Our vision is a world where queer liberation enables meaningful and lasting change and plays a vital part in a more equal and just society.

Over the last year, NHS Talking Therapies (represented by Vicky Cartwright (She/Her) and her team) have worked together with LGBT Foundation to develop this LGBTQ+ specific Positive Practice Guide. The Guide will support NHS Talking Therapies' Practitioners in their understanding of LGBTQ+ experiences and help improve inclusivity in their practices.

This project started with a nationwide survey; collating information on what practitioners wanted the guide to include and the areas they needed the most support in. We also captured feedback from LGBTQ+ communities about their needs from NHS Talking Therapies, to improve access and overall satisfaction with the services. Over 250+ responses in total were analysed.

In addition to the survey, we held three focus groups with NHS Talking Therapies practitioners and LGBTQ+ individuals, to ensure the contents of this guide were reviewed by experts with lived experience at every stage.

This feedback has been the leading force in shaping and finalising this work, and we are proud to present you the **UK's first LGBTQ+ specific Positive Practice Guide for Practitioners of NHS Talking Therapies: Anxiety and Depression**.

Emine Akkunt (She/Her)
Talking Therapies Programme Manager – LGBT Foundation
Project Manager – LGBTQ+ Positive Practice Guide

SECTION 1: BACKGROUND

In this Positive Practice Guide, we use the acronym **LGBTQ+** to refer to **LESBIAN, GAY, BISEXUAL/BI, TRANS**, **QUEER**, and **QUESTIONING** people.

We are aware that the terminology used in relation to the recognition of people's **SEXUAL ORIENTATION** or **GENDER IDENTITY** may depend on the context of its use. Some people may define some terms differently to us. We have tried to use terminology that is generally accepted.

This guide is for working with adults (aged 16+) within NHS Talking Therapies. It is important to note that there are particular considerations when working with children and young people and specific guidance should be sought, as required.

Historically, LGBTQ+ people have been subject to state sanctioned punishment, exclusion and misdiagnosis. For example, it was illegal for two men to have consensual sex in private until 1967 and it was only in 2014 that same-**SEX** marriage became legal. Furthermore, the Diagnostic and Statistical Manual for Mental Disorders (DSM) included the psychiatric diagnosis of homosexuality until 1973 (later removed from the International Classification of Diseases (ICD) in 1990) and the psychiatric diagnosis of Gender Identity Disorder until 2013. This context provides reason why LGBTQ+ people might be mistrustful of authority (e.g., state health service in the form of the NHS) and mental health services in particular. Moreover, LGBTQ+ individuals are often sceptical of mental health services and are concerned that practitioners are not aware and understanding of LGBTQ+ considerations *(Cocks et al., 2019)*. Due to this, practitioners and services need to make sure that they overcome these barriers by demonstrating a welcoming and inclusive stance, and communicate very clearly that the service is welcoming of their identities *(Cocks et al., 2019)*.

In 2018, the *Government Equalities Office* issued their report exploring the experience of LGBTQ+ people in the UK, titled 'National LGBT Survey: Research Report'. Over 108,000 LGBTQ+ individuals completed the survey, making it the largest national survey of LGBTQ+ people to date.

KEY POINTS FROM THE SURVEY INCLUDED:

At least
TWO IN FIVE
respondents had experienced a negative incident e.g., verbal harassment or physical violence because they were LGBTQ+, in the 12 month preceding the survey.

More than
TWO THIRDS
of respondents said that they avoid holding hands with a same-sex partner, for fear of a negative reaction from others.

24%
of respondents had accessed mental health services in the 12 months preceding the survey.

However,
28%
of respondents who had accessed or tried to access mental health services in the 12 month preceding the survey, said it had not been easy at all. The most common reason given was long waiting lists.

The survey also found that **2%** of respondents had undergone conversion therapy*.

***Conversion therapy** is a harmful form of abuse that includes medical, psychiatric, psychological, religious, cultural or any other interventions that seek to change, "cure", or suppress the sexual orientation and/or gender identity of a person *(Ban Conversion Therapy, 2023).*

The forms of conversion therapy are varied and range from pseudo-psychological treatments to, in extreme cases, surgical interventions or 'corrective' rape. Conversion practices have been widely condemned as ineffective and dangerous, with support for a ban coming from the United Nations.

Unfortunately, at time of writing, conversion therapy is still legal in the UK however, multiple professional organisations have supported the ban of conversion therapy.

The Memorandum of Understanding on Conversion Therapy in the UK can be accessed for further information.

The findings discussed on page 4 clearly show that more work needs to be done to improve the experience of LGBTQ+ people in the UK.

It is clearly not acceptable that so many LGBTQ+ people are fearful of holding hands with their partner in public, are a victim of a **HATE CRIME**, are subjected to conversion therapy, and experience mental health difficulties often because of **HARASSMENT** and prejudice.

Encapsulating these points, *Meyer (2003)* suggests that higher incidence of mental health problems in the LGBTQ+ community is due to cultural, societal, and historical **DISCRIMINATION** that LGBTQ+ people are victim to. Adding to this, *Laville (2022)* highlighted that repeated incidences of **HOMOPHOBIA, BIPHOBIA**, and **TRANSPHOBIA** can result in the development of mental health conditions and these negative experiences also lead to elevated risk rates for self-harm and suicide.

Williams et al. (2021) found that for individuals aged between 12 and 25, victimisation and mental health difficulties were significant risk factors for suicide and self-harm. Victimisation was prevalent in 36% of the individuals who identified as LGBTQ+ and this is 3.74 times higher than in **CISGENDER**, **HETEROSEXUAL** counterparts. 39% reported mental health difficulties and this is 2.67 times higher than in cisgender heterosexual individuals within the same age range. Some of the victimisation included cyber bullying as well as homophobic and peer bullying.

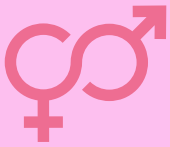
Focusing on the impact of the COVID-19 pandemic, *Laville (2022)* detailed that the pandemic resulted in higher rates of isolation for LGBTQ+ people, particularly older LGBTQ+ people, which elevated risk rates.

Many LGBTQ+ individuals reported having to hide their own identity from family members and said they did not have anyone to talk to.

Moreover, the pandemic had an impact on LGBTQ+ specialist support services, which only operated remotely or not at all, and this will have had a significant impact on the availability, and arguably quality, of support provided to LGBTQ+ people.

Focusing specifically on mental health, previous studies *(Chakraborty et al., 2011; Cocks et al., 2019)* found higher rates of mental health conditions including anxiety and depression in LGBTQ+ people compared to heterosexual and cisgender individuals. It has also been found that LGBQ+ individuals have lower self-esteem than their heterosexual counterparts *(Bridge et al., 2019)* and this may contribute to greater risk for depression, anxiety, suicidal ideation and self-harm.

In May 2020, the LGBT Foundation Helpline saw a 50% increase in calls about mental health from the beginning of the pandemic.



64%
of respondents surveyed by LGBT Foundation about their experiences of the pandemic lockdown indicated that they would... **"prefer to receive support from the LGBTQ+ specific services as they feel safer in inclusive spaces"**
(LGBT Foundation, 2020)

Therefore, a central focus must be to improve practitioners' confidence and competence when working with the LGBTQ+ community. This is particularly important as *Ho et al. (2023)* found that there is significant variability in the presence and quality of psychological therapy training in sexual orientation, and further investigation should explore the presence and quality of training for gender identity.

Training provision needs to be addressed as it is not the role of patients to educate practitioners on matters of sexual orientation and gender identity.

IN THIS POSITIVE PRACTICE GUIDE, WE COVER:

The existing evidence and guidance for supporting LGBTQ+ people in NHS Talking Therapies for anxiety and depression services.

Specific practical advice on how best to improve recovery outcomes for the LGBTQ+ community and how to adapt your own practice to be more LGBTQ+ inclusive.

Links to further sources of guidance and support as well as case studies of good LGBTQ+ inclusive practice in psychological therapies to further develop your practice and improve patient care and satisfaction rates.

SECTION 2: AN OUTLINE OF EXISTING EVIDENCE AND GUIDANCE

THROUGHOUT THIS GUIDE, MULTIPLE ACRONYMS ARE USED.

This is to ensure that the information provided is an accurate representation of what the research concluded. Not every research reference has incorporated all demographics of the LGBTQ+ community.

We acknowledge that there are more sexual orientations than what is covered within this guide including but not limited to **ASEXUAL/ACE** and **AROMANTIC/ARO**, but there is limited research available on other sexual orientations at this time. A glossary of terminology is provided at the back of this guide.

2.1 Evidence and Guidance for Working with the LGBTQ+ Community
Differential Experience and Outcomes for LGBTQ+ Individuals

Individuals should be given opportunities to discuss their sexuality and previous experiences of stigma and discrimination. These experiences can create barriers for accessing and engaging in treatment *(Foy et al., 2019)*. The experiences are different to those of heterosexual individuals and can influence the outcome of treatment.

For example, a participant in *Foy et al. (2019)* study reported that the therapist assumed that they had social anxiety and did not understand that the fear of being in public was regarding their own safety, due to being a "visibly gay/ **GENDER NONCONFORMING** woman".

Foy et al. (2019) recruited 136 participants, where 23.5% identified as gay, 18.4% lesbian, 37.5% bisexual, 12.5% queer, 5.9% other, 1.5% as asexual and 0.7% as mostly heterosexual. There were only 4 people who identified as **TRANSGENDER** and 11 as **NON-BINARY**. 27.2% of participants said that there were issues they did not feel able to discuss with their therapist.

Some patients also reported experiencing stigma within some NHS Talking Therapies and primary care services *(Foy et al., 2019)*, Section 3.3 discusses in more detail ways practitioners can improve their practice to prevent stigma within the service. These findings are consistent with those of *Bachmann and Gooch (2018a)* in a report for Stonewall about LGBT individuals' experiences of discrimination and misunderstanding by healthcare professionals. We also acknowledge the need for equivalent research, to *Foy et al. (2019)*, to be conducted to explore specifically the experiences of **GENDER** diverse communities when accessing psychological therapies.

It is important to be aware that the experiences within the LGBTQ+ population differ for everyone within the community. For example, a person who is bisexual or from an ethnic minority may have differing experiences to the rest of the LGBTQ+ population.

Patients within *Rimes et al. (2019)* study reported that their therapist would make assumptions about their sexuality based on a comment they made about the gender of their partner. For example, assuming they were heterosexual because they mentioned they had a partner of the opposite gender.

bisexual individuals experienced additional stigma, from both the lesbian/gay population and the heterosexual population. There were experiences of biphobia and **HETERONORMATIVITY** and lower disclosure rates from those who identified as bisexual.

NHS Talking Therapies treatment outcomes are variable for the LGBTQ+ population.

Women who identify as being lesbian and both men and women who identify as bisexual, ended their treatment with higher severity of depression, anxiety and functional impairment than those identifying as heterosexual or as a gay man. It is important to note that bisexual patients and lesbian women had higher baseline depression, anxiety and functional impairment than heterosexual patients and gay men had higher baseline functional impairment than heterosexual patients and higher depression than heterosexual women. There were no reliable differences found between men who identified as heterosexual or gay *(Rimes et al., 2019)*.

Furthermore, the data from NHS England, for those who completed treatment between April 2021 and March 2022, highlighted those who identified as bisexual had the lowest recovery rate (42.1%), when compared to the other sexual orientations. Those who identified as non-binary or **GENDER FLUID** had the lowest recovery rate of 37.1%, when compared to other gender identities *(NHS Digital, 2022)*.

It is important to note the data on sexual orientation and gender relies on the initial assessor to check that the demographics are correct and for the patient to feel comfortable to disclose this information. There were 888 (0.28%) people who had no gender recorded who achieved recovery and 84,261 (26.84%) who had no sexual orientation recorded who achieved recovery. The options available for sexual orientation are limited to: heterosexual, gay/lesbian, bisexual, not stated/not known/invalid. Therefore, if an individual identifies as a sexual orientation other than those listed, then there is no option for them to record this so would be included in the 'not stated' category.

It is clear that there is a need for practitioners to have LGBTQ+ education including specialist training, with **87.5%** of patients reporting that this is needed *(Foy et al., 2019).*

As part of the training, assisting practitioners to have more awareness of the specific mental health difficulties that the LGBTQ+ population may experience is essential. For example, it has been found that there are higher levels of **BODY DYSMORPHIA** within the gay male population *(Foy et al., 2019).*

Appropriate training and education for practitioners is essential to decrease the likelihood of patients experiencing a negative effect from engaging with psychological interventions. The needs for training or education are discussed more in Section 3.3.

There is possibility of both positive and negative effects of psychological interventions, and it is important that this is acknowledged *(Crawford et al., 2019).* Although only a small percentage, **5.2**% of people receiving psychological treatment have reported experiencing lasting negative effects *(Crawford et al., 2016).* In *Crawford et al. (2016),* those who were from sexual and ethnic minorities were more likely to report these negative effects. Additional factors that increase the chances of lasting negative effects are appointments not being offered at a convenient time and people not being able to get to the appointment. Some of the factors which increase the likelihood of positive outcomes from psychological therapy include referrals being made at the right time, offering the right number of sessions, and providing the appropriate amount of information about treatment prior to it commencing.

Section 3 addresses this in further detail, highlighting aspects to consider, when completing an assessment with a patient ensuring that the outcome is the most appropriate, for the patient at that time. Therefore, reducing the likelihood of lasting negative effects from the psychological treatment.

There may also be short-term negative effects, such as increased anxiety and temporary discomfort, particularly if patients are engaging in a therapy such as exposure. If the patient is not made aware of the short-term discomfort, they may not be prepared for this and could disengage, and therefore be less inclined to seek therapy in the future. Patients might also see no positive changes and could interpret this as them being "damaged" beyond repair, eliciting a sense of hopelessness *(Bystedt et al., 2014).* An exacerbation of their current symptoms or presenting with new symptoms such as anger, anxiety and low self-esteem is also a possibility. If these occur, it has the potential to reduce the patient's confidence in therapy and impact on further engagement *(Crawford et al., 2019).* However, some examples of positive effects of psychological therapies may include the patient returning to employment and reduced symptoms of anxiety and depression *(Clark et al., 2009).* Practitioners should be aware of both the potential positive and negative factors and should discuss these with the patient and provide sufficient information about the treatment, in the initial assessment, before therapy starts *(Crawford et al., 2019).*

Cognitive Behavioural Therapy (CBT), due to its focus on skills-based approaches, can be well placed to promote positive effects.

CBT focuses on the functionality of behaviour (functional versus dysfunctional) which can make it an appropriate approach for the LGBTQ+ population, who may have previously experienced judgements based on others own moral viewpoints. It challenges unhelpful thoughts and behaviours in a supportive therapeutic environment *(Carvalho et al., 2022).*

Barriers to Effective Care for LGBTQ+ Individuals

McIntyre et al. (2011) conducted interviews with mental healthcare providers in Canada who provide services specifically for the LGBT population. Canada also offers free government-based options for mental health support, delivering CBT using a guided approach in both a group or individual basis *(Ontario, 2024)*. Although they do not have a single national health service like the UK, the three categories for the barriers are applicable to the UK system.

Three barriers for LGBT individuals accessing mental health services were identified: **client-level, provider-level and system-level barriers**.

Client-level barriers are factors which sit with the patient/client who is wanting to seek support but prevents them in doing so (e.g. lack of confidence, poorer socioeconomical status and fear of consequences).

Provider-level barriers sit with the organisation/provider (e.g. lack of resources and knowledge).

System-level barriers sit with the wider context of the healthcare system and so, the following section will further explore some examples of system-level barriers, as reported in the Canadian mental health provider context.

The medical model is a model which assumes that illnesses, including mental health, is caused by physical, biological factors such as: genetics, chemical imbalance or structure of the brain. This model diminishes the individuality of the patient and mental health care as it does not consider the social context of LGBTQ+ people who are seeking mental health support.

Section 1 outlined the prevalence of victimisation within the LGBTQ+ population which increases the likelihood of suicide and self-harm *(Williams et al., 2021)*. This demonstrates the importance of using a biopsychosocial approach when considering mental health of LGBTQ+ people, to avoid diminishing their earlier experiences. Using the perspective of an alternative model, which considers social context, may lead to improved support services for the LGBTQ+ community.

One alternative model could be the minority stress model by *Meyer (2003)*. This model explains how social stressors, such as stigma and prejudice, can explain higher prevalence of mental health disorders within minority populations, such as LGBTQ+ individuals. It is therefore recommended, that course providers and NHS Talking Therapies services should incorporate theoretical content, in more depth within training and education, which would include the minority stress model *(Ho et al., 2023)*.

A further system-level barrier is not having sufficient support available to meet the needs. Patients who identify as LGBTQ+ have often built-up courage to identify their current difficulties, especially if it is in relation to their identity, as they are more likely to have been subjected to discrimination due to being LGBTQ+, which causes higher rates of mental health difficulties *(Meyer, 2003)*.

LGBTQ+ patients can find it challenging to disclose their sexuality because of fears of discrimination, stereotyping or unconscious biases, this fear is still present even if there is no evidence that indicates the practitioner held any discriminatory views *(Morris et al., 2022)*. Due to the challenges that LGBTQ+ individuals face if they have to wait for treatment then this is exacerbated and creates a further barrier for engaging in therapy and can result in an increased dropout rate.

Often to mitigate longer wait times, short term mental health services are provided. However, this allows less time for the social contexts impacting LGBTQ+ patients to be explored *(McIntyre et al., 2011)*.

When considering dropout rates for treatment and potential barriers, *Crawford et al. (2019)* found that whilst there are positive experiences of psychological therapies, there were multiple factors which were associated with an increased likelihood of experiencing lasting negative effects.

The most impactful factors were:

- Being aged between 45 to 54 years old
- Identifying as LGBTQ+
- Asian, Black or Chinese ethnicity
- Treatment taking longer than 12 months to begin

Barriers to access should be considered in an intersectional way *(Crenshaw, 1989)*. *Crenshaw (1989)* defines **INTERSECTIONALITY** as a metaphor for understanding how multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood.

For example, a black lesbian woman might be subject to racism, homophobia, and sexism, which will have an impact on sense of self and sense of belonging within society, with a potential reluctance to access mental health services. These compounded forms of inequality, therefore, need to be jointly understood by practitioners. In Section 4, we have provided links to relevant resources that will support practitioners to develop their consideration of intersectionality within clinical practice.

Enhancing Effective Care for LGBTQ+ Individuals

Recommendations relevant to NHS Talking Therapies:

1. **Incorporate a blended mental health model**, such as the minority stress model *(Meyer, 2003)*, which considers social aspects and structural inequalities.

2. **Increase support for LGBT affirming mental health providers**. LGBT affirming practice allows a focus on the impacts that LGBTQ+ people experience, such as social discrimination and affirms their identity as an LGBTQ+ person by listening to and validating their experiences, Section 3.3 covers this in more detail. *McIntyre et al. (2011)* discussed how peer support was beneficial to those providing LGBT affirming practice.

3. Creating a space where practitioners can discuss challenges and difficulties when working with the LGBTQ+ population and gain support in how to address the client's needs. An example of how this could be implemented within service is discussed in Section 5, with a case study outlining the creation of the national NHS Talking Therapies LGBTQ+ Champion Network. A champion is an individual who has a special interest or passion within a specific area. The role of an LGBTQ+ champion is to increase access and positive experiences that LGBTQ+ people have within the service. They are a point of contact that people can contact for specific LGBTQ+ queries.

4. Services need to understand their local communities and workforce demographics, including an understanding of what the needs are. There should be diversity at all levels across the workforce and monitoring sexual orientation of patients *(Laville, 2022)* and staff should help the service to identify their patient and staff demographics.

   Demographics should be monitored across key protected characteristics, including **GENDER REASSIGNMENT** *(Equality and Diversity Council, 2017).* The practical implementation of this is discussed further in Section 3.2.

5. Services also need to have a robust leadership team which actively promotes LGBTQ+ equality, ensuring that the workplace is free from discrimination. Local NHS organisations should focus on creating an LGBTQ+ friendly workplace. This can include staff training and education, establishing LGBTQ+ staff networks, and initiatives to improve LGBTQ+ representation within senior and board level positions of the workforce *(Equality and Diversity Council, 2017).* Which can be achieved by encouraging people who identify as LGBTQ+ to apply for the vacancies within job adverts.

SECTION 3: PRACTICAL RECOMMENDATIONS FOR SUPPORTING THE LGBTQ+ COMMUNITY

3.1 Reducing Barriers to Access

As detailed in Section 1, LGBTQ+ individuals face barriers in accessing mental health services *(Cocks et al., 2019)*. The primary barrier is the concern that practitioners do not possess the necessary awareness and knowledge regarding sexual orientation and gender identity. It can often be the case that practitioners deem themselves to be inclusive but how would prospective patients be aware of this?

Cocks et al. (2019) provide five recommendations to improve LGBTQ+ practice. The recommendations focus on acknowledging biases and assumptions, improving signposting, improving inclusive practice, improving data collection, and improving supervision processes.

In this section, we explore the recommendation that addresses reducing barriers to access, namely improving inclusive practice with other recommendations discussed later in the guide. We also consider how practitioners and services can advance their inclusive practice more broadly.

Improving Inclusive Practice

Firstly, the responsibility to improve LGBTQ+ inclusion should rest with individual practitioners as well as at a service level. *Cocks et al. (2019)* suggest that visible LGBTQ+ inclusion can be shown:

- On service websites by including images and text that highlights the inclusive nature of the service. This in turn will support LGBTQ+ individuals to have confidence that the service will be understanding of their needs.
- Visible signs of LGBTQ+ inclusion can also be seen in waiting rooms, providing access to **GENDER-NEUTRAL** toilets, and individual practitioners are more frequently wearing LGBTQ+ lanyards and NHS rainbow flag badges. These visible signs have been shown to put LGBTQ+ individuals at ease when accessing services *(Mackay, 2023)*.
- Some NHS Talking Therapy teams attend local LGBTQ+ events (e.g., Pride Festivals) to promote their service, which services have reported to be a useful form of outreach.

Furthermore, other examples of positive practice include practitioners using their **PRONOUNS** to signify to trans and non-binary patients that it is a safe space. The use of pronouns in email signatures is becoming more commonplace in NHS Talking Therapies services and some services have also embedded a question in their self-referral forms that invites prospective patients to provide their pronouns as well.

Following general good practice, we also need to consider clear communication and accessibility. For example, patients should be clearly informed about what treatment they are on a waiting list for and, if possible, given updates on when they are likely to be able to access treatment. This is particularly important for trans individuals who are often on other waiting lists and are therefore, already experiencing significant periods of uncertainty whilst waiting to access a range of healthcare provisions. Options for mode of treatment and patient-practitioner communication should be as accessible as possible and include in-person, telephone, online, and email options.

The environment that the patient accesses treatment from needs to be a confidential space where they can openly share their experiences related to sexuality and/or gender, if relevant. Services should try, wherever possible, to make sure there is equitable wait times for different modes of treatment, so individuals with additional needs do not need to wait an excessive amount of time for an in-person session compared to a remote session, for example. Lastly, having only one practitioner at each level of care will aid rapport and reduce the need to re-explain identity considerations, which can be exhausting for patients.

Improving Accessibility

There are a multitude of factors to consider when understanding and addressing potential barriers for LGBTQ+ people in accessing support for their mental health. The COM-B system, which refers to capability, opportunity and motivation that is required for behaviour change *(Michie et al., 2011)* could be utilised in the initial assessment to help identify if there are going to be any potential barriers for positive behaviour change and whether offering therapy within NHS Talking Therapies would be most beneficial at this time. Consideration should be given as to whether an alternative/additional service would be more appropriate, and an onward referral or signposting should then be offered to the patient. The priority should always be to consider the barriers and provide support and/or adaptations so that the patient can engage with the treatment just as effectively as those who may not have these additional barriers.

When exploring a person's readiness and ability to engage with the treatment there are some considerations to be aware of that may resonate more with the LGBTQ+ population. These potential barriers were highlighted within a focus group by current and previous LGBTQ+ patients within NHS Talking Therapies Service. There was a focus on having to pick which items they would advocate for themselves about, in the limited time they had within the service, such as whether to advocate for their physical health needs, format of materials or to address the heteronormative assumptions or **MISGENDERING** that may have occurred. It is important to ensure that patients do not feel that they need to pick which difficulties to address to ensure that their needs are met. Services need to actively reduce any potential barriers that may impact on treatment.

Some examples of these are:

NEURODIVERSITY

Although further research is required, it has been found that LGBTQ+ individuals are more likely to have traits associated with autism than heterosexual cisgender people. The correlation is particularly noted within those who identify as transgender or non-binary *(Walsh et al., 2018; Warrier et al., 2020)*. It is important that neurodiversity is considered when a patient accesses the service and in the initial assessment all patients should be asked if they have any long-term conditions or are neurodivergent. The practitioner should ask if they require any adaptations.

For example, changes to lighting, sound, longer or more sessions, and different resources to read or listen to, ensuring the resources are accessible by offering the option of paper copies and electronic, further information on how to best support autistic adults within Talking Therapies can be found here *(National Autistic Society, 2024)*. *Ingham et al. (2023)* highlight the need of practitioners having specific training on autism to better meet the needs of autistic people. It would then be appropriate to follow this up with training on intersectionality.

LONG TERM CONDITIONS (LTCs)

The impact and affect that an LTC has on a person is very varied, dependent on what the LTC is. It is important to be aware that the symptoms of an LTC and the impact it has can vary throughout treatment. The LTC could make it difficult for the patient to attend appointments at certain times of the day or in-person. It could also result in them needing to make last minute cancellations or affect their concentration.

Some considerations to reduce this barrier might be: **a)** changing the length of the sessions; **b)** incorporating breaks in session; and **c)** encouraging physical movement in session *(Carroll et al., 2021)*. Practitioners can complete further training on supporting patients with LTCs within an NHS Talking Therapies service and there are E-learning packages available on NHS England E-learning for healthcare website *(NHS England, 2021)*. The full implementation guidance is available here *(National Collaborating Centre for Mental Health, 2018)*.

ENVIRONMENT AND PRIVACY

Consideration needs to be given to the environment that the patient is present in during treatment *(Laville, 2022)*. For example, is the patient in a safe confidential environment? When engaging in remote therapy it is worth considering if there will there be anyone in their environment who may overhear. The patient may not be "out" to those people yet. This is further explored in Section 3.3.

Following on from points raised on page 16 regarding environment and privacy, some treatments within NHS Talking Therapies require the patient to complete in-between session work. This is often in the format of worksheets and recording their thoughts and/or behaviours. The practitioner would need to be mindful that the patient may not be able to fully engage in this activity, if they live with other people who do not know their gender or sexual identity.
A possible solution for this could be to utilise technology to have a password protected document or store notes on a locked device such as a phone or laptop. Utilising problem solving may benefit the patient to identify ways they can safely record their thoughts/behaviours.

WAIT TIMES

As explored in Section 2.1, longer wait times may lead to an increase in people disengaging from the treatment process. Wait times should be equal across the differing modes of delivery, as highlighted in Section 3.1. This is to ensure that if a patient requires a particular method of delivery for their needs, they are not at a disadvantage due to this. If a wait is required for treatment, then having notifications sent to the patient during this time would be beneficial to provide assurance that they are still on the wait list and have not been forgotten about. This will help to reduce uncertainty. It will be important to discuss with LGBTQ+ patients whether regular reminders to their phone would be acceptable or whether there is a more discreet method preferred e.g., to an email address, which accounts for living conditions.

INCLUSIVITY

If a conversation has not been initiated by the practitioner about gender and sexual identity then the patient may not feel comfortable discussing this with the practitioner. Issues of gender and sexual identity should be considered at the initial assessment and patients should normally be asked if they would like to discuss gender identity and sexuality during the assessment. These characteristics should also be part of routine data collection either at the point of referral or in the initial assessment.

As discussed in Section 3.1 practitioners should demonstrate LGBTQ+ inclusivity, having visual displays to demonstrate this; for example, wearing rainbow lanyards and having LGBTQ+ inclusive posters and using their pronouns at introduction, if comfortable to do so. A safe and non-judgemental space must be created for the patient to be able to speak freely, it is important that the practitioner does not make assumptions about a patient's gender, sexual orientation or relationship dynamic. It would be beneficial for practitioners to have an awareness of various types of relationships and dynamics to support the facilitation of a non-judgemental space.

FINANCIAL SECURITY

The second most common reason why trans people wouldn't undergo medical intervention they wanted was due to not having the financial means *(Bachmann & Gooch, 2018b).* People may not have financial security or funds readily available to be able to travel to and attend in-person appointments. This could also limit their access to technology to be able to attend remote appointments or readily access the materials needed for their treatment. In relation to this, there is a higher proportion of transgender people who experience homelessness, which would reduce their ability to be able to access technology and safely store materials from therapy. The LGBT in Britain – Trans report *(Bachmann & Gooch, 2018b)* found that a quarter of trans people have experienced homelessness.

PREVIOUS EXPERIENCES

Patients may have had previous negative experiences of therapy. This could reduce their confidence in the treatment efficiency or ability to be able to feel safe to discuss their identity. This could impact on their motivation to fully engage with the process. It is essential that each service provides accessible and inclusive care and actively works to reduce barriers. Ways to do this is embedded throughout this guide. Creating a positive experience starts from before the point of referral by demonstrating that the service is LGBTQ+ friendly within communities and on their websites. The following sections discuss how to reduce barriers and improve LGBTQ+ people's experiences within treatment.

If barriers to therapy have been identified, the initial assessor should offer signposting to relevant services, if available, to try to support and overcome these barriers. This can be beneficial alongside therapy but should always be discussed in supervision.

3.2 Data Recording and Monitoring

Data recording needs to be accurate and stored sensitively.

If you have acquired information in relation to the gender recognition process in an official capacity, such as someone being transgender, it is an offence to disclose this information to any other person under the *Gender Recognition Act (2004).* It would be appropriate to disclose this information when communicating with the practitioner's supervisor or other health professionals, if it is directly relevant to the patient's condition or likely treatment and to ensure the patient received the best care possible *(General Medical Council, 2024).* Collecting this information is beneficial to allow the data to be analysed, by the service, to improve access, outcomes, and experience for people who identify as LGBTQ+.

This section applies to all patients aged 16 years and above.
Within this section there is reference to a person's sex and gender identity, which are different aspects of someone's identity.

Sex is **assigned to a person, at birth**, based on their biological reproductive organs, e.g. male, female or **INTERSEX.**

Gender is **how a person identifies in terms of masculinity and femininity**. Gender is also how a person perceives themself and who they feel they are. Therefore, gender is more of a social construct and sex is based on biological reproductive organs.

All patients should be asked if they feel comfortable answering the standard demographic questions, including their sexual orientation and gender, at their initial assessment. The practitioner should make the patient aware prior to asking these questions that they can choose not to answer if they prefer. It is **important to ensure that you are asking for the person's gender and not sex**, as these are different aspects of a person. If you ask for a person's sex when you are trying to gain their gender then it can be misleading and/or distressing for trans/non-binary patients and lead to the incorrect information being stored on the system.

Demographic information is collected to help services to understand their local patient population, which can be used to develop services that best meet the population's needs and it is strictly confidential. It is important that practitioners can clearly explain the importance of why we collect this data to the patient. Gender identity and trans status should be kept separate from sexual orientation *(NHS England Equality and Health Inequalities Unit, 2017).*

The following categories should be used for recording sexual orientation:

- Heterosexual
- Gay or Lesbian
- Bisexual
- Other sexual orientation not listed
- Person asked and does not know or is not sure
- Not known (Not recorded)

The categories above fail to acknowledge multiple other sexual orientations that people may identify as. In self-referral forms, it is good practice to provide free-text options for patients to specify their gender identity and sexuality as well as providing more 'tick-box' options for gender identity and sexuality.

This serves three purposes:
a) it allows the individual to describe themselves in the most accurate way; **b)** it reduces the use of 'othering', and **c)** it supports the practitioner to use more inclusive language. Both initiatives further support visible LGBTQ+ inclusion within NHS Talking Therapies services.

Having a space for people to manually type their sexual orientation would be the most inclusive *(Cocks et al., 2019).* When considering data monitoring and analysis, this could create some difficulties as people may make typing errors which would then generate a separate category. It would require manual reviewing to categorise and analyse data which would not be the most efficient way to gather and interpret data accurately.

Services should therefore consider what options they are able to create within their IT systems and if **"other"** needs to be present then a separate space should be made available for the patient to accurately self-identify their sexual orientation. This would not only allow services to analyse their own data for a variety of sexual orientations but also allow the data that is reported to NHS England to remain the same. Services should be aware how their categories map into reporting to the national dataset, to ensure demographics are recorded accurately when reporting at a national level.

The response that the patient provides for their gender, name, pronouns, and sexual orientation should be recorded on the service's electronic patient record system.

If the patient already has an electronic patient record, with alternative name, gender identity or sexual orientation listed then this should be discussed with the patient to offer to change this to reflect their current responses. An individual does not need a Gender Recognition Certificate (GRC) to have their gender updated on their medical records *(Stonewall, 2022)*.

The name that they provide should be listed as their first name and surname and should not be listed as "preferred name". If it is listed under "preferred name" then this would **'OUT'** the patient to other people who have access to the system. It is important to ensure the patient fully understands how this information will be used and who it may be shared with. For example, some IT systems utilise templates which auto populate the patient's name into letters that are sent to their registered GP.

It is not appropriate to ask to see a **GRC** and doing so could result in a large fine and the possibility of having to go to court. However, if a patient says that they have a GRC or that they have been provided with a new NHS number, this needs to be strictly confidential *(NHS Tees, Esk, and Wear Valleys, 2022)*. The practitioner needs to speak directly to their team's equality and diversity data lead about the disclosure, to ensure the information is recorded securely, in line with their service policy.

The equality team will be able to support the practitioner to initiate an open and honest discussion with the patient about the options for recording their data in a way which the patient agrees with. A new profile for this patient needs to be created in their identified gender and new name if applicable.

There are many considerations and exceptions that could apply.

If based in England, it is recommended to discuss each case with your allocated equality and diversity data lead. Consideration would need to be given to omitting certain information. For example, historic medication may potentially 'out' an individual however, it is important to be aware that certain medications may be influenced by a person's assigned birth sex.

This is a conversation which needs to take place between the patient and practitioner to ensure that the patient can make an informed decision about how their data is recorded. It is important to avoid conflicting patient records that may be held by other services, about the same person but with different information. Practitioners should discuss this with the patient ensuring that the patient is comfortable for information on patient records to be aligned across services. The practitioner could offer to update the service(s) on behalf of the patient if this would be something the patient would prefer. It would be good practice to store a signed agreement form with the patient's decision on, in a secure location which is not linked to their new record. It is essential that there is no link between their old patient record and new one *(NHS Tees, Esk and Wear Valleys, 2022)*.

3.3 Inclusive Practice

This section will explore ways to increase the inclusivity for LGBTQ+ people within your own practice.

Firstly, *Laville (2017)* created the 'appropriate' awareness framework for sexual orientation which was updated in *Kell and Laville (2021)* to guide practitioners to consider all patient protected characteristics in an appropriate and measured way. For example, it is all too easy to assume that an LGBTQ+ patient experiencing anxiety or depression would also require signposting to specialist LGBTQ+ services and therefore, the 'appropriate' awareness framework includes the following stages to support practitioners:

A. Consider the patient's protected characteristic(s) *(Equality Act, 2010)* - assuming good data collection has been followed as detailed in Section 2;
B. The qualitative type of information that the patient is sharing regarding their protected characteristic(s) and what further information might be required;
C. Which treatment intervention and/or signposting options would be most appropriate for the patient

Therefore, **'appropriate' awareness avoids assumption-led approaches** and supports practitioners to be aware of areas of practice where knowledge could be developed e.g., knowledge of specialist services for particular communities and groups.

By utilising good information gathering skills, practitioners should be able to develop a good therapeutic alliance with the patient and assess whether a patient is interested in engaging in psychological interventions and/or specialist signposting options.

It is also very important to engage in collaborative and holistic working with the patient and to do so effectively, a safe non-judgmental space needs to be provided. The practitioner needs to create a space where the patient will not feel judged when sharing information about their sexuality, gender identity, and intimate relationships. To support intersectional considerations, *Kell and Laville (2021)* produced nine case vignettes, which all align with the 'appropriate' awareness framework and cover the range of protected characteristics listed in the *2010 Equality Act.*

In the following section, we provide a case vignette for practitioners to consider and apply the 'appropriate' awareness framework to.

To guide practitioners in this process, we have provided a range of reflective questions to support experiential learning. Beyond this guide, we also advocate for the use of providing inclusive case studies within psychoeducational materials too.

CASE VIGNETTE – MATTHEW

Matthew (he/him), a 34-year-old **PANSEXUAL** man, has been referred to your service due to experiences of anxiety. Matthew shares with you that he has recently been experiencing increased stress at work and is finding that he is becoming more irritable with colleagues. The primary reason for his increased stress is due to the unrealistic expectations being set by his line manager. Matthew feels that the goal posts are constantly moving and whilst he achieves similar outcomes to his colleagues, he has experienced a lack of praise. Matthew shares with you that he thinks this is due to being mixed race.

Matthew also shares that some of his current anxiety is due to relationship difficulties with his girlfriend, Alexandra. Matthew has been dating Alexandra for 6-months and whilst she was originally understanding that she was in an equitable **POLYAMOROUS** relationship with Matthew, she has recently stated that she cannot see why it cannot just be her and Matthew. Matthew is yet to discuss this in detail with Alexandra and does not know how to approach this situation or whether he should also speak about it with his boyfriend, Josh. Matthew and Josh have been together for 5-years and have always been open with each other about their feelings and thoughts about how they view their intimate relationship.

Due to the pressures at work, Matthew has withdrawn from seeing friends and is only going out for work and necessary shopping. He shares with you that he is not seeing friends as he often feels very fatigued and cannot find the energy to socialise. His parents live locally but he has not seen them since **COMING OUT** as pansexual a few months ago. Matthew said that his parents struggled to understand what it means to be pansexual, and they said to him that 'he is just greedy'. Therefore, Matthew felt that he could not tell them that he is in a polyamorous relationship. Matthew feels some guilt about not being completely honest with his parents, but he also does not see a way forward with them about his sexuality and relationship.

UNPACKING THE CASE VIGNETTE

Which protected characteristics would you be considering here? From the perspective of the *Equality Act (2010)* and what has been explicitly raised by Matthew, we would be considering the protected characteristics of sexual orientation and race.

What further information do you need to inform next steps? At present, we would need to gather further information on the specific nature of his work-based difficulties, further exploration of his comment about being treated unfairly at work, and explore the difficulties that Matthew is currently facing in his personal relationships. For the latter, we would be exploring the anxiety caused by his close relationships and his current feelings about his parents.

What considerations do you need to make from a diversity and inclusion perspective? It appears that Matthew might currently be experiencing discrimination at work due to his race and there might be a need for Matthew to explore his employer's policies on discrimination as well as the *Equality Act (2010).* However, we need to explore his perspectives on these events in more detail before discussing any next steps.

What potential treatment interventions could be useful for Matthew and why? Regarding psychological treatments, as Matthew is facing difficulties with work, it could be that a low-intensity problem solving intervention is the most appropriate option. This would allow the practitioner to explore all possible next steps with Matthew in a person-centred and collaborative way.

What potential signposting options could be considered at this point? It is currently unclear whether signposting options regarding personal relationships is required, but the practitioner should explore this in more detail with Matthew to make sure we are working in a holistic way.

Building on the 'appropriate' awareness framework, we also need to consider the following recommendations from *Cocks et al. (2019)*:

Recommendation 1

Details the importance of being mindful of any expectations, assumptions, or bias that we might hold towards an LGBTQ+ individual. For example, in a training session delivered by Laville, a trainee shared that when his patient stated that she had split from her partner, he responded that he was sorry to hear that she split up with him. The patient corrected the practitioner by stating that she had split up with her girlfriend. In this case, the practitioner was fortunate that the therapeutic alliance had not been damaged due to the patient being understanding. However, the practitioner reflected that in future he would use gender-neutral language if the gender of a patient's partner is not known and to avoid heteronormative assumptions.

Recommendation 2

Details the importance of developing your knowledge of the specific difficulties that the patient is facing and the impact that appropriate signposting can have. Therefore, it is very important to develop your understanding of appropriate signposting options and using your clinical judgment on when to provide signposting options. The offering of signposting options should be a collaborative discussion with the patient and any barriers in accessing signposting options should also be discussed.

Recommendation 3 and 4

(Inclusive practice and improving data collection) have been discussed earlier in Section 3.1

Recommendation 5

Acknowledges the importance of utilising supervision as an opportunity to share experiences of working with LGBTQ+ individuals and to broaden practitioners' knowledge of current LGBTQ+ topics. Supervision could also function as a space for LGBTQ+ specific CPD, which will support the training needs identified in *Ho et al. (2023)*. Collectively, supervision can function as a safe space for practitioners to develop their confidence and competence in working with the LGBTQ+ community. This in turn, will reduce biases and assumptions made about the LGBTQ+ community, and will further support the development of inclusive practice.

To develop upon the point raised on page 23 about CPD, psychological therapy training and services CPD provision should embed specific LGBTQ+ training content. *Laville (2022)* **details the following components as central to good quality training:**

Establishing a clear case for considering LGBTQ+ in clinical practice.

Laville (2022) details key training points including explicitly considering the impact of cultural, societal, and historical factors on sense of belonging for LGBTQ+ people, and the discrimination that LGBTQ+ people are victim to.

For example, *Laville (2022)* details that incidences of homophobia, biphobia, and transphobia can result in the development of mental health conditions and can also lead to elevated risk rates for self-harm and suicide. Training should also consider the impact of the COVID-19 pandemic on the LGBTQ+ community including instances of needing to hide one's own identity from family members due to a fear of discrimination and potential domestic abuse.

Establishing a safe space to discuss potentially sensitive content including lived experiences.

Laville (2022) details the importance of embedding personal self-reflection time into the sessions, which supports attendees to process potentially new and emotive information. *Laville (2022)* also advocates for trainers to share their own lived experiences, if relevant, within training sessions, as this creates a space for attendees to do the same. This is important as it provides a model for professional practice.

Including explicit content on the importance of data collection for protected characteristics to support assessment practice and treatment pathways.

Further detail on this topic is provided in Section 2.

To utilise the 'appropriate' awareness framework *(Kell and Laville, 2021).*

For example, *Laville (2013)* details the importance of considering the patient's experiences in a holistic way. To do this, we need to be competent in creating a treatment pathway within our service as well as providing information on appropriate signposting options, if required. One route to achieving this is to embed the Minority Stress Model *(Meyer, 2003)* within your clinical practice as this can inform formulation and psychoeducation *(Ho et al., 2023).*

Considering signposting to specialist services.

It is important to share and discuss signposting options in training sessions including modes of delivery. This should include modes such as in-person, telephone, online, or web-based resources. Barriers to accessing signposting options should also be explored.

Use case studies to develop competencies in line with the 'appropriate' awareness framework *(Kell and Laville, 2021).*

The case studies in *Kell and Laville (2021)* support trainees to utilise the 'appropriate' awareness framework, which in turn, incorporates demographic data collection, information gathering, processes to establishing treatment pathways, signposting, and identifying further learning needs to develop future clinical practice.

Please see Section 4 for additional information on the *Kell and Laville (2021)* resource.

SUMMARY

Combining understanding of specific difficulties, demonstrating 'appropriate' awareness and flexibility, and following inclusive practice, can support LGBTQ+ individuals to have more confidence that accessing NHS Talking Therapies will be a positive and affirming process. There has also been an emphasis on utilising a model which accounts for the social influences and minority stresses which are unique to the LGBTQ+ population *(Ho et al, 2023; Laville, 2022)*. One example of implementing this approach has been seen in the creation of an eight-week CBT group intervention for LGBTQ+ people with depression or anxiety *(Hambrook et al., 2022)*. This initiative is further explored in Section 5.

To ensure that a service is inclusive and continuing to improve accessibility and outcomes for LGBTQ+ patients, data on sexual orientation and gender should be monitored within service, generating reports showing the access, recovery, reliable recovery and reliable improvement rates for the LGBTQ+ population. This is why it is essential that this data is collected at the initial point of contact that the patient has with the service, as outlined in Section 3.2. It would be appropriate for management to run and review the reports monthly, allowing those in champion roles to access this data.

The access data should be analysed against the national census data to establish if the service is reaching their demographic population and Section 4 includes information on how to access the most recent 2021 census data. It is important to be aware that the census data was collected per household, therefore people may not have disclosed their identity accurately if their family members are unaware of their identity.

The same principle applies for the patient disclosing their sexual orientation and gender to the service as they may not feel comfortable sharing this information or other people may be present who are unaware of how they identify.

Another important aspect of data collection is collating anonymous feedback from LGBTQ+ people who have accessed or are currently accessing the service. The aim of this feedback is to gain accurate first-hand information on how the service is supporting LGBTQ+ people and what their experiences were. The feedback should ask about areas that the service is currently doing well in and areas of improvement. This more qualitative data should also be reviewed monthly alongside the quantitative data reports.

If services are not receiving a proportionate number of referrals from LGBTQ+ people within their area, if recovery rates for LGBTQ+ people are lower than their cisgender heterosexual counter parts, or if they are receiving multiple pieces of constructive feedback, then an action plan should be generated to improve LGBTQ+ inclusion and practice. It would be advised to utilise this guide and the recommendations on pages 26 to 27 to establish if, as a service, you are taking all the recommended steps to reduce barriers and increase the positive outcomes for LGBTQ+ people.
An audit tool is included in Section 4.2, to help support with analysing and improving the service for LGBTQ+ people.

SUMMARY TABLE OF RECOMMENDATIONS

Access Inclusion Assessment Treatment Supervision Monitoring

NUMBER	RECOMMENDATION	DOMAIN
1	Improve visible LGBTQ+ inclusion: This can be achieved by including images and text that highlight the inclusive nature of the service on the service's website. Visible signs of LGBTQ+ inclusion can also be shown in waiting rooms and by practitioners wearing LGBTQ+ lanyards and NHS rainbow flag badges.	Improving access
2	Attend local LGBTQ+ events to promote the service.	Improving access
3	Barriers to access should be considered in an intersectional way.	Improving access
4	In self-referral forms and initial data collection, provide a space for patients to self-identify as well as providing more options for gender identity and sexuality.	Improving data collection
5	In email signatures, practitioners should consider using pronouns to signify to trans and non-binary patients that it is a safe space. Services should embed a question in their self-referral forms that invite prospective patients to provide their pronouns as well.	Improving LGBTQ+ inclusion
6	If the patient has not self-referred, practitioners should ensure that patient information on gender and sexual identity (including 'prefer not to say') is completed at their initial assessment. Then, if relevant, and by utilising the 'appropriate' awareness framework *(Kell and Laville, 2021)*, identity considerations should be discussed at the start of the treatment process.	Improving clinical practice - assessment
7	Data recording needs to be accurate and recorded sensitively and securely. The response that the patient provides for their gender, name, pronouns, and sexual orientation should be recorded on the services' electronic patient record.	Improving clinical practice – assessment
8	Formulation and subsequent psychoeducation should utilise a model which accounts for the social influences and minority stresses which are unique to the LGBTQ+ population. It is recommended that practitioners pay due consideration to the Minority Stress Model *(Meyer, 2003)* and use the 'appropriate' awareness framework *(Kell and Laville, 2021)* to guide information gathering.	Improving clinical practice – assessment
9	The COM-B system *(Michie et al., 2011)* can be utilised in the initial assessment to identify if the therapy is likely to result in a positive behaviour change and if offering therapy within NHS Talking Therapies would not be most beneficial at this time, to then consider signposting or offer to make an onward referral to an alternative, more appropriate service for the patient.	Improving clinical practice – assessment
10	Patients should be clearly informed about what treatment they are on a waiting list for, and the service should provide regular updates on when the patient is likely to be able to access treatment. This is particularly important for trans individuals who are often on other waiting lists and are therefore, already experiencing significant periods of uncertainty whilst waiting to acess a range of healthcare provisions.	Improving clinical practice – treatment

Access Inclusion Assessment Treatment Supervision Monitoring

NUMBER	RECOMMENDATION	DOMAIN
11	Options for treatment modality and patient-practitioner communication should be as accessible as possible and include in-person, telephone, online, and email options. This is particularly important for LGBTQ+ people as the environment that the patient accesses treatment from needs to be a confidential space where they can openly share their experiences related to sexuality and/or gender, if relevant.	Improving clinical practice – treatment
12	Services should try, wherever possible, to make sure there is equitable wait times for different modes of delivery so individuals with additional needs do not need to wait an excessive amount of time for an in-person session.	Improving clinical practice – treatment
13	Aim to have only one practitioner at each level of care throughout the treatment process to aid rapport and reduce the need to re-explain identity considerations, which can be exhausting for patients.	Improving clinical practice – treatment
14	Consider the environment that therapy occurs within, whether this is in- person or remote. Routinely discuss if it is a private and confidential safe space to talk openly without people overhearing and potentially being **'OUTED'** and put at risk. Practitioners should be aware of the potential need to switch therapy from remote to in-person if circumstances at home change for the patient.	Improving clinical practice – treatment
15	Utilise supervision as an opportunity to share experiences of working with LGBTQ+ individuals and to broaden knowledge of current LGBTQ+ topics including CPD sessions. Supervision can function as a safe space for practitioners to develop their confidence and competence in working with the LGBTQ+ community and this in turn, will reduce biases and assumptions made about the LGBTQ+ community, and will further support the development of inclusive practice. Supervisors should also support practitioners to discuss their own biases and assumptions.	Improving clinical practice – supervision
16	Services should review their recovery and, access and reliable improvement data, and patient's anonymous feedback monthly. If there is a discrepancy between the data for LGBTQ+ people and cisgender heterosexual people, then an action plan should be generated to improve this. Data for the LGBTQ+ population should be disaggregated to analyse each differing sexuality and gender identity to establish where improvements are needed. As part of analysing the data, services should conduct audits and support research which addresses the differing outcomes for the LGBTQ+ population. This could include, but is not limited to, providing staff with education and training opportunities and provide LGBTQ+ tailored interventions.	Improving clinical practice – outcome monitoring

We recognise there are not additional resources given for any specific action therefore those identified are no cost/low cost in nature and can be considered when making any wider changes to the overall programme.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SECTION 4: RESOURCES

This section provides resources which would be beneficial for therapists to use within their practice. Service leads may wish to consider these resources to evaluate how their own services can be developed and improved to increase access, reduce barriers, and improve the recovery rate for the LGBTQ+ population. This section has shortened hyperlinks, designed for those accessing the guide as a digital copy. If using a printed version, the reference list provides the full hyperlink address.

4.1 Data Collection

As highlighted in Section 3.2, the way we collect and record data is important for the purpose of analysis, as well as making sure patients are not excluded.

One consideration when evaluating access is to compare your service data with the local population. This can be done by collecting and reviewing the census data. When completing this, it is important to remember the point highlighted in Section 3.2, that some people may not have answered honestly, due to the data being collected by household, rather than on an individual basis. The data for the census can be accessed and downloaded as a XLSX format to then analyse in a software program like Excel.

You can access the most recent census data for 2021 here: Sexual orientation (detailed) for geographic areas in England and Wales: Census 2021 *(Office for National Statistics, 2021).*

4.2 Audit Tool

Audit tools are a helpful way to reflect and improve services in a structured way. When utilising an audit tool, it is important that it is not treated as a "tick box" exercise. For it to achieve its purpose, the user needs to be committed to making it a meaningful exercise.

Cullingworth and Webster (2010) developed a LGBT Mental health audit tool for use by any individual or service that provides mental health services. This audit tool is designed to be utilised continuously to continue to review and develop the service and to improve the experience for LGBTQ+ people. It is sectioned into five categories: **staff awareness**, **accessibility** and **safety of the service**, **policies and procedures for inclusive practice**, **equality monitoring**, and **promotion, publicity and engagement**.

4.3 Further Appropriate Awareness Case Studies

Case studies can be a helpful tool to utilise within supervision sessions to explore our own biases and share knowledge and experiences with other practitioners. Section 3.3 explored a case vignette of 'appropriate' awareness as a practitioner.

Further examples are included in *Kell and Laville (2021)* publication, which can be retrieved from the BPS website here.

4.4 History of LGBTQ+, Important Dates and Terminology

Understanding the history of the LGBTQ+ community and how society has evolved over time, helps in the understanding of why active inclusion is so important for the LGBTQ+ community. *Stonewall (2021)* has a website with a timeline of events which covers 1951 – 2021.

This can be viewed here: Key dates for LGBT+ equality.

Often, we hear therapists say that they are worried about saying something wrong. This can be a barrier to initiating a conversation with a patient about gender and sexual orientation. Stonewall has a very helpful guide of terminology that people may use and what this means.

The terms can be viewed here: List of LGBTQ+ terms.

4.5 Positive Practice Guide and Guidelines

The bitesize version of the LGBTQ+ Positive Practice Guide is also available here on LGBT Foundation's website.

As discussed in Section 3, intersectionality is a key component to be considered when identifying how best to support individuals from the LGBTQ+ community.

Further guidance on other protected characteristics can be accessed below:

- Positive Practice Guide for Older People *(Laidlaw, 2024).*
- Black, Asian and Minority Ethnic Service User Positive Practice Guide *(Beck et al., 2019).*
- Armed Forces Veterans Positive Practice Guide *(Bacon et al., 2022).*
- Learning Disabilities Positive Practice Guide *(Dagnan et al., 2015).*
- Guide to support reasonable adjustments and adaptations when working with autistic adults in NHS Talking Therapies services *(National Autistic Society, 2024).*
- Good practice guide: For professionals delivering talking therapies for autistic adults and children *(National Autistic Society & Mind, 2021).*
- Guidelines for psychologists working with gender, sexuality and relationship diversity for adults and young people aged 18 and over *(The British Psychological Society, 2019).*

4.6 Gender Dysphoria and Hormone Replacement Therapy (HRT)

When someone experiences **GENDER DYSPHORIA**, they may opt to transition. Further information on treatments that are available for gender dysphoria can be found on the NHS website here *(NHS, 2020).*

As part of **TRANSITIONING,** some people may decide to use Hormone Replacement Therapy (HRT), like most medications this can cause some side effects, which could include changes to a person's mood. More information on this can be found here *(NHS, 2023).*


OUT
AND
PROUD

SECTION 5: CASE STUDIES

CASE STUDY 1

The NHS Talking Therapies LGBTQ+ Champions Network by Daisy Carter (she/her)

As someone who 'came out' as a lesbian when I was in my early 30s, I quickly gained a lot of lived experience of the assumptions and prejudice an LGBTQ+ person can face. This includes the stares from some strangers when I hold hands with my soon-to-be wife, to being given the twin room at hotels and even having to 'come out' every time I meet someone new, with people making assumptions when I talk about my partner, and getting asked 'what's he called' or 'what does he do?'.

I originally joined NHS Talking Therapies mid-pandemic having changed career from being a Mental Health Social Worker in Manchester. During my CBT training, there was little focus on Equality, Diversity and Inclusion (EDI) and no mention of therapy adaptations or cultural considerations for those from the LGBTQ+ community.

I began reflecting that if incidents of discrimination had an impact on me and my own wellbeing, then such situations are likely to be faced by other LGBTQ+ people. I began my own research into the Minority Stress Theory *(Meyer, 2003)* and spent time reading research about the outcomes of treatment for those from the LGBTQ+ community and how CBT can be adapted for LGBTQ+ people. *(Rimes et al., 2017; Lloyd, Rimes and Hambrook, 2021).*

On completion of my training, I began working remotely for the Isle Of Wight NHS Talking Therapies service. With my knowledge of the high prevalence of mental health difficulties, and the poor outcome rates for the LGBTQ+ community, I was keen to understand how best I could support those accessing therapy from the LGBTQ+ community and became the team's first LGBTQ+ Champion. I have delivered bespoke LGBTQ+ training to my colleagues and I have also made connections with local LGBTQ+ charities to make them aware that we are an inclusive and diverse service. I also work with local sexual health and drug and alcohol recovery services to attend the annual Isle Of Wight Pride event which is a chance for us to show how passionate we are about inclusivity and improving the health and wellbeing of LGBTQ+ people.

I was keen to do more, and I began to investigate how I could get in touch with other LGBTQ+ Champions. It quickly became apparent that other than the Future NHS platform, there wasn't a space for LGBTQ+ champions from different services across England to contact each other or meet on a national level.

It was at this point that I decided to create the NHS Talking Therapies LGBTQ+ Champions Network.

I organised our first meeting in September 2022, and we have met every 6 weeks since. The Network has been pivotal in connecting champions across England. It is great place for us to share best practice ideas and discuss how we can improve accessibility and outcomes for those within the LGBTQ+ community. Importantly I believe in creating the network I have created a safe space for champions to discuss the more challenging aspects of being LGBTQ+ Champions and any barriers we may face within our services or on a more national level.

The Network continues to grow and now has close to 100 members from NHS Talking Therapies services across England. Our membership continues to grow, with NHS Talking Therapies practitioners who are typically LGBTQ+ champions within their service, and the majority would also identify as LGBTQ+ themselves.

We consistently receive positive feedback from our members, and practitioners regularly share examples of how they disseminate information from our Network back to their local teams, for example:

> "I JUST LOVE ALL THE KNOWLEDGE AND SUPPORT THAT THERE IS IN THE GROUP"

> "THIS IS WHY I LOVE THIS GROUP... I CAN PICK EVERYONE'S BRAINS"

The Network is a fantastic example of what can happen when we work together to improve outcomes and patient experience within NHS Talking Therapies.

We always welcome new members, and if you'd like to join us, please email: iownt.lgbtq-network@nhs.net

CASE STUDY 2

TalkPlus, part of North Hampshire Urgent Care (NHUC)
NHS Talking Therapies Service for anxiety and depression
covering North East Hampshire and Farnham

Since its inception in 2010, TalkPlus has engaged a LGBTQ+ workstream including High Intensity CBT Therapists and Psychological Wellbeing Practitioners.

Focusing on **5 aims:**

1. To educate colleagues
2. To introduce LGBTQ+ friendly and appropriate policies and procedures
3. To increase visibility of LGBTQ+ within TalkPlus
4. To outreach to our local community
5. To link with other organisations and allies both local and national

EDUCATE COLLEAGUES

The project group understood their most important function was to train and educate their colleagues. Therefore, they identified videos, TedTalks, information about terminology and new research regarding trans issues to share with the team and to ensure such training was included in team training schedules. They crewed a LGBTQ+ stall at the Team training days which provided opportunities to share resources, to initiate conversations and raise the profile of the project. They also sought to educate other workstreams within TalkPlus; for example, with the Long-Term Conditions workstream, so that topics such as menopause are not only centred on cisgender patients.

TalkPlus commissioned external Culturally Sensitive Training for all supervisors. The training aimed to integrate diversity into supervision and increase psychological safety within the reflective practice of the service.

During Pride Month, the workstream distributed various resources to the team including links to TedTalks and fun quizzes related to Pride and issues facing the LGBTQ+ community.

LGBT VISIBILITY AND OUTREACH TO LOCAL COMMUNITY

- The team was encouraged to add preferred pronouns to email signatures.
- Rainbow Lanyards were available to replace the NHS blue lanyards.
- Social media posts promoting Pride and discussion of LGBTQ+ issues (see Figure 1 on page 35).
- Attended local Pride Events.

POLICY AND PROCEDURES

A number of policies and procedures were introduced, for example:

- "Initial Assessment" templates included a question on identity in the cultural belief section. The following question was added: Is there anything from your background, culture or how you live your life that we need to consider during your support?
- More widely, NHUC has launched its Equality, Diversity & Inclusion Pledge for 2023/24 which sets out our plans to ensure that NHUC is a welcoming place where all staff and patients can provide and receive the best possible care and outcomes.
- Guided Self-Help resources have been revised to include more gender-neutral terms.
- A review of our referral documents to ensure they include appropriate gender and sexual orientation choices.

LINKS WITH OTHER ORGANISATIONS

- Links with Champions from other local NHS Talking Therapy services.
- Attendance at the LGBTQ+ Champions Network, which is chaired by Daisy Carter

THE FUTURE

Despite the achievements, there is more work to do. Future aspirations include:

- Include a LGBTQ+ page on our new intranet.
- Gather information on how the patient wishes to be addressed in letters/onward referrals/ voicemails to ensure they are not 'outed' to anyone.
- Introduce Reciprocal Mentoring into our organisation. Can our colleagues from the LGBTQ+ community provide mentoring to Senior management?
- If Virgin Atlantic can provide "pronoun lapel badges" for their crew uniforms, why can't we?

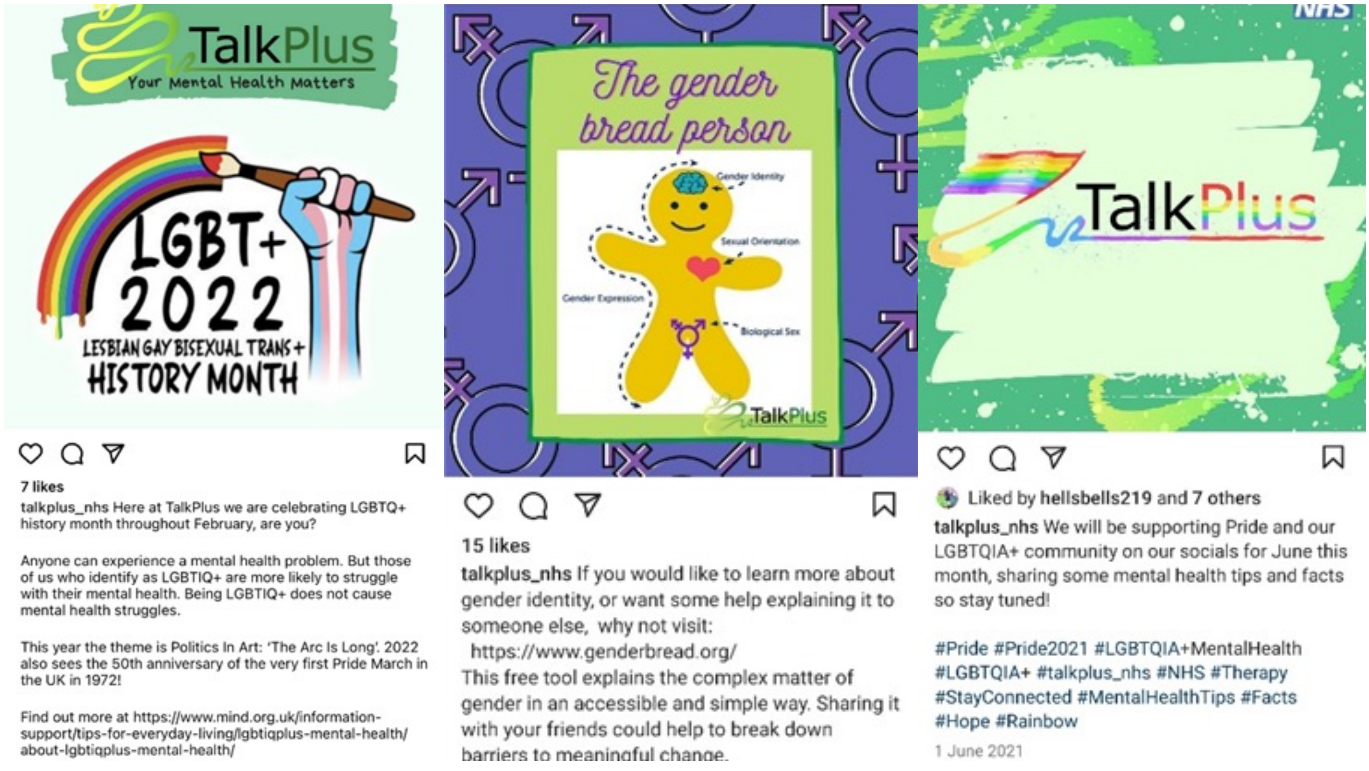

Figure 1: Social media content created by TalkPlus, part of the North Hampshire Urgent Care (NHUC) NHS Talking Therapies for anxiety and depression.

CASE STUDY 3

Leeds Mental Wellbeing Service & Leeds LGBT+ Minds

Leeds LGBT+ Minds is a coproduction project working towards improved access and experience to Leeds Mental Wellbeing Service (LMWS) for all LGBTQIA+ people in the city. The project started in late 2020 at the request of a patient with a specific interest in LGBTQIA+ healthcare.

Our team is made up of LGBTQIA+ individuals that have used, needed, or worked within mental health support services, collaborating on a range of actions to make our service more LGBTQIA+ friendly, based on the specific needs of our local community.

So far, our work has involved:

1. **Researching the mental health needs of the local LGBTQIA+ community to identify key themes and priorities.** To gather this insight, we organised a six-day Community Wellbeing Festival, which invited local people to share their experiences and feedback around using (or attempting to access) mental health services. We also offered a range of wellbeing activities and the opportunity to connect with peers. Priorities identified through the research included the need for LMWS to support LGBTQIA+ patients to be more connected to their community, the need for thorough and consistent staff training on LGBTQIA+ identities, changes to patient records management, and improvements in communication from the service.
2. **Producing a more inclusive set of gender and sexual orientation options** for our referral forms and client records and advocating for these to be mandatory fields for patient data.
3. **Using social media to share our work and that of other local LGBTQIA+ groups**, as well as reaching out to people that might not access our service or project through more traditional routes.
4. **Engaging in activism around issues facing the wider LGBTQIA+ community;** for example, co-writing a response to statements published by the Equality and Human Rights Commission on conversion therapy and the *Gender Recognition Act (2004).*
5. **Attending events to promote LGBTQIA+ inclusion.** Project team members had the opportunity to share their own lived experience to inform other inclusion work going on across the city.
6. **Coproducing a quarterly magazine created by and for the local LGBTQIA+ community, with a focus on wellbeing and community connections.** Members of the Leeds LGBT+ Minds project team have made contributions, and we have reached out for submissions on social media and through other local LGBTQIA+ groups that we have connections with either as part of our project or individually. The magazine will be given to any interested patients following referral, shared online, and distributed to community venues, GP surgeries and relevant groups and organisations.
7. **Making recommendations to our wider service on LGBTQIA+ inclusion and reviewing new materials and initiatives to ensure accessibility and representation.** The priorities listed above influenced the content of the service-wide Health Equity Action Plan, specifically around staff mandatory training and reviewing the accessibility of communications. The project team also weighed in on the service's decision about whether to allow clients to request a therapist of a specific gender when needed (for example, due to a traumatic experience), and signed off the wording on this used for the website to ensure it was inclusive.

Members of the project team have shared the following about their experience:

"IT IS EASY TO FEEL ISOLATED FROM THE LGBTQIA COMMUNITY OR KNOW WHAT GROUPS ARE SAFE TO JOIN. [LEEDS LGBT+ MINDS] HAS HELPED THIS."

"IT HAS REALLY EMPOWERED ME IN MY QUEER IDENTITY AND MADE ME FEEL THAT PEOPLE WANT TO HEAR MY VOICE AND MY EXPERIENCES. MY VIEWS ARE WANTED AND USEFUL."

CASE STUDY 4

LGBTQI+ Inclusion in an NHS Talking Therapy Service — Shropshire, Telford & Wrekin Talking Therapies for Anxiety and Depression

In our team, difference is normal and the challenge to heteronormative cisgender ideologies is so entwined within everyday working practices that a challenge of heteronormative ideals is seen as every day and expected. We support people to be their authentic self and have advocated a cultural environment of mutual challenge and coaching for career progression. In our service, we have visible trans and queer advocates and staff networks. Our services have challenged the NHS data dictionary in their outdated terminologies and representation of gender and we are proud that our patient record system can record a wide variety of gender identities and sexualities. Patients have reported positive outcomes from this change. This provides a clear message for patients when accessing our services that they can be themselves and our clinical system is reflective of this. We don't expect square pegs to fit in round holes.

We have invested in the development of Community Development Workers - Senior PWPs (CDW-SPWPs), who reach out to communities and community agencies. They have improved access for people who identify as LGBTQI+ to access our services and have engaged with agencies supporting older adult LGBTQI+ populations. The community development work also extends to attendance at pride events and developing champions within the services, and creating LGBTQI+ visibility through leadership opportunities. We have provided informal career development opportunities, through supporting unsuccessful job applicants. We have supported individuals by developing champion roles and providing senior leadership support, which provides opportunities to shadow senior practitioners and leads in their work. We have also provided opportunities in service development or research and asked for volunteers in an LGBTQI space, in order to support career development skills and opportunities.

An example of this was the development of a project team to develop a step 2 LGBTQI group, based on the work of *Hambrook et al (2022)*. The group was supported by the clinical lead to be released to undertake the work, negotiate with managers to adjust individual contact targets to allow for development work and provide leadership & senior supervision opportunities.

Providing an anti-discriminatory practice focus *(Thompson, 2020)* within clinical supervision at a senior practitioner lead level has assisted in incorporating narratives of intersectionality *(Rosenthal, 2016)* and the minority stress model *(Meyer, 2003; Frost and Meyer, 2023)*. This has assisted a wider understanding of issues that impact health inequalities. It has also assisted in developing formulations within specific conceptual frameworks and assisted therapists in working beyond the struggle in the therapeutic relationship. The struggle reported in the therapeutic relationship is where the presenting problem has been linked to specific areas of diversity and the systemic issues associated with the development of the common mental health problem. Encouraging therapists to incorporate this understanding within their formulations, has allowed patients to feel understood and heard. This has been evidenced through therapist feedback, who have reported improved outcomes for patients or an increase in their own self confidence.

We also have positive case studies outlining our work:

1

During a treatment session, a client was talking about their teenage son who identifies as trans, he wants to encourage him to access our service as he can struggle with anxiety. When they both looked at the website, it was the first time that they noticed the inclusion of pronouns so prominently on a service's web page. This made them both feel welcome.

- Therapist A

When I first self-referred to Telford IAPT, following advice from a mental health nurse, I completed the application process on your website. I was instantly impressed, that clear consideration has been given during its design, with regards to the LGBTQ+ community. It was the first 'official' website (including many other NHS services) where I had seen an extensive list of pronouns, as an option. I was further surprised to see the option to add a 'known as' name. I was instantly impressed, as the parent of a transgender teenager myself. So much so, that I felt the need to show him straight away, and he was equally impressed. I can't begin to tell you just how important this is, to a trans person. Being called by their **'DEAD NAME'**, or different pronouns, can feel like a real backwards step. Something so simple, really did give him faith in your service. Subsequently, (he) also now has a Telford IAPT referral, following several years of not being keen to seek support, with their own mental health. I genuinely believe that your website removed some of the barriers to seeking support, making (him) feel like they were more likely to be understood. Thank you for this, it really does mean a lot.

- Carer A

2

I began my NHS career in 2007, with my sexual identity hidden. Although aware of being gay, I only shared with close friends. It was hidden from my family and I held caution with sharing personal information with others. Prior to NHS employment, I encountered homophobic comments while working in retail. Witnessing regular gay slurs formed a work culture where this felt normalised.

Progressing as a PWP, I shared more of myself from becoming more comfortable in my work surroundings. Forming bonds with colleagues, I recognised the role of allies in promoting LGBTQ+ positive practice. Self-expression also came from gaining reflective supervision opportunities within the service. Building trust with my supervisor enabled reflection on personal experiences that related and contrasted with patients. Increased self-awareness promoted subtle empathic reflections to convey understanding to LGBTQ+ patients. Reflective supervision supported understanding the complexities of LGBTQ+ stressors, when struggling with parents who disapproved of their child's sexuality.

Feeling valued, I remained with Talking Therapies for Anxiety and Depression (TTAD) services, while advancing towards training PWPs. Taking the lead on teaching LGBTQ+ issues, increased awareness of TTAD services not reaching LGBTQ+ patients. A noticeable increase in LGBTQ+ colleagues has increased visibility, and I hope brings multiple perspectives for holistic positive practice for LGBTQ+ inclusivity for patients.

A significant impact came by challenging data collection practices by including preferred pronouns at referral, demonstrating commitment to respectfully recognise diverse gender identities. Letter template enhancements aims to communicate respect for preferred prefixes when writing to patients. I noticed more patients at assessment identifying with they/them pronouns and identifying as gender nonconforming, enabling inclusive language at first contact.

Currently, the service is embarking upon developing an LGBTQ+ group, considering the needs of the local LGBTQ+ population. My visibility has resulted in being asked to be a consultant supervisor for this group, something I never thought possible. Enthusiasm for the LGBTQ+ group could foster a sense of community. The service intends to learn how well Talking Therapies is meeting its commitment to LGBTQ+ positive practice, and steps for continued development from research evaluation.

- Therapist B

CASE STUDY 5

Individual Practitioner Case Study
by Clare Rose (She/Her)

BACKGROUND

Harry (psedonym) was an eighteen-year-old cisgender man seeking treatment for moderate depression and mild anxiety several years after being groomed and sexually abused by a male youth worker. Although below caseness for PTSD, he endorsed specific distressing symptoms on the PCL-5 *(Weathers et al., 2013)*: repeated, disturbing, unwanted memories and dreams, hypervigilance, and sleep disturbance. He was driving recklessly and drinking up to 60 units of alcohol per week. Harry identified as bisexual; his sexual identity caused him minimal distress, indicating some difficulty within his family of origin when he came out. He had been in several relationships with men and women.

THE NEED FOR LGBTQIA+ INCLUSION

While Harry was clear that his sexuality was separate from the abuse, there were some difficulties that presented during treatment. As with many survivors of abuse and grooming, Harry expressed beliefs that he 'let it happen' and 'must have wanted it' because he did not disclose what was happening. He identified that he had not known boys could be sexually assaulted, nor what grooming was. He identified anxieties about being in relationships with men, despite physical attraction and not feeling this way with women.

HOW TREATMENT WAS LGBTQIA+ INCLUSIVE

We did psychoeducation around abuse and grooming as part of standard CBT. Harry was interested in the behaviour of abusers during grooming, identifying with the encouragement of loving feelings from Harry, the appearance of choice where there was none, and pressure to keep the abuse secret via emotional manipulation. This psychoeducation helped Harry reappraise the 'relationship' as abuse rather than a legitimate expression of his sexuality (as he had been encouraged to think). Exploring the nature of abuse in conjunction with sexuality-appropriate relationships education regarding same-sex interactions allowed Harry to feel more confident in identifying unhealthy romantic and sexual interactions. This required the therapist to be well-informed about the nature of abuse and to help the patient identify the gaps in his understanding that the abuser took advantage of.

We explored Harry's anxieties about being in relationships with males, using an example of feeling anxious about being touched despite being attracted to a date. He was able to identify intrusions related to the abuse, so we used stimulus discrimination to help Harry distinguish 'that' man from other men. We re-emphasised the importance of Harry engaging in sexual activity at his own pace and discussed how Harry can take steps to reduce his anxiety in healthy relationships over time (consistent with the principles of graded exposure). It was important to manage this phase of treatment in a way which would enable Harry to reclaim this part of his identity safely and confidently, as with heterosexual patients after abuse. It required direct communication and handling with both confidence and sensitivity by the therapist, being open to getting things wrong.

OUTCOMES

Harry reached reliable recovery on all measures, with reliable improvement on the PCL-5 *(Weathers et al., 2013)*. He was using what he had seen as inappropriate anger positively to help others who might be similarly at risk and was positive about his future.

CASE STUDY 6

Individual Practitioner Case Study
by Nakita Oldacre (She/Her)

This case review will investigate aspects of LGBTQ+ matters as well as depression, OCD (pure obsessional) and risk to self.

Client A was seen for 10 weeks within Low Intensity CBT to work on his symptoms of severe depression. He was white British, in his late 30s, and was in a long-term relationship with his partner (cisgender woman). At the time of his treatment, his pronouns were he/him. Unfortunately, due to his depression, he was signed off work and was struggling with his personal care and daily routine. At the time he was also undereating and had lost a significant amount of weight and his motivation was low.

As a result, we implemented behavioural activation (BA) to manage his personal care and basic needs in the hopes of preparing him for High Intensity CBT treatment. Common behavioural activities included eating snacks and a small meal but avoiding times such as the morning when motivation was particularly low and initially scheduling personal care once a week which later increased to three times a week. I also worked alongside the GP who managed his nutrition and prescribed 'Ensure' nutritional drinks to increase his calorie intake.

The client stated that he had started cross-dressing a few years ago and which lead to him feeling confused about his sexuality. As a result, this often led to feelings of guilt, intrusive thoughts of a sexual nature and suicidal and self-harm ideation. There were times when he scheduled cross-dressing into his activity diary as it felt pleasurable despite the guilt he felt, and he felt like it was an important aspect for him to explore. This was initially difficult as he had not discussed this with his partner, and he would often schedule this activity while she was at work which led to anxiety. Typically, this complexity would not be seen within Low Intensity CBT, due to the session time (30 minutes) and session frequency (fortnightly) however in this instance brief BA was given to prepare him for High Intensity CBT and to overcome the challenges with waitlist times. As his depression and presentation were complex, it was decided via case-management supervision that there were grounds for reasonable adaptions. As a result, the sessions were extended to weekly 45 minutes, weekly.

As part of his treatment intervention within Low Intensity CBT, some problem-solving strategies were adapted, and he was given space to talk about cross-dressing and his sexuality. This eventually allowed him to open up to his partner, who he found was very supportive. I drew upon common factor skills such as funnelling, normalising and reflection to support this process.

We also focused on risk management reduction strategies which I believe had a knock-on effect on his intrusive thoughts. The coping strategies adopted to improve his physical safety also increased his psychological safety and he reported not feeling as hopeless as before. Additionally, his sense of belonging increased and he no longer felt as much of a burden to his partner as he was able to communicate what he was going through I believe that the strategies and hope generated from the support given at step 2, prepared and increased the client's motivation to engage in High Intensity CBT.

The client's compulsion to suppress his sexual thoughts reduced as he was able to explore the questions he had about his sexuality, rather than cancelling the thoughts out with mental rituals.

KEY LEARNING POINT:

As mentioned although this client's presentation would typically not have been seen within Low Intensity CBT, the initial intervention, allowed him to be in a better place to receive a more intensive level of support. Although I had no first-hand experience with questioning my own sexuality or gender, utilising key common factor skills was an important part of this client's treatment. I was able to create an outlet for the client to process some of his internal struggles whilst caring for his external needs.

On reflection, I also realised the individuality of someone's journey when it comes to LGBTQ+ matters. Due to gender and sexual orientation being protected characteristics, there are many barriers that someone can face. However, making reasonable adaptions allows someone to access the support needed while considering the parameter of what can be achieved within the CBT framework.

CASE STUDY 7

Individual Practitioner Case Study – Working with People who identify as Transgender at Low Intensity by Ellie Vialls (She/Her)

I worked with Vanessa (pseudonym) while working within Low Intensity CBT in an adult Talking Therapies service. Vanessa was an 18 year old, White-British transgender woman (pronouns were she/they). Vanessa had self-referred following a period of low mood and was struggling to find the motivation to complete their college work on time. We used the intervention, behavioural activation and worked at allocating time for routine activities (studying) as well as increasing the pleasurable activities (meeting friends outside of college). This helped them to break down their studying and overcome procrastination.

During the treatment sessions, I used open and non-assumptive questions to ask Vanessa whether she felt that being transgender is an important topic to discuss and consider within treatment, by asking 'I can see from your booking notes that you have marked 'transgender'. I was wondering if this would be something you would like to talk more about during our sessions?' Vanessa initially did not feel this was needed.

At a later session, she asked for more support on how to explain their experience to their family and friends, as well as link in more with the transgender community. She wanted their friends and family to understand more about their experience as a transgender woman. I used person-centred questioning to explore how we could solve these queries. Vanessa organised time, within their activity schedule, to speak specifically to their family about their experience as a transgender woman. She also felt it would be helpful to have more information to provide them with too.

I asked Vanessa if she wanted to know more about other services and materials that may be able to provide a community as well as advice about materials or information to give to family. Vanessa felt this would be helpful and I signposted them to a relevant local service (omitted to ensure anonymity for client) that could help with their queries.

I made regular use of Clinical Case Management and Clinical Skills supervision to provide Vanessa with appropriate treatment and best practice. It was through Clinical Skills supervision, for example, that I learnt about the appropriate signposting service. Vanessa's minimum data set scores went into recovery by the 6th session, and she reported that the sessions had been helpful, especially when we focused on their **TRANSITION** and relationship with their family, which she felt was meaningful.

REFLECTIONS AND TIPS

I learnt, through working with Vanessa, that taking a non-assumptive stance and asking questions helped to ensure important information, that was relevant and meaningful for Vanessa, was not being missed. It meant we could collaboratively agree a plan and actions in order to support Vanessa in all areas which helped to aid recovery. Therefore, my top tip would be to be mindful of any assumptions made and to check in with the client to ensure that you are not missing anything or assuming something based on your own experiences, rather than the clients. The client is the expert in their life.

CASE STUDY 8

Individual Practitioner Case Study
by Natalie Meek (She/They)

The following case study is in relation to CBT within a private practice, but the practitioner was a CBT therapist within an NHS Talking Therapies Service and delivered CBT based on the NHS Talking Therapies High Intensity CBT Training.

Lola (pseudonym) accessed private therapy, through a workplace scheme, with a provisional working diagnosis of Post Traumatic Stress Disorder (PTSD), as such was put forward to be seen by a CBT therapist. Lola was in her mid-30's and had migrated from Europe to the UK to attend University and has moved into employment within the UK following graduation. Assigned female at birth Lola uses she/her pronouns and identifies as a gay woman, Lola is married to a woman, and they currently live together. Lola identifies as White European and speaks Spanish and English, therapy was delivered in English. Lola is employed but is unhappy with her current employment. Treatment goals were to be able to speak to her family without experiencing flashbacks and to do more e.g. engage in hobbies.

As part of the assessment process, I shared relevant aspects of my identity with Lola, such as pronouns, gender, and sexuality so we could explore the similarities and differences in our identities and identify any challenges that may arise due to these. *Foy et al., (2019)* found that **SEXUAL MINORITY** individuals have concerns of experiencing stigma or rejection within therapy and may not disclose their identity as a result. By discussing my own identity, I hoped to demonstrate acceptance and understanding, shown to improve treatment for sexual minority clients *(Foy, et al., 2019)*. Lola did not disclose any concerns based on our common, or not common, identities, we agreed to keep this in mind as treatment progressed.

We proceeded in treatment with the Ehlers and Clark model of PTSD *(Ehlers & Clark, 2000)* and were able to develop a safe space and formulate collaboratively.

When exploring barriers to treatment goals, Lola was able to identify that the traumatic event she experienced in her hometown and the ongoing anxiety and flashbacks, prevented engagement with her family. On further exploration Lola disclosed that her family did not agree with her sexuality and were not happy that she married a woman, which the client shared in our third session.

Sexual minorities experience greater levels of mental health difficulties *(Meyer, et al., 2003)*, which can also be worsened by parental rejection *(Puckett, et al., 2015)*. I utilised validation, such as stating that anyone who had this experience would feel a similar way, to recognise the impact of these experiences on Lola's mental health and did not move to challenge cognitions that Lola experienced as a result *(Craig, et al., 2013)*. To address trauma memories, we utilised narrative writing and hot spot updating, which Lola found very helpful in processing the memories. Considering recommendations in the literature *(Puckett, et al., 2015)* we agreed to utilise this technique in processing memories of parental rejection due to being gay.

Lola found this very cathartic to engage in and moved on to write a letter to her parents exploring her feelings and the impact of their treatment, which she did not send. At the end of treatment Lola had travelled back to Spain and spent time with her family, without experiencing flashbacks, and was able to better enjoy her time with family.

CASE STUDY 9

Individual Practitioner Case Study
by Libby Adams (She/They)

This case study is based on experience working with a client however the client's name and age have been removed to allow anonymity.

Client X identifies as transgender. They self-referred to their local NHS IAPT Talking Therapies service for support with generalised anxiety disorder. Their main goal for therapy was "to get out of the house once a day on my lunch break". When the therapist asked what was stopping them from achieving their goal, they stated that they fear abuse and harassment from others based on their gender identity.

Client X's previous experiences of harassment during their **SOCIAL TRANSITION** fuelled her core beliefs that others cannot be trusted, and that the world is dangerous. To protect themselves, they lived by the rule of never staying in one set place for longer than a few minutes when out and ensuring they always remains hypervigilant and alert when they are in a busy public place or crowd.

Where typically, a therapist would support their client to reappraise their beliefs by gathering evidence in the defence and opposition of their belief. In client X's case, their previous experiences of harassment would fuel the defence of these beliefs, likely creating a significantly longer list in the defence of this belief than in the opposition, thus keeping them stuck in a vicious cycle of avoidance.

With statistics consistently demonstrating that violence against trans people is rising each year, it is understandable that the client felt cautious of their safety. Instead of appraising beliefs in the defence and opposition style, we discussed the "terms and conditions" that come with each belief. By discussing the "T&C's" the therapist allows the client to reflect on times where this belief has served them – where they remained alert, experienced a **TRANSPHOBIC** attack and sought safety. The therapist then helped them to consider times where the belief has hindered their wellbeing, client X identified that when out they can often ascribe danger to something or someone that is not dangerous.

When reworking her belief, the client stated "worrying can help me to be aware of danger in the relevant circumstance or location which helps keep me safe, but it can equally be overwhelming and lead to false positives of danger". Client X and the therapist concluded the key take home learning point for the session – that more flexibility is needed to ensure they have a better quality of life. This involved setting up a behavioural experiment for the next week, involving leaving the house. Future sessions built on this learning at a pace that was comfortable for the client and honouring the places where they felt generally threatened. This involved the therapist asking the client and encouraging them to ask themselves...

> "IS MY AVOIDANCE DUE TO ACTUAL THREAT OR ANXIETY?"

If the client perceived actual threat and did not feel comfortable doing an experiment, we explored whether not doing this has a long-term impact. Client X did not feel comfortable getting public transportation as they had experiences of other passengers being an actual threat. We discussed whether this would have an impact on their life (not being able to get the bus), they stated they can get a different bus, they can drive or they can get an Uber, so they did not see this as having a major negative impact on their life.

The function and impact of the client's behaviour was key here, as therapists may view this behaviour as avoidance due to GAD, thus encouraging patients to challenge this, when actually, the client felt a real sense of danger to their safety.

By the end of treatment, the client scored in the recovery range on psychometric measures and had made significant progress towards her goals. Client X is now able to assess situations based on anxiety vs. actual threat. Life now looks brighter as they are able to enjoy going shopping, going out for a coffee and spending time with friends.

KEY LEARNING POINTS FOR PRACTITIONERS

1. **Managing anxiety can sometimes come with additional challenges for transgender clients.** Therapists can adapt therapy by supporting clients to understand their own personal boundary in terms of what is an actual threat vs. what is the manifestation of an anxiety disorder.
2. **Therapists may have a different understanding to their client of what is anxiety and what is an actual threat.** The client is the expert in terms of what changes they feel able to make and it is important to honour their limitations.
3. **Therapists must approach topics of harassment sensitively**, whilst empathy is a crucial part of this, we must ensure therapy techniques do not inadvertently minimise the client's experience.
4. **Once the therapist has supported the client to identify areas of their life where more flexibility is needed, the therapist should support them to make small manageable changes.** This can be achieved through exploring the function and impact.

   For example, "Why do you avoid going out?" and "Are you able to live your life fully and in the way that you want to, whilst doing this?".

   If the behaviour is having an impact on quality of life, this can be explored further, for example "I understand that being hypervigilant as a trans person is important for you to navigate the world and stay safe and in many situations, this has served you well. Do you think the current level of hypervigilance you hold is necessary in all scenarios or are there any scenarios where there is room for a bit more flexibility?". The therapist can then work collaboratively with the client, "What would be a meaningful change for you that we could look at putting in place together?".

CASE STUDY 10

Individual Practitioner Case Study
by Ely Athron (He/Him)

This case study involves a gay cis-gender man in his twenties whose pronouns **are he/him. For the purposes of protecting his anonymity I will refer to him as Piotr. He lives with his mother, father and two younger siblings.**

He presented to the service with symptoms of depression and anxiety. His PHQ-9 and GAD-7 scores were both in the moderate range albeit, towards the higher end of the bracket. He also described himself as autistic. Piotr preferred either face-to-face or video-therapy treatment as he becomes anxious if not able to see the person he is speaking to.

His general goals were to reduce the level of anxiety and worry he experienced most days. Some of his main recurring worries were to do with his sexual orientation.

He explained that over the course of the years he had come to terms with his sexual orientation. He described this as a long process as he found that being autistic meant that he had a period of multiple years where he kept questioning his sexual orientation. He had not had a relationship or sexual contact with other men. We agreed to spend slightly longer at the beginning of our sessions understanding how this process was for him and whether he still had ambivalence or not. Through sensitive discussion, we established that he knew that he was physically/sexually attracted to men and was accepting of this.

We agreed that the worry management, with worry postponement and/or problem solving might be the best treatment. He found the five-areas model particularly helpful as it gave him a clear tool to be able to explore situations that triggered his anxiety. He was very aware of the physical impact of the anxiety and we would often start to discuss the physical symptoms, relate this back to thoughts and his emotional response (anxiety).

After completing a worry diary, it came to light that one of his main concerns was about "coming out" to his family. He described having a religious family which he felt was a difficulty in his coming to terms with his sexual orientation, too. However, he said he had now accepted that he was attracted to men but had been unable to tell his family. "I don't know how to do this."

He found it easier to deal with hypothetical worries as he knew he could not do much about them and because "It doesn't make sense to spend time on them". He found the Worry Tree helpful as it was logical to him and "just makes sense". However, the practical worry of coming out was very difficult for Piotr and was having a significant impact in his life. It caused him anxiety, tension and sleep disturbance.

He also wished to go on to develop friendships with other gay men and to go on a date, too. We agreed that Problem Solving might be the best focus for the remainder of the treatment for Piotr.

Piotr explained that part of his being autistic meant that he benefited from having fixed routines for home, work and exercise. We agreed to have our sessions at the same time and day for this reason and, if either of us was unable to make the agreed day/time, we agreed to have a two-week break instead. He said he found this helpful as he was able to organise his week.

Piotr's main focus for Problem Solving was coming out to his family. We discussed the safety aspect of this and he did not feel his family would be physically violent towards him, that he would not be made homeless and that he did not have to participate in conversion therapy if this subject arose at any point.

I explained the importance of this from a safeguarding perspective and he appreciated it. We discussed how coming out can be a rite of passage and that every person's experience is different. We also discussed how it may be an on-going process, too. We discussed how society in the UK is generally hetero-normative and that at times he may need to come out again to people – if he wishes to. Piotr found it helpful to discuss this.

In the interest of time and given the nature of short-term treatments within NHS Talking Therapies, we agreed that I would provide him with signposting and that he will watch videos and read more on the subject out of session. I signposted him to Stonewall and It Gets Better. Piotr reported later in the sessions that this was very helpful as it provided him with a variety of examples of how coming out can be for people.

We completed the psychoeducation for Problem Solving together and Piotr developed a plan of how he would like to come out to his family. We were still at the planning stage at this point. Interestingly, Piotr decided to do it spontaneously instead in between one of our sessions. He said: "I was feeling brave and thought "what the hell" and did it. We discussed the process of how he came out and his family's responses. Overall, he described it as a positive experience. He has positive responses from his family and one of his sisters immediately wanted to introduce him to a friend of hers. His brother was not very responsive but he said that generally he was like that anyway. Piotr said he felt proud that he came out to his family.

He said: "I know some people have a terrible time when they come out. I'm just glad it was not like that for me".

We spoke about his family being religious and whether he had any responses. He was told that "God will love him no matter what." We discussed how he viewed this response and he thinks that God loves him for who he is, including the fact that he is gay - and not despite it. We discussed signposting for gay-friendly, inclusive congregations and Piotr found this very helpful.

He was excited and wanted to move onto his next goals, of developing friendships with gay men and of going on a date. Piotr continued to work on Problem Solving in these two areas and found it helpful as it gave him a structure to get ideas and make plans. He also found it helpful to receive further signposting to organisations or websites where he could do an activity and meet other gay or bi men. He was interested in sports and camping, so we agreed he would look into this. By the second-to-last session, Piotr had already attended an event with a charity organisation called Outdoor Lads and enjoyed this. He was apprehensive of attending because he is autistic, but he pushed himself to go. He said people were friendly and that he met two people with similar interests. He planned to go for a coffee with them. He also had planned in more events for the next two months which included going on walks and attending another social event. In the summer, he wished to attend a camping event too.

We ended treatment at this point, after completing a wellbeing and recovery action plan. Piotr's scores decreased and he entered recovery with his PHQ-9 score and had reliable recovery on his GAD-7 score. He expressed that he was grateful and glad he decided to engage in a talking therapy and that he had many plans for the future.

Needless to say, working with Piotr during this rite of passage for him was a rare privilege that I feel very grateful for. It was important to liaise with the LGBTQIA+ champion in my service. I was provided with many helpful resources to support Piotr. Also, it was essential for me to discuss safeguarding in case management and clinical skills supervision at various points and to discuss openly with Piotr any potential risks.

CASE STUDY 11

The LGBTQ+ Wellbeing Group in Talking Therapies, Southwark

Dr David Hambrook (He/Him)
(Principal Clinical Psychologist & Senior Team Leader, Talking Therapies Southwark, South London & Maudsley NHS Foundation Trust)

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Southwark in South East London has one of the highest proportions of LGBTQ+ residents in the UK. LGBTQ+ people are much more likely to experience depression and anxiety compared to heterosexual and cisgender people. However, LGBTQ+ people often hesitate about seeking help due to fears of stigma and discrimination within the healthcare system. They also report that Talking Therapies practitioners can lack a compassionate awareness of the unique challenges they may have faced as an LGBTQ+ person and may fail to discuss their sexuality or gender identity in a helpful way *(Foy et al., 2019)*. lesbians and bisexual service-users have poorer treatment outcomes in Talking Therapies services in England *(Rimes et al., 2019)*.

In 2016 we decided that within our IAPT/Talking Therapies service we would offer a therapy group specifically tailored for LGBTQ+ patients. We are committed to an evidence-based strategy both in designing and evaluating our work. We reviewed the existing evidence base to help us understand what types of psychological interventions had already been proven effective for LGBTQ+ people.

We drew on this research, existing theory (including Meyer's Minority Stress Theory (2003) and Hatzenbuehler's Psychological Mediation Framework (2009)), standard CBT theory and practice, and embedded an LGBTQ+ affirmative stance when designing our own LGBTQ+ Wellbeing Group. The first pilot of the group took place in May 2017, and we have since then provided three cycles per year on average.

Group CBT is recommended in NICE guidelines for people presenting with problems such as depression and anxiety; this intervention also included specific identity-related content. The group consists of eight weekly sessions lasting 90 minutes. It is a structured, psychoeducational and interactive CBT group. Each session follows a different topic/theme e.g., being kinder to ourselves, reducing avoidance, developing LGBTQ+ confidence and pride, making meaningful connections and addressing loneliness. It includes a combination of psychoeducation, practice of key CBT interventions, interactive discussions and small group work. Throughout the whole course an affirmative stance is adopted by therapists, whereby we aim to fully accept, affirm, de-pathologize and celebrate participants' sexual and gender identities, whilst also validating the impact of minority stress on their wellbeing.

We have facilitated the group in both face-to-face and online (video call) formats and both have been shown to lead to significant reductions in symptoms of depression, anxiety and improving functional impairment *(Hambrook et al., 2022)*. The majority of people who complete the group move to recovery and most do not need further therapy after the group has finished. We also ask for open-ended patient feedback to inform any refinements for the next cycle. Patient feedback indicates that the LGBTQ+ affirmative group environment has really helped them engage with CBT in a unique, validating and powerful way *(Lloyd et al., 2021)*.

For example, one group attendee reported that:

> THE LGBTQ+ FOCUS WAS REALLY HELPFUL

Personally, a large part of my difficulties stemmed from being LGBT+ and the experiences, feelings and sense of identity within this. Relating critical/ automatic negative thoughts to internalised homophobia, micro-aggressions and then core beliefs relating to me being LGBT was really important". Another said that "The LGBT lens was so useful, learnt to see how my experience chimes with others, and how homophobia in society has made things difficult for us".

> THE LGBT LENS WAS SO USEFUL, LEARNT TO SEE HOW MY EXPERIENCE CHIMES WITH OTHERS, AND HOW HOMOPHOBIA IN SOCIETY HAS MADE THINGS DIFFICULT...

Group facilitation by appropriately qualified and out LGBTQ+ therapists also seems to create a sense of psychological safety for participants. One patient told us that having "friendly, experienced and kind facilitators, who were also LGBT+/queer friendly really helped".

> FRIENDLY, EXPERIENCED AND KIND FACILITATORS, WHO WERE ALSO LGBT+ REALLY HELPED

Our 8 session LGBTQ+ Wellbeing group is now a standard part of our Low Intensity therapy offer, and connections with local LGBTQ+ community groups helps increase awareness and referrals. We hope that this ongoing effort is helping to break down barriers and improve access to and outcomes from talking therapy for our local LGBTQ+ population.

CASE STUDY 12

Gateshead Talking Therapies Case Study

This case study is based on working with a same-sex couple, delivering Couples therapy for depression.

For the purpose of this case study the couple have been given pseudo names.
Patient 1 – Carly, Cisgender gay/Lesbian Woman, 33.
Patient 2 – Lisa, Cisgender gay/Lesbian Woman, 35.

The couple referred to NHS Talking Therapies: Couple's Therapy for Depression (CTfD) due to them having difficulties with communication within their relationship, and they were offered couples therapy for depression as a treatment option. The couple were offered and attended 20 sessions over a 6 month period of time.

The couple had been together for 7 years, married for 3 years, and had sought support with their relationship due to having difficulties with depression and communication, as well as struggling to process a break of trust within their marriage. Both members of the couple were experiencing long term difficulties with depression and anxiety. The couple identified difficulties within the relationship began when Carly had an affair last year while Lisa was struggling with depression. During the couples therapy formulation at the start of treatment we identified that both Carly and Lisa were experiencing depression, and we also were able to see a pattern where both were struggling to communicate their feelings or rebuild their trust in each other.

We identified that when Carly was feeling low she would prefer to socialise and be around others, while Lisa would prefer to be alone in her own space and company. We discussed within the sessions how both members of the couple were trying to give their partner what they needed, but by doing so it would increase their own depression, either by being alone without support, or being around others which felt overwhelming.

Within the CTfD treatment we worked towards helping the couple understand one another, working towards building empathy and care, and encouraging them to communicate. By doing this the couple were able to share more about their past experiences of relationships, their fears in their current relationship, and how they both made sense of the affair. Carly was able to share that her previous relationships had been abusive and coercive, and there were elements of gas lighting, which caused Carly to feel she could not trust and would need to be self-sufficient. By sharing this Lisa was able to begin to notice when Carly was pulling away, and the couple were able to begin working as a team. Carly shared when she was struggling, and Lisa put more consideration into showing Carly she could trust her.

Lisa had previously been in relationships with men, and her relationship with Carly was her first same-sex relationship. Through the therapy we explored how Lisa's family responded to her relationship with Carly, and how she felt her family did not show her acceptance or understanding. This led to Carly's family withdrawing from her, and she stated she did not have contact with them for a number of years, until more recent times when Carly reconnected with her family after the significant loss of a family member. Lisa struggled to communicate within her relationship with Carly, as well as other areas in her life, which became a difficulty we highlighted within the relationship that the couple wanted to change. Throughout the therapy the couple were encouraged to improve their listening skills, support one another and through the sessions the couple began making more compromises, showing more understanding and care towards one another, and offering each other space in the week to connect and communicate. The couple were able to understand what had been missing in their relationship, and how they could work as a couple to voice their needs or wants within their relationship, so both of their needs could be met.

The CTfD sessions encouraged the couple to practice a range of exercises over the weeks, such as putting time aside to show their partner a caring gesture, using commutation tools, practice their listening skills through feeding back what they had heard from their partner, and taking time through the week to spend time together as a romantic couple.

By the end of the therapy Carly and Lisa's depression had significantly decreased, and the couple shared they felt the relationship was the best it had been for a long time. The couple felt they understood one another more, and they showed each other compassion which increased their feelings of connection. The couple were able to encourage each other through their difficulties with communication and trust, and were prioritising their relationship.

The couple worked really well with the CTfD model, and I feel the model worked to meet the couple's goals and expectations. The couple's work and goals were successfully met with the CTfD model, as the CTfD therapy model works on the basis of the relationship being the main focus of treatment, and understanding each relationship is individual.

ADAPTIONS THAT WERE MADE WITHIN THE THERAPY:

1. The couples were given the opportunity to explore and discuss the impact family relationships, and lack of family support, had on their relationship. Carly had not previously been in a same-sex relationship, and had been raised by a family that did not accept her sexuality once her relationship with Lisa began. We identified within the couples therapy this had an impact on Carly's self-worth and her identity, as well as how she felt being in a relationship with Lisa.
2. The couple also discussed judgements they felt were put onto them as a same-sex couple by others in their lives, and how this caused difficulties within their relationship. We discussed how Carly's mother felt that due to her being married to a woman she would not have children and provide her with grandchildren. The couple were encouraged to reflect on how they would like to communicate if these comments were made to them again in the future, or how they would challenge these beliefs with assertive communication skills that they both felt comfortable with.
3. The couple discussed their thoughts around having a more open relationship, and how their relationship was something that they both wanted to fit their own needs, rather than what they felt others perceive their relationship should be. The therapy sessions offered the couple an opportunity to discuss their thoughts and feelings about how they wanted their relationship to be, how an open relationship would function for them as a couple, how to communicate about this once the treatment came to an end, and how to help them both feel they were in a safe and non-judgemental environment when communicating with each other.

CASE STUDY 13

Everyturn Talking Therapies and Limbic Access Case Study

This case study explores the journey of a non-binary individual who accessed Everyturn Talking Therapies service through Limbic Access, shedding light on the importance of inclusive self-referral methods for LGBTQIA+ communities.

ABOUT LIMBIC ACCESS

Limbic Access is an Artificial intelligence (AI)-powered clinical assessment assistant that acts as a digital front door for patients self-referring into the service.

Co-designed within the framework of NHS Talking Therapies, it functions as a user-friendly, stigma-free entry point for everyone with internet access, irrespective of their background. When a user arrives on the website of a participating service, Limbic Access pops up in the browser window, and conversationally guides the user through making a referral. It collects essential details, and completes an eligibility check using NHS Spine before collecting essential MDS questionnaire information on behalf of the service.

With the AI Limbic Layer, Limbic Access also selects the two most relevant and clinically valuable ADSMs on behalf of the service, meaning a more comprehensive and informative referral is completed. All this information is then placed in the Patient Management System to assist the clinician when completing the assessment.

SUPPORTING ACCESSIBILITY FROM DISADVANTAGED AND MINORITY BACKGROUNDS

In a real-world study published in Nature Medicine involving 129,400 patients across 28 NHS Talking Therapies services in England, it was observed that services implementing Limbic Access experienced a significant 179% increase in non-binary individuals seeking support *(Habicht et al., 2024)*.

Using qualitative feedback from individuals, the study found that non-binary individuals value the human-free aspect of the tool more, highlighting the importance of alternative and inclusive self-referral methods for LGBTQ+ individuals.

MEET CHARLIE

'Charlie' (pseudonym), a non-binary individual, embarked on their Talking Therapy journey through Limbic Access within the Everyturn Talking Therapies service. They first encountered Limbic Access on the Everyturn website, and it allowed them to self-refer by expressing their emotions and thoughts freely. In their own words, Limbic Access 'helped me discover what I was truly feeling,' providing them with a positive and affirming start to their treatment pathway.

At the point of referral, Charlie indicated they were struggling with 'extreme stress and anxiety' and chose anxiety as their primary therapeutic focus. The unique insights and information gathered by Limbic Access at the front door enables the service to review initial PHQ9 and GAD7 scores before assessment, helps to monitor any potential risk concerns promptly, and allows patients to choose and book their assessment at the end of the referral. This has positively increased access to the services and created a streamlined pathway for patients.

Limbic Access supports patients to be signposted or referred to other services sooner in the process, reducing duplication of assessments and repeating their stories. It reduces delays for more complex or high-risk patients accessing appropriate care via triage from our internal risk team within the service who liaise with local crisis services. This also means assessors are able to focus on Talking Therapy appropriate assessments which can reduce burnout for staff.

Charlie's primary presenting problem and other information gathered at referral were then confirmed in their assessment with a Psychological Wellbeing Practitioner (PWP). The information allowed the practitioner to focus on Charlie's specific issues from the start.

In collaboration with Charlie, a treatment plan was agreed, and they were offered low intensity computerised cognitive behavioural therapy (cCBT), supported by a PWP, through Space from Generalised Anxiety Disorder program on Silvercloud.

Charlie completed their cCBT with regular reviews with a PWP. Everyturn's cCBT review calls and email content is always personalised to the specific issues and content shared by the patient. All correspondence with Charlie was personalised and focused on their specific challenges with a focus on supporting with change and acceptance. They were discharged from service in recovery. Charlie's scores changed from moderate PHQ9 score and Severe GAD7 score at referral to non-clinical scores on both PHQ9 and GAD7 at the end of treatment. They reported that the 'therapy was starting to help to get down to the root of my problems, so I feel less anxious about situations than usual.' At the end of their treatment. Charlie was able to apply for jobs and go to job interviews which they had not been able to achieve before. They also had ongoing access to their cCBT programme for 12 months following the completion of treatment.

All of this was achieved with Charlie referring and completing their assessment within 7 days. This allowed them to access appropriate therapy promptly, minimising the escalation of their symptoms and helping them to stay focused on their goals. They were discharged from the service within 2 months of referral in recovery.

SECTION 6: EXPERTS BY EXPERIENCE

Those who have experienced using NHS Talking Therapies Services, first hand as a patient, hold the most valuable insight into their own experiences within the service. All services should gather and value their patient feedback and use this to consider appropriate changes to their service to improve the experiences of LGBTQ+ patients. Below are some quotes from a variety of LGBTQ+ patients, from across England, that have been provided based on their own experiences.

We asked the following questions:

IF YOU COULD GIVE ONE PIECE OF ADVICE TO NHS TALKING THERAPIES AND THEIR STAFF, WHAT WOULD THIS BE?

WHAT IMPACT WOULD THIS HAVE ON THE PATIENT?

Educating yourself on LGBTQ+ issues is helpful and will take you so far, but it's normal and okay to have some "blind spots", and most people do- there is so much diversity under the queer umbrella, after all! Don't feel you have to know everything, and don't feel afraid to ask questions when you're not sure. My best experiences in therapy have been with clinicians who sometimes got the language wrong - but were brave enough to ask me about my experiences as a queer person, and how they have impacted on my mental health. These wonderful therapists helped me to feel comfortable, trusting, and open, which has ultimately facilitated my recovery.

To approach uncertainty with curiosity rather than fear. Belonging to the LGBTQ+ community has different meanings for everyone, so it is near impossible to be an 'expert' in this arena. If you would like to know more about what a patient is describing, asking gentle questions such as "Would you feel comfortable sharing what that means to you/looks like to you?", "May I ask your experience around that?", would be a great first step. Also, by checking in with the patient around how they found being asked those questions and if there is anything they would like you, as the therapist, to brush up on for the next session to help you understand them better.

It would show the patient that you have their point of view in mind when working together to improve their mental health. I believe it demonstrates to the patient that you are not trying to know everything, but understand as much as you can to help with their difficulties. I believe the patient may feel heard and validated, without feeling exhausted from spending their session time teaching the basics. It may strengthen your patient's trust in you as a reflective and compassionate clinician.

Give credibility to what you hear, LGBTQ+ people have a different experience of mankind. To be actively listened to and therefore be more engaged and get more out of their therapy.

Sometimes young LGBT people with depression/ anxiety etc is caused as a result of being gay/LGBT sometimes there are other things going on in their life and actually they're quite happy with their sexuality. It would make it more person-centred.

I think, make sure people know about non-binary and trans people and how to speak respectfully to them e.g. use of pronouns, not suggesting childhood sexual assault is what turned them gay, etc.

I mean, I've personally disengaged from medical services due to misgendering, and I know someone who dropped out of therapy because their therapist was convinced that because he was gay he'd been sexually assaulted as a child and was just repressing it when he was there to talk about work stress and just happened to be gay...


QUEER HOPE AND JOY!
QUEER HOPE AND JOY!
QUEER HOPE AND JOY!
QUEER HOPE AND JOY!
LGBT FOUNDATION
W: LGBT FOUNDATION
T: 0345 3 30 30 30
Indigo.

REFERENCES

Bachmann, C.I. & Gooch, B. (2018a). LGBT in Britain: Health Report. Stonewall. https://www.stonewall.org.uk/lgbt-britain-health

Bachmann, C.L., & Gooch, B. (2018b). LGBT in Britain: Trans Report. Stonewall. https://www.stonewall.org.uk/system/files/lgbt_in_britain_-_trans_report_final.pdf

Bacon, A., Farrand, P., & Collins, A. (2022). Armed Forces Veterans Positive Practice Guide. https://babcp.com/Portals/0/Files/Therapists/Armed%20Forces%20Veterans%20Positive%20Practice%20Guide%20Nov22.pdf?ver=2022-11-07-165501-277

Ban Conversion Therapy (2023). Available at: https://www.banconversiontherapy.com/

Beck, A, Naz, S., Brooks, M., & Jankowska, M. (2019). Black, Asian and Minority Ethnic service user positive practice guide. 2019. https://babcp.com/BAME-Positive-Practice-Guide

Bridge, L., Smith, P., & Rimes, K. A. (2019). Sexual orientation differences in the self-esteem of men and women: a systematic review and meta-analysis. Psychology of Sexual Orientation and Gender Diversity, 6, 433–446.

Bystedt, S., Rozental, A., Andersson, G., Boettcher, J., & Calbring, B. (2014). Clinicians' perspectives on negative effects of psychological treatments. Cognitive Behaviour Therapy, 43(4), 319-331. https://doi.org/10.1080/16506073.2014.939593.

Carroll, S., Moss-Morris, R., Hulme, K., & Hudson, J. (2021). Therapists' perceptions of barriers and facilitators to uptake and engagement with therapy in long term conditions. British Journal of Health Psychology, 26(2), 307-324.

Carvalho, S., Castilho, P., Seabra, D., Salvador, C., Rijo, D., & Carona, C. (2022). Critical issues in cognitive behavioural therapy (CBT) with gender and sexual minorities (GSMs). The Cognitive Behaviour Therapist, 15, E3. https://doi.org/10.1017/S1754470X21000398

Chakraborty, A., McManus, S., Brugha, T. S., Bebbington, P., & King, M. (2011). Mental health of the non-heterosexual population of England. Br J Psychiatry, 198(2), 143-148.

Citizens Advice. (n.d.). Check what you can do about harassment. https://www.citizensadvice.org.uk/law-and-courts/discrimination/taking-action-about-discrimination/taking-action-about-harassment/

Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. Behaviour Research and Therapy, 47(11), 910-920. https://doi.org/10.1016/j.brat.2009.07.010.

Cocks, L., Jonas, K., & Laville, A. (2019). Exploring LGBT mental health and recommendations for clinical practice . CBT Today, 47(3), 14-15.

Craig, S. L., Austin, A., & Alessi, E. (2013). Gay affirmative cognitive behavioral therapy for sexual minority youth: A clinical adaptation. Clinical Social Work Journal, 41, 258-266.

Crawford, M. J., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., & Parry, G. D. (2016). Patient experience of negative effects of psychological treatment: results of a national survey. Br J Psychiatry, 208(3), 260-254.

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. University of Chicago Legal Forum, 1(8), 139-167.

Cullingworth, J., & Webster, S. (2010). LGBT Mental Health Audit Tool: A guide for mental health services and organisations to becoming more LGBT inclusive. https://www.lgbthealth.org.uk/wp-content/uploads/2021/05/LGBT-Mental-Health-Audit-Tool.pdf

Dagnan, D., Burke, C.K., Davies, J., & Chinn, D. (2015). Learning Disabilities: IAPT Positive Practice Guide. https://www.learningdisabilities.org.uk/learning-disabilities/publications/learning-disabilities-iapt-positive-practice-guide2

Doan-Minh, S. (2019). Corrective Rape: An Extreme Manifestation of Discrimination and the State's Complicity in Sexual Violence. Hastings Women's Law Journal, 30(1), 167-196. https://repository.uclawsf.edu/hwlj/vol30/iss1/8/

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. Behaviour research and therapy, 38(4), 319-345.

Equality Act 2010, c39. https://www.legislation.gov.uk/ukpga/2010/15/contents

Equality and Diversity Council. (2017). Improving lesbian gay bisexual and trans (LGBT) equality across the NHS. British Journal of Healthcare Assistants, 11(4), 162-165.

Foy, A. A., Morris, D., Fernandes, V., & Rimes, K. A. (2019). LGBQ+ adults' experiences of Improving Access to Psychological Therapies and primary care counselling services: informing clinical practice and service delivery. The Cognitive Behaviour Therapist, 12(42).

Frost, D. M., & Meyer, I. H. (2023). Minority stress theory: Application, critique, and continued relevance. Current Opinion in Psychology, 101579.

Gender Recognition Act 2004. c 7. https://www.legislation.gov.uk/ukpga/2004/7/enacted

General Medical Council. (2024, January). Trans healthcare. https://www.gmc-uk.org/professional-standards/ethical-hub/trans-healthcare#Confidentiality-and-equality

Government Equalities Office. (2018). National LGBT+ Survey: Research Report.

Hambrook, D. G., Aries, D., Benjamin, L., & Rimes, K. A. (2022). Group intervention for sexual minority adults with common mental health problems: preliminary evaluation. Behavioural and Cognitive Psychotherapy, 50(6), 575-589.

Hatzenbuehler, M. L. (2009). How does sexual minority stigma 'get under the skin'? A psychological mediation framework. Psychological Bulletin, 135, 707–730.

Ho, J. K. Y., O'Rouke, C., Laville, A., Chellingsworth, M., & Callaghan, P. (2023). Clinician experiences on training and awareness of sexual orientation in NHS Talking Therapies Services for Anxiety and Depression. The Cognitive Behaviour Therapist, 16(24), 1-28.

Ingham, B., Miller, P.K., Thwaites, R., Wilson, C., Greaves, J., McMeekin, P., Rodgers, J., Dewison, N., Bowden, S.L.J., & Dagnan, D. (2023). Improving taking therapies for autistic people.

Kell, L., & Laville, A. (2021). Diversity and Inclusion Vignettes: For Psychological Wellbeing Practitioner Training Programmes. Retrieved from BPS: https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/PWP%20Diversity%20and%20Inclusion%20Vignettes.pdf

Laidlaw, K. (2024). NHS Talking Therapies Positive Practice Guide: Older People 2024. https://babcp.com/Therapists/Older-Adults-Positive-Practice-Guide

Laville, A. (2013). Diversity matters. CBT Today, 41(2), 15.

Laville, A. (2017). The importance of data collection, signposting and "appropriate" awareness in working with sexual orientation. CBT Today, 45(4), 14-15.

Laville, A. (2022). LGBT+ History Month: The importance of awareness and understanding for LGBT+ considerations within clinical practice. CBT Today, 50(1), 14-15.

LGBT Foundation (2020). Hidden Figures: the impact of the COVID-19 pandemic on LGBT communities in the UK. Available at: https://lgbt.foundation/wp-content/uploads/2023/12/Hidden20Figures-20The20Impact20of20the20Covid-1920Pandemic20on20LGBT20Communities.pdf

LGBT Foundation. (2023, August, 8). What is means to be non-binary. https://lgbt.foundation/help/what-it-means-to-be-non-binary/

Lloyd, C. E. M., Rimes, K. A., & Hambrook, D. G. (2021). LGBQ adults' experiences of a CBT wellbeing group for anxiety and depression in an Improving Access to Psychological Therapies Service: a qualitative service evaluation. The Cognitive Behaviour Therapist, 13. https://doi.org/10.1017/s1754470x20000598

Mackey, L. (2023). Sexual minorities, suicide and self-harm: new research in England deepens our understanding. https://www.nationalelfservice.net/populations-and-settings/lgbtq/sexual-minorities-suicide-self-harm-new-research-in-england-deepens-our-understanding/

McIntyre, J., Daley, A., Rutherford, K., & Ross, L. E. (2011). Systems-level barriers in accessing supportive mental health services for sexual and gender minorities: Insights from the provider's perspective. Canadian Journal of Community Mental Health, 30(2), 173-186.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychological Bulletin, 129, 674–697.

Michie, S., Van Stralen, M.M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Implementation Sci 6, 42.

Morris, D.D.A., Fernandes, V., & Rimes, K.A. (2022). Sexual minority service user perspectives on mental health treatment barriers to care and service improvements. International Review of Psychiatry, 34, 230-239. https://doi.org/10.1080/09540261.2022.2051445

National Autistic Society. (2024). NHS Talking Therapies for anxiety and depression: Guide to support reasonable adjustments and adaptations when working with autistic adults. https://www.autism.org.uk/shop/products/books-and-resources/nhs-talking-therapies

National Autistic Society., & Mind. (2021). Good practice guide: For professionals delivering talking therapies for autistic adults and children. https://s2.chorus-mk.thirdlight.com/file/24/asDKIN9as.klK7easFDsalAzTC/NAS-Good-Practice-Guide-A4.pdf

National Collaborating Centre for Mental Health. (2018). The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms. Full implementation guidance. London: National Collaborating Centre for Mental Health.

NHS (2020, May, 28). Treatment Gender dysphoria. https://www.nhs.uk/conditions/gender-dysphoria/treatment/

NHS (2023, January, 3). Side effects of hormone replacement therapy (HRT). https://www.nhs.uk/medicines/hormone-replacement-therapy-hrt/side-effects-of-hormone-replacement-therapy-hrt/

NHS Digital. (2022). Psychological Therapies, Annual report on the use of IAPT Services, 2021-22. https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2021-22#

NHS England. (2021, September 21). E-learning for healthcare my Elearning. https://portal.e-lfh.org.uk/myElearning/Index?HierarchyId=0_54306&programmeId=54306

NHS England Equality and Health Inequalities Unit. (2017). Sexual Orientation Monitoring: Full Specification. London: NHS England.

NHS GIDS. (n.d.). Definitions and descriptions of common terms. https://gids.nhs.uk/glossary/

NHS Tees, Esk and Wear Valleys NHS foundation trust. (2022). Minimum standards for clinical record keeping: Ref CORP-0026-002-v1.1.

Office for national statistics. (2021). Sexual orientation (detailed) for geographic areas in England and Wales: Census 2021. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/datasets/sexualorientationdetailedforgeographicareasinenglandandwalescensus2021

Ontario. (2024, February). Find mental health and addiction services in your community. Canada's Ministry of Health. www.ontario.ca/page/mental-health-services

Puckett, J. A., Woodward, E. N., Mereish, E. H., & Pantalone, D. W. (2015). Parental rejection following sexual orientation disclosure: Impact on internalized homophobia, social support, and mental health. LGBT health, 2(3), 265-269.

Rimes, K. A., Broadbent, M., Holden, R., Rahman, Q., Hambrook, D., Hatch, S. L., & Wingrove, J. (2017). Comparison of Treatment Outcomes Between Lesbian, Gay, Bisexual and Heterosexual Individuals Receiving a Primary Care Psychological Intervention. Behavioural and Cognitive Psychotherapy, 46(3), 332–349. https://doi.org/10.1017/s1352465817000583

Rimes, K. A., Ion, D., Wingrove, J., & Carter, B. (2019). Sexual orientation differences in psychological treatment outcomes for depression and anxiety: National cohort study, 87(7), 577-589.

Rosenthal, L. (2016). Incorporating intersectionality into psychology: An opportunity to promote social justice and equity. American Psychologist, 71(6), 474.

Stonewall. (n.d.) List of LGBTQ+ terms. https://www.stonewall.org.uk/list-lgbtq-terms

Stonewall. (2021). Key dates for lesbian, gay, bi and trans equality. https://www.stonewall.org.uk/key-dates-lesbian-gay-bi-and-trans-equality

Stonewall. (2022). Reform of the gender recognition act: Parliamentary Briefing February 2022.

Stonewall. (2022). 5 things you should know about aromantic people. https://www.stonewall.org.uk/about-us/news/5-things-you-should-know-about-aromantic-people

Stonewall. (2023). Ban Conversion Therapy. https://www.stonewall.org.uk/our-work/campaigns/ban-conversion-therapy#:~:text=Conversion%20practices%20have%20been%20widely%20condemned%20as%20ineffective,UK%2C%20and%20from%20all%20across%20the%20LGBTQ%2B%20community.

The British Psychological Society. (2019). Guidelines for psychologists working with gender, sexuality and relationship diversity – for adults and young people aged 18 and over. https://explore.bps.org.uk/binary/bpsworks/986e577a2e5c686b/dd77909e434237fe7bd656c718998a266faa1f304fa51648cfd96ff20db3cc0d/rep129_2019.pdf

Thompson, N. (2020). Anti-discriminatory practice: Equality, diversity and social justice – 7th edition. Bloomsbury Publishing.

UK Government. (n.d.-a). Discrimination: your rights. https://www.gov.uk/discrimination-your-rights/how-you-can-be-discriminated-against#:~:text=direct%20discrimination%20%2D%20treating%20someone%20with,characteristic%20at%20an%20unfair%20disadvantage

UK Government. (n.d.-b). Workplace bullying and harassment. https://www.gov.uk/workplace-bullying-and-harassment

UK Government. (n.d.-c). Report hate crime. https://www.gov.uk/report-hate-crime

Walsh, R.J., Krabbendam, L., Dewinter, J., & Begeer, S. (2018). Brief report: Gender identity differences in autistic adults: Associations with perceptual and socio-cognitive profiles. Journal of autism and developmental disorders, 48(12), 4070-4078.

Warrier, V., Greenberg, D.M., Weir, E., Buckingham, C., Smith, P., Lai, M.C., Allison, C., & Baron-Cohen, S. (2020). Elevated rates of autism, other neurodevelepmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. Nature communications, 11(1), 3959.

Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for DSM-5 (PCL-5).
Williams, A. J., Jones, C., Arcelus, J., Townsend, E., Lazaridou, A., & Michail, M. (2021). A systematic review and meta-analysis of victimisation and mental health prevalence among LGBTQ+ young people with experiences of self-harm and suicide. PLoS One, 16(1).

World Health Organisation. (2019). International Statistical Classification of Diseases and Related Health Problems (11th ed.). https://icd.who.int/en

APPENDIX

APPENDIX 1: GLOSSARY OF TERMS

AROMANTIC/ARO
An umbrella term for people who do not typically experience romantic attraction. People who do not experience romantic attraction, can still experience sexual attraction *(Stonewall, 2022).*

ASEXUAL/ACE
A term used to describe people who have a lack of, varying or an occasional experience of sexual attraction *(Stonewall, n.d.).*

BIPHOBIA
The dislike or fear of someone who identifies as Bi. Biphobic bullying can be targeted at people who are or are perceived to be bi. It is based on prejudice, negative attitudes, beliefs or views *(Stonewall, n.d.).*

BISEXUAL/BI
Having a romantic and/or sexual orientation towards more than one gender, people who are Bisexual may describe themselves using a wide variety of terms such as: Bisexual, Pan and Queer *(Stonewall, n.d.).*

BODY DYSMORPHIA
This is when a person experiences persistent preoccupation with one or more perceived defects or flaws in their appearance. These may be slightly noticeable or even unnoticeable to other people. The person may think others are noticing this perceived defect(s) and often try to alter or camouflage the perceived defect(s) and may avoid situations which increases the distress about the perceived defect(s) *(World Health Organisation, 2019)*

CISGENDER
When a person's gender identity is the same as the sex that they were assigned at birth *(Stonewall, n.d.).*

CISGENDER NORMATIVITY
This is the assumption that everyone's gender is congruent with their sex assigned at birth (see cisgender definition). People assume and prioritise cisgender identities to be the norm.

COMING OUT
This refers to when a person first tells a person(s) about their own orientation and/or gender identity *(Stonewall, n.d.).* Coming out isn't something that just happens once.

CORRECTIVE RAPE
This term is used when someone, who does not conform to gender or sexual orientation norms, is raped. The motive of the perpetrator is to "correct" the individual or to "teach them a lesson" and this is usually made clear prior and/or during the assault through verbal abuse *(Doan-Minh, 2019).*

DEAD NAME / BIRTH NAME
Calling someone by their name that they were given at birth when they have since changed their name, often when a trans person is transitioning *(Stonewall, n.d.).*

DISCRIMINATION
This is a term used when someone is treated less favourably who has a protected characteristic than other people. This can be both direct or indirect *(UK Government, n.d.-a).*

GAY
Refers to a man who has a romantic and/or sexual orientation towards men. Also a generic term for lesbian and gay sexuality - some women define themselves as gay rather than lesbian. Some non-binary people may also identify with this term *(Stonewall,n.d.).*

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GENDER
Gender is largely culturally determined and is often expressed in terms of femininity or masculinity. Gender is something that is assumed at birth, based on the persons sex assigned at birth *(Stonewall, n.d.)*.

GENDER DYSPHORIA
This is when a person experiences discomfort and/or distress due to their gender identity not matching their sex assigned at birth *(Stonewall, n.d.)*.

GENDER FLUID
This is when a person's gender can change and fluctuate, meaning that they do not permanently identify with one particular gender. They may also refer to themselves as non-binary *(LGBT Foundation, 2023)*.

GENDER IDENTITY
A person's own sense of their own gender, which could be male, female, non-binary or something else. It can be different or the same as the sex they were assigned at birth *(Stonewall, n.d.)*.

GENDER-NEUTRAL
The term gender-neutral refers to something, such as objects and words, which do not refer to or associate with gender, particularly male or female.

GENDER NONCONFORMING
This is a term used when an individual's appearance or behaviour does not conform to the cultural and social expectations of their gender.

GENDER REASSIGNMENT
This is a way of describing someone's transition from one gender to another which they identify as *(Stonewall, n.d.)*. See the definition for transitioning and social transition further down.

GENDER RECOGNITION CERTIFICATE (GRC)
A certificate which allows trans people to be recognised, legally, in their affirmed gender and to be issued with a new birth certificate. You need to be 18 years old or over to apply for this and not all trans people will apply for a GRC. You do not need a GRC to change your gender at work or on your passport *(Stonewall, n.d.)*.

HARASSMENT
This is when someone behaves in a way to make someone feel intimidated, scared, humiliated or offended. This can include, but is not limited to, unfair treatment, picking on someone, regularly undermining someone, spreading malicious rumours, bullying and includes sexual harassment. This can occur by any means of communication *(Citizens Advice, n.d.; UK Government, n.d.-b)*.

HATE CRIME
This is when a crime is committed against a person because of their disability, transgender identity, race, religion or belief and/or sexual orientation. This may include, but is not limited to, threatening behaviour, online abuse, assault, robbery, harassment, damage to property and inciting others to commit hate crimes *(UK Government, n.d.-c)*.

HETERONORMATIVITY
Assuming that heterosexual, cisgender people are the 'norm' and that anything other than that is perceived to be 'different'. A world view that promotes heterosexuality as the preferred sexual orientation.

HETEROSEXUAL
When a person's romantic and/or sexual orientation is towards the opposite gender. e.g a Male attracted to a Female, or a Female attracted to a Male *(Stonewall, n.d.)*.

APPENDIX 1: GLOSSARY OF TERMS

HOMOPHOBIA
The dislike or fear of someone who identifies as lesbian/gay/bi. Homophobic bullying can be targeted at people who are or are perceived to be lesbian, gay or bi. It is based on prejudice, negative attitudes, beliefs or views *(Stonewall, n.d.).*

INTERSECTIONALITY
A metaphor to understand how multiple forms of inequality or disadvantages can sometimes compound themselves and create obstacles that are often not understood *(Crenshaw,1989).* E.g. A black lesbian woman may be subjected to racism, sexism and homophobia.

INTERSEX
A person who may have the biological attributes of both male and female sexes or their biological attributes do not fit with societies assumptions about what constitutes as male or female. People who are Intersex may identify as male, female or non-binary *(Stonewall, n.d.).*

LESBIAN
A woman who has a romantic and/or sexual attraction towards other women. Non-binary people may also identify with this term *(Stonewall, n.d.).*

LGBTQ+
Lesbian, Gay, Bisexual, Transgender, Queer/ Questioning plus.

MISGENDERING:
Misgendering someone is when a person uses a word, such as a pronoun or title that does not reflect the individual's gender identity.

NON-BINARY
This is a term used when someone's gender identity does not sit with 'male' or 'female'. People may see themselves with some aspects of being a 'man' or a 'woman' and others may not identify with either *(Stonewall, n.d.).*

OUTED
When someone who identifies as being LGBTQ+ has their sexual orientation or gender identity disclosed to someone else without their consent *(Stonewall, n.d.).*

PANSEXUAL/PAN
Someone's sexual and/or romantic attraction to others is not limited by sex or gender *(Stonewall, n.d.).*

POLYAMOROUS
Characterised by or involved in the practice of engaging in multiple romantic (and typically sexual) relationships, with the consent of all the people involved.

PRONOUNS
Words used in conversation to refer to someone's gender. E.g He/Him She/Her They/Them and Ze/Zir *(Stonewall, n.d.).*

QUEER
A label often used by people wanting to reject specific romantic/sexual orientation/gender identity labels *(Stonewall, n.d.).*

QUESTIONING
When someone is in the process of exploring their own sexual orientation and/or gender identity *(Stonewall, n.d.).*

SEX
This is something that is assigned to a person at birth, based on their genitalia and reproductive functions *(Stonewall, n.d.).*

SEXUAL MINORITY
This term is used for anyone whose sexual orientation is something other than heterosexual.

SEXUAL ORIENTATION
This is someone's sexual attraction to others and includes the lack of sexual attraction towards others *(Stonewall, n.d.).*

SOCIAL TRANSITIONING

This is the process of someone changing how they present their gender so that it matches their internal gender identity. This can often include changing how they dress, names and pronouns *(NHS GIDS, n.d.).*

TRANSEXUAL /TRANS/TRANSGENDER

A term used to describe someone when their gender is not the same as the sex that they were assigned at birth *(Stonewall, n.d.).*

TRANSITIONING

The process someone takes to live in the gender which they identify with. It can include medical transitioning, but someone does not have to medically transition to transition to their gender identity *(Stonewall, n.d.).*

TRANSPHOBIA

The dislike or fear of someone who is trans. Transphobic bullying can be targeted at people who are or are perceived to be trans. It is based on prejudice, negative attitudes, beliefs or views *(Stonewall, n.d.).*

ABOUT THE AUTHORS

Sarah Beattie (She/Her) is a Senior Psychological Wellbeing Practitioner (SPWP) within NHS North Yorkshire Talking Therapies Service. Sarah has been in post since 2022; prior to this she began her Psychological Wellbeing Practitioner (PWP) training in 2019, qualifying with a degree in Low Intensity Cognitive Behavioural Therapy (LI-CBT) with the University of Sheffield, in 2020. After qualifying, Sarah established the LGBTQ+ champion role within North Yorkshire Talking Therapies.

In 2016, Sarah gained a degree in Psychology with York St. John University and progressed to acquiring a MSc in Forensic Psychology in 2017, with the University of York. She has worked within mental health settings since 2017, including a medium secure hospital, predominantly within an autism ward.

Sarah is an accredited PWP with the British Association for Behavioural and Cognitive Psychotherapies (BABCP). She is a member of the LGBTQ+ specialist interest group (SIG) within the BABCP and the national Talking Therapies LGBTQ+ champion group. She is also a member of the North East and Yorkshire Lead PWP and SPWP Community of Practice network.

Professor Allán Laville (He/Him) teaches Clinical Psychology at the School of Psychology and Clinical Language Sciences (SPCLS), University of Reading. Allán joined Reading in 2011 as a PWP Clinical Educator in the Charlie Waller Institute (CWI). By December 2013, he had progressed into the role of Senior PWP Clinical Educator working across CWI and SPCLS. He was appointed a Lecturer in Clinical Psychology in July 2019, promoted to Associate Professor of Clinical Psychology in August 2021, and most recently, promoted to Professor of Equity in Psychology. Since 2020, Allán has also held the role of Dean for Diversity and Inclusion at the University of Reading.

Allán is a National Teaching Fellow and Senior Fellow of the Higher Education Academy and an Associate Fellow of the British Psychological Society (BPS). He is a member of the Scientific Programme Advisory Group for the British Association for Behavioural and Cognitive Psychotherapies. He is also a member of the BPS Equality, Diversity and Inclusion Strategic Board.

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CONFLICTS OF INTEREST

Professor Allán Laville receives income from training in aspects of working therapeutically with sexual and gender diversity.

Sarah Beattie has no conflicts of interest to declare.

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