

“A Part of Me Needs to Keep Staying Hidden”

**Navigating Neuroqueerness in the Therapeutic Space: An Interpretative
Phenomenological Analysis of Neuroqueer Client’s Experiences of
Psychotherapy**

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Caitlin Payne

Student Number: 2218988

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Abstract

Neurodivergent and queer individuals experience disproportionately poor mental health outcomes associated with minority stress, even within therapeutic settings intended to be supportive. Evidence also suggests that minority stress may be compounded for individuals with multiple marginalised identities. Despite growing recognition of the relationship between neurodivergence and queerness (or *neuroqueerness*), limited research has examined the experiences of neuroqueer clients in psychotherapy.

Using Interpretative Phenomenological Analysis (IPA), this study explored the therapy experiences of six neuroqueer individuals, adopting a critical intersectional perspective. Three themes were identified: (1) *Navigating neuronormative therapeutic frameworks: the unequal burden of engaging in therapy*; (2) *“A part of me needs to keep staying hidden”: negotiating neuroqueer identity and safety*; (3) *Neuroqueer understanding and collaboration as transformative to the therapeutic process*. Participants experienced therapy as unhelpful or harmful when therapists lacked understanding of neuroqueerness and reinforced neuronormative expectations of therapeutic engagement. Participants described experiences of misgendering, cisheteronormative assumptions, the pathologisation of neurodivergence and stigmatising misattributions linking queerness to experiences of abuse. Conversely, therapy was experienced as more helpful when neuroqueerness was understood, accepted and accommodated.

These findings contribute to literature on neurodiversity- and LGBTQ+-affirming psychotherapy by highlighting the need to queer traditional therapeutic approaches through person-centred, collaborative and anti-oppressive practices that prioritise shared understanding and accommodate neurodivergence. This study calls for greater therapist training, cultural humility and critical reflection on ableist, neuronormative, and cisheteronormative assumptions within therapeutic practice, recognising therapists' capacity to reproduce minority stress and reinforce broader systems of oppression.

Key words: psychotherapy; LGBTQ+; neurodivergent; neuroqueer; affirmative practice; minority stress theory; intersectionality; Interpretative Phenomenological Analysis

Declaration

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.



Signed:

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STATEMENT 1

This dissertation is being submitted in partial fulfilment of the requirements for the degree of Master of Arts in Psychotherapeutic Practice: Humanistic



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STATEMENT 2

This dissertation is the result of my own independent work / investigation, except where otherwise stated.

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.



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Chapter 1: Introduction

Background and Context

Across academic literature, it is increasingly recognised that societies structured around cisheteronormative and neuronormative standards create a range of social, psychological and systemic challenges for people whose identities diverge from these norms (Legault, Bourdon and Poirier, 2021; Radulski, 2022; Bartels et al., 2025; Costa and Novo, 2025; Radford et al., 2025). This divergence from these norms aligns with the concept of queerness and queer theory which seeks to challenge normative assumptions surrounding gender, sexuality and identity, along with the power structures which sustain them (Brim and Ghaziani, 2016; Nadal and Scharrón-del Río, 2021). Historically used as a derogatory slur to mean odd, weird or deviant, the term *queer* has been reclaimed in recent decades as an umbrella term for individuals whose gender or sexuality does not align with heterosexual norms or traditional ideas of gender (Russell, Bishop and Fish, 2023).

Similarly, the term “neurodivergent” refers to individuals whose cognitive functioning differ from dominant societal standards of cognition (Walker and Raymaker, 2021). This can include differences in attention, executive functioning, learning, memory, language, perceptual-motor control and social cognition, as well as neurodevelopmental conditions like autism, ADHD, dyslexia, dyspraxia and Tourette’s syndrome (Walker, 2021; Shah et al., 2022; Chapman and Botha, 2023). Neurodivergent people are estimated to constitute approximately 15-20% of the population (Doyle, 2020). Emerging from disability and autistic self-advocacy movements, the Neurodiversity Paradigm (NDP) conceptualises neurological differences as natural forms of human variation rather than inherent deficits requiring correction (Singer, 1999; Walker, 2021). This challenges the dominant pathology paradigm and medical model of disability that pervades healthcare systems, recognising both the intrinsic value and strengths associated with neurodivergence, alongside its challenges (Botha and Gillespie-Lynch, 2022; Quigley et al., 2024). Similarly, the NDP aligns with queer theory in its commitment to questioning socially constructed notions of normality (i.e. neuronormativity). Both argue that dominant assumptions surrounding gender, sexuality and cognition are constructed and maintained through socio-political processes which require critical examination and

deconstruction (Legault, Bourdon and Poirier, 2021; Walker, 2021; Chapman and Botha, 2023).

Beyond theoretical similarities, queer and neurodivergent populations consistently experience disparities in mental health outcomes, consistently reporting poorer mental health than their cisgender, heterosexual and neurotypical counterparts. Across both groups, higher rates of anxiety, depression, self-harm and suicidality have been widely documented (Hirvikoski et al. 2016; Lai et al., 2019; Moagi et al., 2021; Kölves et al., 2021; Marchi et al., 2022; Klinger et al., 2024; Kroll et al., 2024). Despite greater utilisation of healthcare services (Lai et al., 2019; Zerbo et al., 2019; Kroll et al., 2024), both populations report lower treatment satisfaction (Filice and Meyer, 2018; Rimes et al., 2019), poorer therapeutic experiences (Lefevor et al., 2019; Lawson et al., 2020) and reduced quality of life ratings compared to cisgender, heterosexual and neurotypical individuals (Platt, Wolf and Scheitle, 2018; Bränström, Fellman and Pachankis, 2023).

Minority Stress Theory (Meyer, 1995; 2003) explains that such disparities result from individuals with marginalised identities experiencing chronic stress arising from prejudice, stigma, exclusion and discrimination. These external (distal) stressors are internalised over time as proximal stressors, contributing to elevated psychological distress and reduced wellbeing (Frost and Meyer, 2023). While originally formulated to explain the experiences of singular minority groups, more recent work has extended this theory through an intersectional lens, contributing to growing recognition of mental health disparities experienced by people who hold multiple marginalised minority identities (Parra and Hastings, 2018; Bauer et al., 2021; Rivas-Koehl, Rivas-Koehl and McNeil-Smith, 2023).

Intersectionality, rooted in Black feminist activism and scholarship, seeks to explain how co-existing social identities, such as race, gender, class, sexuality and ability simultaneously impact a person's lived experience. This highlights how interlocking systems of oppression contribute to a person's disenfranchisement and marginalisation, as well as their proximity to privilege, power and access to resources (Crenshaw, 1989). Related research suggests that mental health outcomes may be worse for individuals with multiple minority identities due to cumulative or compounded minority stressors (Fagrell Trygg, Gustafsson and Månsdotter, 2019; Robertson, Akre and Gonzales, 2021; Rubin-McGregor, Heitt and

Hunger, 2025). In particular, emerging evidence indicates that individuals with autistic traits and experiences of gender minority stress report poorer mental health outcomes (George and Stokes, 2018; Kung, 2024).

Relatedly, a growing body of empirical evidence demonstrates a significant relationship between neurodivergent traits and sexual and gender divergence (Warrier et al., 2020; Barnett, 2024; Gayatri and Singh, 2024). Consistently, research indicates that individuals with neurodivergent conditions like ADHD and autism, are more likely to identify as a sexual and/or gender minority group, compared to neurotypical populations (Thrower et al., 2020; Corbett et al., 2022; Bouzy et al., 2023; Kallitsounaki and Williams, 2023). Neuroqueer Theory integrates intersectional, queer and neurodiversity frameworks to capture this overlap (Yergeau, 2018; Egner, 2019; Walker, 2021). This work emphasises the interrelatedness of neurodivergence, disability, gender, and sexuality, and how these overlapping identities and ways of being challenge neuronormative and cisheteronormative standards and societal structures (Yergeau, 2018; Egner, 2019; Walker, 2021; Walker and Raymaker, 2021). Such work has been quickly accepted within online community spaces and steadily adopted within academic investigations across fields including sociology, social work and medicine, although it's application within psychotherapy remains comparatively limited (Stevens and Kirby, 2025). There remains a notable paucity of literature exploring how minority stressors associated with intersecting identities of queerness and neurodivergence (or neuroqueerness) may manifest in therapeutic settings and impact the quality of mental health support received.

Psychotherapy Experiences of Neurodivergent and Queer Populations

Historically, queer and neurodivergent communities have shared parallels in their oppression and experiences of pathologisation within healthcare systems. Both groups have been subjected to interventions, like conversion therapies and Applied Behavioural Analysis (ABA) intended to suppress or erase, reduce or 'correct' these identities and traits to align with social norms (Drescher, 2015; Chapman and Bovell, 2022; Bottema-Beutel, 2024). Such practices are rooted within the medical model of disability and the broader pathology paradigm which conceptualises deviations from heterosexism, cisgenderism and neurotypicality as personal core-deficits or

dysfunctions requiring diagnosis and treatment, rather than natural forms of human diversity (Oliver, 1990; Drescher, 2015). Both interventions have been criticised for reinforcing harmful social expectations and prioritising behavioural conformity over personal autonomy and wellbeing (Wilkenfeld and McCarthy, 2020; Trispiotis and Purshouse, 2022; Bottema-Beutel, 2024). Such interventions have gained variable empirical support and have contributed to an ongoing mistrust of healthcare systems amongst queer and neurodivergent communities, yet are still practiced today (Meanley et al., 2020; Leaf et al., 2022; Trispiotis and Purshouse, 2022; Bottema-Beutel, 2024).

In response, there has been a growing shift towards non-pathologising, culturally responsive and identity-affirming approaches to psychological care when working with individuals from marginalised communities (Pachankis, 2018; Chapman and Botha, 2022; Pellicano and den Houting, 2022; Lemon, 2023; Pliskin and Crehan, 2024). Such approaches intend to make mental health support more inclusive and responsive to clients' lived experiences, attempting to mitigate the impact of minority stress and discourage interventions that exacerbate harm (Chapman and Botha, 2023; Burger and Pachankis, 2024).

Despite these developments, evidence suggests that even in services intended to be supportive, both neurodivergent and queer people continue to encounter distal and proximal stressors and barriers to appropriate support at individual, interpersonal and systemic levels, that exacerbate distress and perpetuate inequalities in mental health support (Rees, Crower and Harris, 2021; Brede et al., 2022; McConnell and Minshew, 2023; Lemon, 2023). However, relatively little is known about how these experiences manifest for individuals who identify as both neurodivergent and queer.

Problem Statement

While there is growing recognition of the overlap between neurodivergence and queer identities, the concept of neuroqueerness remains insufficiently acknowledged and underexplored within psychological and psychotherapy research. Although intersectionality and the NDP have become increasingly influential across academic and social discourse, research continues to examine neurodivergence, gender and sexuality as separate entities, with a paucity of literature that seeks to directly

explore their overlap in a therapeutic context (Kroll et al., 2025). Consequently, there remains a lack of understanding of how neuroqueer people experience psychotherapy and how intersecting minority stressors may manifest within the therapeutic space.

Related research continues to call for more nuanced and contextually sensitive investigations adopting intersectional frameworks in order to better understand the therapeutic needs of multiple marginalised identity populations (Mazurek et al., 2023; Burger and Pachankis, 2024; Jones, Hamilton and Kargas, 2025; Kroll et al. 2025). Until neuroqueerness is sufficiently acknowledged, and neurodiversity and queerness are viewed through an intersectional lens, holistic understanding of their combined impact on wellbeing and access to effective mental health support remains limited (Botha and Gillespie-Lynch, 2022; Kroll et al., 2025).

Existing literature remains largely shaped by the pathology paradigm and clinician perspectives, limiting the extent to which the lived experiences of queer and neurodivergent individuals are included in understandings of their therapeutic experiences and in the development of interventions intended to support them (Gowen et al., 2019; Lerner, Gurba and Gassner, 2023; Barnett, 2024; Gayatri and Singh, 2024). Such practices perpetuate epistemic injustice, limiting our understanding and contributing to the depoliticisation, marginalisation and consequential fragmentation of these communities (Legault, Bourdon and Poirier, 2021; Catala, Faucher and Poirier, 2021; Chapman and Carel, 2022; White, 2024).

Addressing these gaps in understanding requires qualitative methods which actively centre and amplify the voices and lived experiences of multiply marginalised groups, like neuroqueer people. Such work is paramount to combating the pervasive epistemic injustice present within academia and to further inform the development of inclusive, person-centred and affirmative models of psychotherapy that better reflect the realities of neuroqueer individuals and support more equitable mental health outcomes (Chapman and Carel, 2022; Burger and Pachankis, 2024).

Purpose of Research

This research aims to address the identified gaps in literature by exploring the psychotherapy experiences of individuals who identify as both neurodivergent and queer (or neuroqueer). Using Interpretative Phenomenological Analysis (IPA; Smith,

Larkin and Flowers, 2021) this work seeks to gain insight into the realities of individuals holding multiple marginalised identities and how neuroqueerness impacts experiences of psychotherapy. Adopting a critical intersectional perspective, this research aims to identify key barriers and facilitators influencing neuroqueer individuals' experiences of psychotherapy. This will consider the broader systemic, relational, and cultural factors that may be involved.

Structure of Dissertation

This introduction has provided an overview of the key contextual, theoretical, empirical foundations for the present study, highlighting gaps in understanding and establishing rationale for exploring the psychotherapy experiences of neuroqueer people. The research seeks to answer the question: *What is it like to be a neuroqueer client in therapy?* Chapter 2 presents a literature review that critically examines and integrates existing theory and research related to neurodivergence, queerness, intersectionality and psychotherapy. The methodology chapter outlines the epistemological and philosophical positioning of the research, alongside the chosen methodology and analytic procedures associated with IPA. The findings are then presented and interpreted in relation to the research aims. The discussion chapter considers how these findings relate to existing literature and theory, along with addressing methodological limitations, reflexive considerations and implications for practice and future research. Finally, the concluding chapter provides a summary of the study's key findings and overall contributions.

Chapter 2: Literature Review

Introduction

The present chapter aims to synthesise existing literature through a critical intersectional lens to address existing empirical fragmentation and integrate understanding on mental health and psychotherapy experiences of LGBTQIA+ and neurodivergent populations. The review focuses on literature relating to queerness, neurodivergence, intersectionality, neuroqueerness, mental health disparities and psychotherapy experiences. Relevant literature was identified through searches conducted using Google Scholar and the university's library search service. Search terms combined concepts related to LGBTQIA+ identities (e.g. *queer*, *LGBTQIA+*, *sexual minority*, *gender diverse*), neurodivergence (e.g. *neurodivergent*, *autism*, *ADHD*), psychotherapy (e.g. *psychotherapy*, *therapy*, *counselling*) and the emerging concept of *neuroqueer*.

Neuroqueering Psychotherapy: Theoretical Foundations

Queering Psychotherapy

Queer theory provides a critical lens through which dominant normative assumptions surrounding gender, sexuality, identity and traditional relationship structures can be examined and challenged (Foucault, 1978; Butler, 1990, 1993). Such work views these facets of identity as socially constructed and regulated through social, cultural, political and institutional powers that privilege certain identities, like whiteness, able-bodiedness, cis-genderism, heteronormativity and neuronormativity, while marginalising those who deviate from these norms (Butler, 1990, 1993; Feinberg, 1992; Grzanka, 2019). Applied to psychotherapy, *queering* refers to the critical examination of how Western psychology and psychotherapeutic practice has historically centred white, cisgender, heterosexual, male and Western perspectives (Nadal and Scharrón-del Río, 2021). From this perspective, psychotherapy can be understood as embedded within broader systems of power that hold the capacity to reproduce structural inequalities, harm and oppression for marginalised communities. This aligns with anti-oppressive and decolonial perspectives, which emphasise that without critically examining these underlying structures,

psychotherapy risks superficially acknowledging diversity whilst leaving harmful and exclusionary practices unchallenged and unchanged, ultimately limiting its capacity to provide equitable and effective therapeutic support for these communities (Grzanka and Miles, 2016; Timothy and Umana Garcia, 2020; Nadal and Scharrón-del Río, 2021; Udonsi, 2022; Turner, 2025).

Historically, research on minority identities has largely relied on singular, one-dimensional frameworks of analysis, examining social identities in isolation. This approach falsely assumes that oppression only occurs along one axis at a time, often prioritising one identity over others, and falsely conceptualising identity as fixed and discrete, despite recognition of its innate fluidity, and deeply relational and contextually embedded nature (Crenshaw, 1989; Collins, 2015; Leraas and Fehr, 2022). Such single-axis frameworks obscure the complex and unique forms of marginalisation experienced by individuals with multiple minoritised identities (Fattoracci, Revels-Macaliano and Huynh, 2021). An intersectional perspective is therefore essential for understanding how interlocking systems of oppression compound experiences of minority stress and individuals' experiences within mental health services and psychotherapy.

The Neurodiversity Paradigm and Neuroqueer Theory

The Neurodiversity Paradigm (NDP) provides an important conceptual framework as this seeks to resist, disrupt and shift power away from psychiatric pathologisation by challenging neuronormativity, reframing cognitive and neurological diversity as a natural form of human variation rather than pathologies requiring correction (Singer, 1999, 2017; Kapp, 2020; Chapman, 2021; Walker, 2021). In doing so, the NDP highlights how dominant structural norms of mental health can create barriers to neurodivergent people's wellbeing (Fletcher-Watson et al., 2019; Rosqvist, Chown and Stenning, 2020; Leadbitter et al., 2021). The NDP acknowledges how many difficulties experienced by neurodivergent people arise through interactions with social, institutional and environmental structures organised around neuronormative expectations (Kapp, 2020; Chapman, 2021; Walker, 2021). This echoes other critical and social justice movements which also challenge biological and psychiatric framings of social difference, including race, sexuality and gender (Yergeau, 2018; Smilges, 2023; White, 2024). Walker and Raymaker (2021) emphasise that

neurodiversity is analogous to other forms of human diversity, such as gender, sexuality and disability, arguing that each are shaped by comparable systems of oppression. Similarly, Botha and Gillespie-Lynch (2022) argue that the sustainability of the neurodiversity movement relies upon engagement with other social justice movements to ensure the intersections of multiple identities can be meaningfully acknowledged.

Neuroqueer theory integrates queer theory, intersectionality and the NDP to articulate the interconnected nature of neurodivergence, disability, gender and sexuality (Yergeau, 2018; Walker, 2021). It encourages the deconstruction of binary and hierarchical understandings of identity, instead conceptualising minds, bodies, gender and sexuality as fluid, relational and expansive forms of human diversity which are not rooted in pathology (Walker and Raymaker, 2022). Although neuroqueerness resists a singular definition, Stevens and Kirby (2025) identify three recurring themes within the literature: the inseparability and embodied nature of queerness and neurodivergence; recognition that gender, sexual and neurological norms are constructed through social and institutional power, and that neuroqueering is a creative and political practice which seeks to disrupt social norms.

Collectively, these perspectives provide a valuable framework for developing a more nuanced understanding of neuroqueer identities and experiences (Yergeau, 2018; Egner, 2019; Walker, 2021), and for critically examining how psychotherapy may reproduce cisheteronormative and neuronormative assumptions, thus reinforcing minority stress for neuroqueer people (PettyJohn, Tseng and Blow, 2020; Timothy and Umana Garcia, 2020; Arora et al., 2022). Highlighting these assumptions creates opportunities to address experiences of harm and facilitates a shift away from pathologising models of psychotherapy to more culturally responsive, affirmative, anti-oppressive forms of psychotherapeutic care for marginalised communities.

Mental Health Disparities and Minority Stress Theory

Minority Stress Theory has been widely applied to explain the disproportionate mental health disparities observed in queer and neurodivergent populations (Frost

and Meyer, 2023). In LGB populations, distal stressors such as discrimination, victimisation and microaggressions, combined with proximal stressors like identity concealment, rejection anticipation and internalised stigma, are consistently associated with elevated rates of anxiety, depression, suicidality, post-traumatic stress disorder and poorer psychological wellbeing (Dürrbaum and Sattler, 2020; Pachankis et al., 2020; Marchi et al., 2023; Flentje, Sunder and Tebber, 2025). Importantly, such disparities are not experienced equally across the LGBTQ+ community. Transgender and gender diverse populations report higher rates of minority stressors, poorer health and wellbeing and treatment outcomes compared to cis-gender sexual minority and heterosexual groups (Valentine and Shipherd, 2018; Price-Feeney, Green and Dorison, 2020; Berry et al., 2023; Marchi et al., 2023; Puckett et al., 2023). Further work highlights how disparities for individuals with identities beyond LGBT categories (e.g. queer, non-binary, pansexual, asexual) may be even larger, yet they remain comparatively underrepresented in research (Platt, Wolf and Scheitle, 2018; Borgogna et al., 2019; Lefevor et al., 2019; Klinger et al., 2024).

Comparable patterns in mental health disparities have been reported across neurodivergent populations (Lai et al., 2019; Kölves et al., 2021; Lai, 2023). Growing evidence suggests that poorer mental health is strongly associated with experiences of social exclusion, stigma, identity invalidation, and trauma arising from navigating neurotypical social structures, as well as internal experiences of masking (or ‘camouflaging’) and autistic burnout. These processes have been linked increased stress, exhaustion, anxiety, depression, suicidality and overall reduced wellbeing and mental health outcomes (Hull et al., 2017; Cassidy et al., 2018; Botha and Frost, 2020; Raymaker et al., 2020).

Emerging research has found individuals who are both LGBTQ+ and neurodivergent consistently report poorer mental and physical health than those with either a singular LGBTQ+ or neurodivergent identity (Hall et al., 2020), including higher rates of anxiety, depression and PTSD, alongside lower quality of life scores (Murphy et al., 2020; Strauss et al., 2021; McQuaid et al., 2023; Kroll et al., 2024; Napoli, 2025). Despite this growing evidence documenting poorer mental health outcomes among neuroqueer populations, little is known about how these challenges may shape experiences of psychotherapy. Such understanding is essential for informing psychotherapeutic practices that are responsive to the needs

of neuroqueer individuals and better equipped to address these mental health disparities.

Psychotherapy Experiences in Neurodivergent, LGBTQ+ and Neuroqueer Populations

Barriers to Psychotherapy

Despite recent advances in psychotherapeutic practice promoting affirmative and person-centred approaches when working with marginalised communities, evidence suggests queer and neurodivergent populations continue to experience significant barriers to accessing and engaging with therapy, even within services intended to be supportive. Across both LGBTQ+ and neurodivergent populations, access to psychotherapy is consistently shaped by structural constraints. For neurodivergent people, these include long wait times, prohibitive costs and having to meet crisis level thresholds for access to care (Cassidy et al., 2018; Tint and Weiss, 2018; Camm-Crosbie et al., 2019; Crane et al., 2019; Brede et al., 2022). Although LGBTQ+ literature appears to place greater emphasis on in-session therapy experiences, broader reviews indicate similar systemic barriers to accessing affirming support (Rees, Crown and Harris, 2021; Bishop, Crisp and Scholz, 2022; Mezzalira et al., 2025). Such experiences act as initial structural barriers which shape engagement before therapy has even begun.

Within psychotherapy itself, research across both populations' highlights therapeutic settings as contexts in which experiences of marginalisation can be reproduced. For LGBTQ+ clients, research consistently reports stigmatising experiences, including microaggressions rooted in cisheterosexist norms, identity rejection and the pathologisation of sexual and gender diversity by therapists (Mizock and Lundquist, 2016; Spengler, Miller and Spengler, 2016; McNamara and Wilson, 2020; Cronin, Pepping and Lyons, 2025). Such experiences often involve practitioners displaying discomfort when discussing gender and sexuality, reliance on heteronormative language, assumptions of heterosexuality and linking client's sexual or gender identity to their mental health difficulties in harmful ways (Mizock and Lundquist; McNamara and Wilson, 2020). These therapeutic experiences reflect broader

manifestations of cisheteronormativity identified across healthcare settings (Bartels et al., 2025). Notably, across groups an educational burden is often placed on clients in which they felt required to explain their identity in the absence of clinician knowledge, shifting therapeutic focus away from the clients presenting concerns (Rosati et al., 2022). Collectively, these dynamics contributed to clients feeling judged, dismissed, misunderstood and pressured to disclose their identity, which can negatively impact the therapeutic relationship and has been associated with increased likelihood of early termination and poorer therapeutic outcomes (Filice and Meyer, 2018; O'Shaughnessy and Speir, 2018; Leitch and McGeough, 2023; Crummy and Hansford, 2025; Mezzalira et al., 2025).

Similarly, comparable relational barriers are consistently reported in neurodivergent populations. Autistic individuals frequently describe feeling unsafe, judged, otherised, invalidated, dismissed, and misunderstood in the therapeutic space (Turville, 2024; Di Marco, Wood and Troop, 2025; Jones, Hamilton and Kargas, 2025). Such work also found that positive therapy experiences often relied on clients' ability to advocate for themselves and educate their therapist about their neurodivergence (Turville, 2024). This dynamic is argued to extend to other disabled populations, arising from a broader absence of critical self-reflection on ableism within training programs (Andoni, 2024).

Another related, recurring theme across both autistic and LGBTQ+ literature is the limited confidence and competence of therapists when working with these populations. Therapists frequently report low perceived competence a lack of autism or neurodivergent specific training, alongside widespread misconceptions and outdated beliefs about autism, despite openness to receiving training appearing high (Zerbo et al., 2015; Cooper, Loades and Russell, 2018; Maddox et al., 2020; Lipinski et al., 2022). Likewise, autistic clients consistently report limited clinician knowledge as a significant barrier to accessing appropriate mental health support (Adams et al., 2025; Di Marco, Wood and Troop, 2025). This lack of understanding has been found to contribute to insensitivity from therapists, along with stereotyping and diagnostic overshadowing, in which mental health concerns and personal challenges are dismissed, underestimated or misattributed to autism (Tint and Weiss, 2018; Crane et al., 2019; Adams and Young, 2021; Brede et al., 2022).

Within LGBT+ populations, comparable findings reporting a lack of clinician

competency has been consistently highlighted as barrier to the therapeutic process, negatively impacting therapeutic outcomes (Rees, Crown and Harris, 2021; Nowaskie and Najam, 2022; Bishop, Crisp and Scholz, 2022; Mezzalana et al., 2025). Relatedly, one systemic review found that although mental health practitioners generally held positive views towards LGBTQ+ people, many recognised their lack of knowledge and skills, and expressed a desire for further training (Cruciani et al., 2024). Consistent with this, lower levels of LGBTQ+ cultural competence have been associated with disparities in the quality of care provided to LGBT patients (Nowaskie and Roesler, 2022). This study also identified variation in competence across groups, with cisgender heterosexual male healthcare professionals demonstrating the lowest levels of competence, while LGBTQ+ professionals and cisgender heterosexual females were most competent. Such findings highlight the need for clinicians to critically reflect on and be attuned to their own attitudes, positionality, and intersectional identities, and how these may shape therapeutic interactions to prevent harm (Fuld and McKelvie, 2024).

Accommodating Neurodivergence

For neurodivergent populations, another significant challenge reported is the mismatch that arises between traditional therapeutic formats and neurodivergent communication styles, cognitive, and sensory processing differences, including challenges with interoception and emotional processing associated with alexithymia (Nicolaidis et al., 2015; Camm-Crosbie et al., 2019; Brede et al., 2022).

Neurodivergent people have noted the use of abstract or ambiguous language, reliance on metaphor, particular questioning styles and being given limited processing time can hinder their ability to engage with therapy, contributing to feelings of confusion, alienation and overwhelm (Maloret and Scott, 2018; Camm-Crosbie et al., 2019; Jones, Hamilton and Kargas, 2025). Similarly, autistic clients describe the challenges of speaking in session and with aspects of the session format, like when the therapeutic process is not properly explained (Camm-Crosbie et al., 2019; Mazurek et al., 2023). Together, such work highlights the importance of therapist awareness of these differences and the need to adapt the therapeutic frame. Despite this, a resistance to adapt services to consider neurodivergent

differences and needs has been consistently reported, with services continuing to be based around neurotypical norms that require neurodivergent people to mask distress or fit neurotypical expectations in order to access care (Adams and Young, 2021; Pantazakos and Vanaken, 2023). Overall, it appears clear that greater openness and consideration from therapists is necessary to accommodate for the needs of neurodivergent people, however implementation in practice remains inconsistent (Camm-Crosbie et al., 2019; Crane et al., 2019; Paynter, Sommer and Cook, 2025).

Facilitators of Psychotherapy

Although work which centres the voices of neurodivergent and queer populations has primarily identified barriers involved in therapy experiences, some facilitative factors have been noted. Across LGBTQ+ and neurodivergent populations, therapist acceptance, identity affirmation and cultural competence consistently emerge as central to the development of safe and effective therapeutic experiences.

Within autistic populations, positive therapeutic experiences are consistently associated with therapist's understanding of autism (whether through training or personal connection to autism), identity acceptance and taking a flexible, collaborative approach to adapt the therapeutic process to fit individual communication and sensory needs (Camm-Crosbie et al., 2019; Adams and Young, 2021; Mazurek et al., 2023; Pappagianopoulos et al., 2025). Such findings compliment research reporting that feeling heard, believed and understood supported engagement, self-advocacy and empowerment for neurodivergent people in therapy (Brede et al., 2022; Jones, Hamilton, and Kargas, 2025). Emerging quantitative evidence has also found autistic clients experienced improvements in symptoms of anxiety, depression and self-harm comparable to neurotypical clients when therapy incorporated identity validation, reasonable accommodations, and opportunities for identity exploration (Kroll et al., 2024).

Similarly, research in LGBTQ+ populations highlight that recognition of a person's social identity as well as clinical knowledge on the experiences of minority communities strengthens the therapeutic relationship (Orlowski et al., 2025). Relatedly, LGB clients perceived their therapists as more skilful when they created a

safe space, had completed cultural competence training and if they were also LGB (Bishop, Crisp and Scholz, 2022). Similarly, transgender and gender-diverse clients have been found to express a preference for therapists with shared identity, although their engagement in therapy primarily relied on feelings of trust, safety and perceived acceptance within the therapeutic relationship (Leitch and McGeough, 2023).

Collectively, such findings suggest that effective psychotherapy for both populations is facilitated not just by therapists' knowledge and competence, but by their ability to create safe, affirming and collaborative relationships in which client's identities and needs are acknowledged and respected.

Intersectional and Neuroqueer Psychotherapy Experiences

Within mental health services, intersectional research examining experiences of individuals with multiple marginalised identities also highlights inequalities in access to care, unmet health needs and unsatisfactory treatment experiences (Fagrell Trygg, Gustafsson and Månsdotter, 2019; Hempeler et al., 2024). Such work also replicates epistemic and relational barriers including concerns surrounding practitioner knowledge and experiences of microaggressions in therapeutic settings. However, such investigations focused on research on the intersection of race, sexuality, gender and mental health, not including ability or neurodivergence, limiting the applicability of such findings to neuroqueer populations.

Of the few investigations which have explored neuroqueer experiences generally, findings suggest that they may encounter distinct challenges relating to experiences of discrimination, social isolation, identity formation and interpersonal relationships (Hillier et al., 2020; Lewis et al., 2021). These experiences are likely to have implications for psychological wellbeing, however their application to therapeutic contexts remains underdeveloped in the literature.

Most recently, Gorski et al. (2026) explored the psychotherapy experiences of trans and gender expansive individuals with ADHD. This work identified key themes including identity masking, internalised stigma, gender identity development, executive functioning-related challenges, as well as therapist's ignorance about this intersection of identity. This work also highlighted the importance of affirming spaces on identity validation and engagement with therapy, aligning with previous work discussed. However, this research focused on a relatively specific neuroqueer

subpopulation, indicating the need for further investigations which include a broader range of neurodivergent and queer identities.

Overall, the ways in which minority stressors and overlapping systems of oppression may manifest in therapeutic settings for neuroqueer people remain underexplored. Given the potential for compounded experiences of marginalisation within therapeutic settings, such insights appear critical to the formulation of effective and affirming mental health support for neuroqueer populations.

Addressing Epistemic Injustice

Importantly, a disconnect between academic understanding and clinical practice appears evident, and the pathologisation of neurodivergence and centering of clinician perspectives remains widespread (Walker and Raymaker, 2021; Chapman and Carel, 2022; Pantazakos and Vanaken, 2023). Within existing literature, neurodivergent perspectives have often been excluded due to the stigmatising belief that their perspectives are less reliable than their neurotypical counterparts (Chellappa, 2023). Relatedly, research continues to misrepresent their experiences, as evidenced by the ongoing use of stereotypical, derogatory language within the literature (Botha and Cage, 2022; Botha, Hanlon and Williams, 2023). Further, most of the literature relating to neurodivergence discussed has disproportionately involved autistic white males and has failed to acknowledge other forms of neurodivergence despite encouragement to broaden the scope of investigations (Kalb et al., 2022; Fuld and McKelvie, 2024). Similarly, research in LGBTQ+ populations has disproportionately focused on LGB groups, particularly on white gay or bisexual men (O'Shaughnessy and Speir, 2018; McKinney, Desposito and Yoon, 2020). Although efforts to include transgender and gender diverse groups in research have grown in recent years, many investigations have often focused on binary transgender individuals (Mezzalana et al., 2025).

Consequently, large portions of both queer and neurodivergent populations remain underrepresented in the literature, particularly non-binary and gender diverse people and neurodivergent people who are not autistic or male, limiting the generalisability of the work discussed, our understanding of their experiences and how this may present in therapeutic contexts (Lovelace et al., 2021; Ghorbanian,

Aiello and Staples, 2022; Lemon, 2023; Kroll et al., 2024; Tudor-Sfetea and Topciu, 2024). Together, these research practices contribute to epistemic injustice through marginalising certain lived experiences whilst neglecting the socio-cultural contexts that shapes these, despite evidence that such contexts are central to psychological wellbeing (Pellicano and den Houting, 2022; White, 2024). Thus, research utilising methods which centre to voices of neuroqueer people appear necessary to address these epistemic gaps.

Conclusions

Evidently, both neurodivergent and LGBTQ+ populations experience significant barriers to accessing appropriate mental health support, including microaggressions, identity invalidation and pathologisation, along with a lack of clinician awareness regarding these identities (McNamara and Wilson, 2020; Bishop, Crisp and Scholz, 2022; Brede et al., 2022). Neurodivergent populations also report barriers related to therapists' resistance to accommodate sensory or communication differences, and an implicit expectation to mask neurodivergent traits to gain access to support (Adams and Young, 2021; Brede et al., 2022). Literature in this area has scarcely identified facilitative factors to the therapeutic process for both populations, however the importance of therapist competency and identity acceptance appear paramount in facilitating positive therapeutic experiences (Adams and Young, 2021; Mazurek et al., 2023; Cruciani et al., 2024).

Chapter 3: Methodology

Introduction

Building on the theoretical and empirical background provided in previous chapters, the present chapter will outline the philosophical underpinnings of this research and how this informed the chosen methodological approach. The relationship between these processes is depicted in Figure 1.

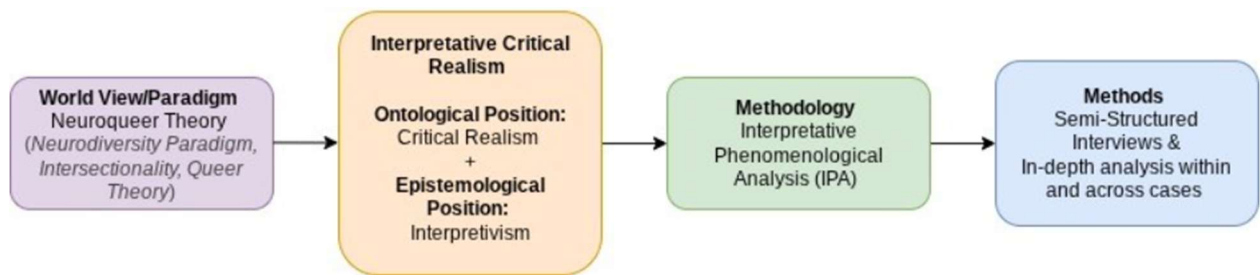


Figure 1. Relationship between the study’s worldview, ontology, epistemology, methodology, and methods.

Philosophical Framework: Ontological and Epistemological Positioning

Drawing upon Neuroqueer Theory, this study adopts an interpretive critical realist position (Bhaskar, 1979; Crotty, 1998; Willig, 2013). This position recognises that reality exists independently of individual perception and that our access to such realities is mediated through human interpretation. Ontologically, this research acknowledges that social structures such as cisheteronormativity and neuronormativity exist independently of a person’s awareness whilst possessing the ability to shape actions and meaning-making processes, which can consequently influence and reproduce such structures (Bhaskar, 1979; Archer, 1995).

Accordingly, critical realism has been argued to possess emancipatory potential by enabling researchers to uncover the mechanisms that reproduce inequalities within social systems while informing transformative change for marginalised populations (Stavrianos, 2025). Further, this research rejects positivist assumptions that reality and experience can be understood independently of meaning, identity, and context. Instead, this work aligns with the neuroqueer concept of *bodymind*, which conceptualises mental and physical processes as fundamentally inseparable and rejects Cartesian dualism of the mind and body (Price, 2015; Schalk, 2018; Walker,

2021). In this way, neurodivergence and queerness are understood as embodied ways of being which cannot be separated from their social, cultural, institutional and historical contexts and systems of power (Foucault, 1975/1995; Bhaskar, 1979, 1989; Willig, 2013; Butler, 1990).

Epistemologically, this study adopts an interpretative understanding of knowledge in which meaning is actively co-constructed through individuals' interactions with the world (Berger and Luckmann, 1966; Crotty, 1998; Willig, 2013). In this way, knowledge can be considered subjective and contextual, aligning with post-positivist assumptions that external reality can only be known imperfectly and probabilistically through interpretation (Guba and Lincoln, 1994; Madill, Jordan and Shirley, 2000).

This research explicitly acknowledges the philosophical tension between critical realist understandings of an independently existing reality and constructionist understandings that knowledge is socially mediated. This study argues that such positions are complementary, recognising that neuroqueer experiences are simultaneously shaped by social, relational, and institutional structures while also being constituted through interpretative processes of meaning-making.

In this way, therapy is not considered value-neutral but rather a socially embedded practice which is shaped by institutional norms surrounding mental health, gender, sexuality, and neurocognitive functioning. Therapy can therefore be understood as a space in which identities are negotiated and meaning is co-created, possessing the potential to reproduce or resist normative expectations and thus may function as a space of either affirmation or marginalisation for neuroqueer people (Foucault, 1975/1995). Thus, the integration of these perspectives is necessary to capture the multiplicity of neuroqueer experiences and ways of being in order to address the research question (Dwyer, 2022).

Methodology

This research adopted a qualitative design using Interpretative Phenomenological Analysis (IPA), a methodology grounded in phenomenology and hermeneutics (Husserl, 1913/1983; Heidegger, 1927/1962; Smith, Larkin and Flowers, 2021). IPA seeks to explore how individuals experience and make sense of their lived

experiences, viewing participants as active interpreters of their own experience (Crotty, 1998; Smith, Larkin and Flowers, 2021).

Related research has emphasised the utility of IPA for exploring complex, deeply personal and relational experiences such as psychotherapy experiences and aspects of personal identity like neurodivergence, gender and sexuality (Howard, Kastos and Gibson, 2019; MacLeod, 2019; Murray et al., 2023; Smith, Larkin and Flowers, 2021). Its focus on lived experience provides an framework to meaningfully examine how systems of power like cisheteronormativity and neuronormativity, and minority stressors, are experienced and how these may manifest within therapy (Meyer, 2003; Lopez and Willis, 2004; MacLeod, 2019). To add, IPA's idiographic focus and holistic view of the self allows detailed exploration of participants experiences in which multifaceted, fluid parts of identity can be acknowledged and respected (Smith, Larkin and Flowers, 2021; Walker, 2021). This is particularly relevant when working with neurodivergent and gender diverse populations who are often underrepresented or misrepresented within research (Chan and Farmer, 2017).

Importantly, IPA involves the double-hermeneutic process, recognising that knowledge and meaning are cocreated between the participant and researcher, thus the inevitable impact of the researcher's identities, experiences and positionality on the analytic process (Finlay, 2002; Smith, Larkin and Flowers, 2021). Shared understanding and lived experience between researchers and participants may facilitate rapport, interpretative sensitivity, and increase transparency within the research process (Finlay, 2002; Smith, Larkin and Flowers, 2021). This is particularly important when working with marginalised populations, as differences in lived experience between the researcher and participant may inadvertently contribute to misunderstandings or over-interpretation (Howard, Kastos and Gibson, 2019; Botha, Dibb and Frost, 2022).

Crucially, IPA enables participants' voices and lived experiences to remain central within the research process, aligning with broader calls for research involving marginalised communities to meaningfully include their perspectives in knowledge production (Fletcher-Watson et al., 2019; Dark, 2024; Fletcher-Watson et al., 2025). Such an approach enhances the relevance and impact of the present work, providing the opportunity to meaningfully address the epistemic injustice arising from the historical misrepresentation and pathologisation of neurodivergent and queer

populations (Aldridge, 2016; Fletcher-Watson et al., 2019; Legault, Bourdon and Poirier, 2021; Kaplan-Kahn and Caplan, 2023; Fletcher-Watson et al., 2025).

Other qualitative methodologies were considered for this research, including grounded theory, descriptive phenomenology and reflexive thematic analysis, due to their capacity to explore meaning, lived experience and social processes (Glaser and Strauss, 1967; Braun and Clarke, 2006, 2023; Charmaz, 2006; Giorgi, 2009; Willig, 2013). However, these approaches appear less aligned with the philosophical underpinnings and central aims of the current research. For example, grounded theory and thematic analysis primarily focus on identifying patterns across datasets, whilst descriptive phenomenological approaches seek to describe the qualities of experience. Although interpretative elements are present across these approaches, IPA provides more explicit idiographic focus on how individuals interpret and make sense of their experiences (Charmaz, 2006; Giorgi, 2009; Smith, Larkin and Flowers, 2021; Braun and Clark, 2023).

Furthermore, while reflexivity is increasingly recognised across qualitative methodologies, the level of engagement with the researcher's positionality varies considerably, often appearing superficial or performative (Folkes, 2023; King, 2024; Strunel and Cordoba, 2025). Whilst reflexive thematic analysis explicitly acknowledges researcher subjectivity, IPA offers a more established and structured way to engage with this through the double-hermeneutic process (Smith, Larkin and Flowers, 2021; Braun and Clarke, 2023). Collectively, these considerations indicate that IPA was the most appropriate methodology for achieving the idiographic and interpretive depth required for the present research, whilst attending to subjective lived experiences and researcher positionality.

Researcher Positionality and Reflexivity

The researcher acknowledges their role as an interpretative agent in the co-construction meaning with participants, and how their own identities, experiences, and assumptions may influence data collection, analysis, and interpretation (Finlay, 2002; Willig, 2013). The researcher is white and from a middle-class background. They identify as neuroqueer, possessing autistic and ADHD traits, and as pansexual,

queer and cis-gender. The researcher is also a trainee psychotherapist with experience as both a neuroqueer client and therapist in therapy.

The researcher recognises that these identities and personal lived experiences motivated their selection of the research topic and shaped the interpretative lens through which the research was conducted. Whilst this may have facilitated understanding and nuanced interpretation, this also required ongoing critical reflection throughout the analytic process. Reflexivity was maintained using a reflective journal in which the researcher documented personal reflections, monitored their interpretative process, and recorded analytic decisions made.

Rigour and Trustworthiness

To support the rigour and trustworthiness of this research, Yardley's (2008, 2017) four principles; sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance, were considered throughout the research process. Additionally, the markers of high-quality IPA research proposed by Nizza, Farr and Smith (2021) informed the interpretative process.

Ethical Considerations

This research received ethical approval by the University of Wales Trinity Saint David's (UWTSD) Research Ethics Committee on 12 November 2025. This research is bound by the ethical guidelines of the British Psychological Society (BPS, 2021) and the British Association for Counselling and Psychology (BACP, 2018, 2019).

In accordance with these guidelines, all participants were provided with complete information about the study to provide fully informed consent. This included details about the nature and purpose of the research, what their participation would involve, the confidential nature and handling of their data, and how this would be stored and used. Participants were informed of their right to withdraw from the study at any stage without penalty. Written informed consent was obtained prior to data collection, with verbal consent captured at the start of each interview.

Due to the sensitive nature of the research, which involved participants with

multiple marginalised identities reflecting on potentially sensitive or distressing therapeutic experiences, several measures were implemented to support participant wellbeing, psychological safety and accessibility. Such measures align with trauma-informed and person-centred approaches, along with recommendations for neuroinclusive and ethically responsive research involving marginalised populations (Alessi and Khan, 2023; Dark, 2024). The actions taken before, during and after data collection, and their rationale are outlined in Tables 1 – 3.

Table 1. Ethical Actions Prior Interviews

Actions Taken	Rationale
Study materials and design were reviewed by an advisory group	To ensure clarity, accessibility, cultural sensitivity and appropriateness of study design and materials. To identify any aspects which might be considered offensive, inaccessible, or reflect unintended bias or exclusion, such as ableist language or outdated terminology (Bottema-Beutel et al., 2021; Monk et al., 2022; Dark, 2024).
Participants were given interviews schedules & procedures in advance	To minimise stress and/or uncertainty about what participating in the interview will be like and to enable preparation/pre-processing of questions (Kaplan-Kahn and Caplan, 2023; Hedlund et al., 2026).
Option in participant criteria questionnaire to provide preferred pronouns	To ensure respect of participant identity and prevent misgendering
Option in participant criteria questionnaire to request any reasonable adjustments (e.g. visual aids, environmental considerations, camera off)	To enhance accessibility; provide to opportunity for sensory needs to be acknowledged and ensure participants can engage with the interview process comfortably
Within the information sheet, participants were encouraged to reflect on the personal ways in which they could prepare before, during and after the interviews. Examples of self care suggestions were provided.	To support participant comfort, psychological and emotional safety throughout the process
Researcher positionality, identity and experience were provided in information sheet	To manage power imbalances and increase knowledge equity between researcher and participant (Kaplan-Kahn and Caplan, 2023). Participant awareness of shared identity can increase comfort and encourage more authentic responses (Kaplan-Kahn and Caplan, 2023).

Table 2. Ethical Actions During Interviews

Actions Taken	Rationale
Interviews were conducted online	To minimise cognitive demands of traveling to a novel, in-person location (Crane et al., 2023; Dark, 2024).
Flexibility with interview time-frame	The meeting time was set to 1.5 hours to ensure participants didn't feel under pressure or rushed, and to ensure they were able to express everything they wanted to.
Interviews were conducted by the principal researcher who is a trainee psychotherapist and has had therapeutic experience working in a neuro-inclusive, trauma-informed, LGBTQ+ -affirming manner.	To ensure the creation of a safe, respectful and non-judgemental interview environment & sensitive topics, and potential distress to be safely managed.
Prioritising participant autonomy; that participants did not have to answer any questions they didn't want to, that they could take breaks at any point and leave at any time if they began to feel uncomfortable, overwhelmed or distressed in any way.	To protect participant wellbeing by reducing the risk of distress, overwhelm or discomfort during the interview. To minimise potential power imbalances between the researcher and participant.
Discussed interview procedure and participants preferred response style (e.g. structured, intuitive, associative)	To accommodate neurodivergent thinking and information processing styles
Discussing the possibility of 'getting off track'	Assuring participants that the researcher will bear the responsibility of ensuring that all questions have been answered and linking back to questions when needed in order to reduce mental load and anxiety for participants (Hedlund et al., 2026).
Encouraging participants intuitive behaviours and attending to present needs (e.g. stimming/movement, silences, taking breaks when needed)	To encourage authentic expression, remove the need for masking behaviours and to reduce the impact of social and sensory demands throughout the interview process (North, 2021; Dark, 2024; Hedlund et al., 2026).
Encouraged to request more clarity, prompts and/or rewording of questions when needed	To ensure understanding about what is being asked
Asked for preferred pseudonym or opinion on this, e.g. something feminine/masculine/gender neutral.	To ensure participants are accurately represented To prevent mismatch between pseudonyms used and gender identity of participants in order to minimise harm.
Participants were debriefed and a cooling off period was offered	To ensure participants felt comfortable and that no harm was caused To provide support and additional processing of topics discussed if needed
All necessary information was provided in written format and verbally	To accommodate for differing processing styles

Table 3. Ethical Actions After Interviews

Actions Taken	Rationale
Participants were able to contact the researcher up to 2 weeks after interview to provide any additional comments or feedback	To accommodate for post-processing insight and delayed processing styles (Kaplan-Kahn and Caplan, 2023) To encourage feedback and mentality of open communication between researcher and participants (Kaplan-Kahn and Caplan, 2023).
A debrief document was sent reminding participants of the purpose of the research, how their data would be used and the next steps of the research.	To ensure participant understanding, transparency and certainty of the research process and what to expect after data collection.
A support & signposting document was sent to participants.	To ensure participants had access to relevant resources and support after interviews.
Pseudonyms were used for participants and any contextually identifiable information will be removed	To ensure confidentiality and security.
Allowed data withdrawal up to one month after interview	To provide transparency and respect participant autonomy. To enable time for reflection after participation and to manage any potential distress or regret for participation.

Methods

Participant Recruitment

Consistent with IPA (Smith, Flowers and Larkin, 2021) participants were recruited using purposive sampling strategies. This involved contacting relevant neurodivergent and LGBTQIA+ community organisations, online support groups, and social media platforms. Snowball sampling was also used to broaden the reach to participants who weren't easily accessible through formal networks. Participants were recruited across a range of LGBTQ+ identities to support a more holistic understanding of the phenomenon of neuroqueerness and to avoid the exclusion of less represented groups, consistent with purposive sampling approaches that seek diverse and information-rich cases (Callary, Rathwell and Young, 2015).

Six participants were included and selected based on the following inclusion criteria:

- 1) They self-identify as *neurodivergent* and/or have a clinical diagnosis of a specific neurotype, such as Autism, ADHD, Dyslexia, Dyspraxia etc.
- 2) They self-identify as *queer* regarding their gender identity and/or sexuality
- 3) They have been a client in psychotherapy for at least six weeks or more
- 4) They are over the age of 18

All potential participants completed a recruitment questionnaire to confirm eligibility. This included definitions of the terms *neurodivergent*, *queer* and *neuroqueer*. Participants were invited to indicate if they personally identified with and used these terms to define themselves. Participant demographic information collected is presented in Table 4.

Participants were recruited in order of expression of interest, provided they completed the required documentation and met the inclusion criteria, until the intended sample size was reached.

Table 4. Participant Demographics

Participant	Age	Pronouns	Self-Described Identity	Description of Therapy	Length of Therapy	When Therapy Occurred
Kit	26	They/Them	Neurodivergent (Autistic), Queer (Non-binary, Bisexual/Pansexual), Neuroqueer	Blended approach of CBT and psychotherapy with minor ACT elements	9 sessions over 6 months	0-1 years ago
Daisy	45	She/Her	Neurodivergent (Autism, ADHD [inattentive], Rejective Sensitivity Dysphoria (RSD), Dyslexia, Dyspraxia, Complex Post Traumatic Stress Disorder, Generalised Anxiety Disorder), Queer (Transgender), Neuroqueer	Compassion Based Trauma Therapy	Once a week for 18 months, then bi-weekly	2+ years ago
Osian	57	She/They	Neurodivergent (Autistic), Queer (Asexual)	Person-centred & CBT	'A long time'	2+ years ago
Ash	23	They/Them	Neurodivergent (ASD, level 1), Queer (Non-binary, Bisexual), Neuroqueer	Counselling/Talk therapy	For the last 10 years, ranging from monthly to weekly appointments	0 - 1 years ago
Sam	37	They/Them	Neurodivergent (Diagnosed Autistic with ADHD traits), Queer (Gender Queer/Non-binary, Bisexual), Neuroqueer	CBT & Integrative	For approximately one year across multiple settings	0 - 1 years ago
Kai	22	They/She	Neurodivergent (Autistic traits), Queer (Non-binary, Lesbian), Neuroqueer	Habit Reversal Therapy, Art Focused grief counselling, CBT, Integrative Person-Centred, Non-directive Experiential	For multiple years	0 - 1 years ago

Procedure

Advisory Group

An advisory group was implemented in line with recommendations for neuroinclusive research and research involving minority populations, which emphasise the importance of meaningfully involving individuals with relevant lived experience at all stages of the process whenever possible (Dark, 2024; Fletcher-Watson et al., 2025).

Three individuals with relevant lived experience of neurodivergence and/or queerness (see Table 5 for demographic information) were recruited via community networks. These individuals did not form part of the main study sample but played a consultative role. Prior to meeting, participants were provided with an information sheet, consent form, draft study materials, and after the meeting, a debrief sheet (Appendices 1-3).

The group met online via Microsoft teams with the researcher to review and provide feedback about the study design and materials. This included interview questions, supporting refinement of the questions, which reduced the need for a separate pilot interview. Discussion focus was placed on clarity, accessibility and identifying aspects of the materials that may be considered culturally insensitive, offensive or

reflect unintended bias or exclusion (Bottema-Beutel et al., 2021; Monk, Whitehouse and Waddington, 2022; Dark, 2024).

Feedback was recorded by the researcher during the meeting and informed three key amendments to the study materials. First, the information sheet and covering letter were merged to reduce repetition and improve engagement with key information. Second, information regarding data storage and usage was added to the debrief sheet, reflecting advisors' preference to be reminded of this following participation, rather than having to revisit the original information sheet. Third, additional signposting to complaints procedures and advocacy services was included within the support and signposting document to support participants if their interview highlighted concerns about their therapeutic experiences.

Table 5. Advisory Group Member Demographics

Advisory Group Member	Self Described Identity	Therapy Experience
1	Neurodivergent with Autistic traits	Yes
2	Neurodivergent & Dyspraxic	Yes
3	Neurodivergent & AuDHD	Yes

Data Collection

Data were collected through one-to-one, semi-structured interviews conducted online via Microsoft Teams, lasting approximately one hour each.

Prior to interviews, participants were provided with the information sheet, participant recruitment questionnaire and consent form (Appendices 4-6), to ensure they met the inclusion criteria, understood what their participation involved and to provide fully informed consent. An interview schedule was subsequently shared, consisting of eight open-ended questions informed by an initial literature review of therapeutic experiences in neuroqueer populations (Appendix 7). The schedule was intended to provide a broad structure to the interview process while allowing flexibility to explore participants' individual experiences.

Upon attendance of the interview, participants were reminded of the

information sheet, given the opportunity to ask any questions and verbally confirmed consent for the interview to be recorded and transcribed. Any necessary accommodations were discussed and implemented where possible. After answering all questions, participants were debriefed and their wellbeing was supported before ending the interview. Afterwards, participants were sent a debrief document and signposting and support document (Appendices 8-9).

Data Analysis

Data were recorded and transcribed using Microsoft Teams' transcription feature. Transcripts were reviewed and corrected against the original recordings prior to analysis to support accuracy. Data were then analysed in line with the six stages of IPA outlined by Smith, Larkin and Flowers (2021).

First, transcripts were read repeatedly to facilitate immersion within the data (Stage 1). Relevant extracts were then transferred into an Excel spreadsheet, where initial notes were made (Stage 2). This involved line-by-line analysis in which initial linguistic, descriptive, and conceptual comments were made. Extracts were subsequently developed into emergent themes (Stage 3). These were reviewed against transcripts, and additional notes were made to identify connections between emergent themes. Emergent themes were grouped into superordinate and subordinate personal experiential themes (PETs), along with brief descriptions to consolidate experiential meaning (Stage 4). Stages 1-4 were repeated for each transcript (Stage 5). Finally, Stage 6 involved considering convergent and divergent patterns across all individual case PETs to develop group experiential themes (GETs).

Chapter 4: Findings

Themes that were endorsed by more than half of the participants are presented below. The relationship between PETs and GETs is represented in Figures 2 - 4.

1. NAVIGATING NEURONORMATIVE THERAPEUTIC FRAMEWORKS: THE UNEQUAL BURDEN OF ENGAGING IN THERAPY

This superordinate theme captures how therapy was commonly experienced as constrained by neuronormative features of the therapeutic frame. Consistently, participants described their therapy experiences as fundamentally shaped by their neurodivergence and being faced with the task of having to navigate neurotypical practices and expectations of engagement. As a result, an unequal amount of effort appeared to be required for participants to engage in therapy.

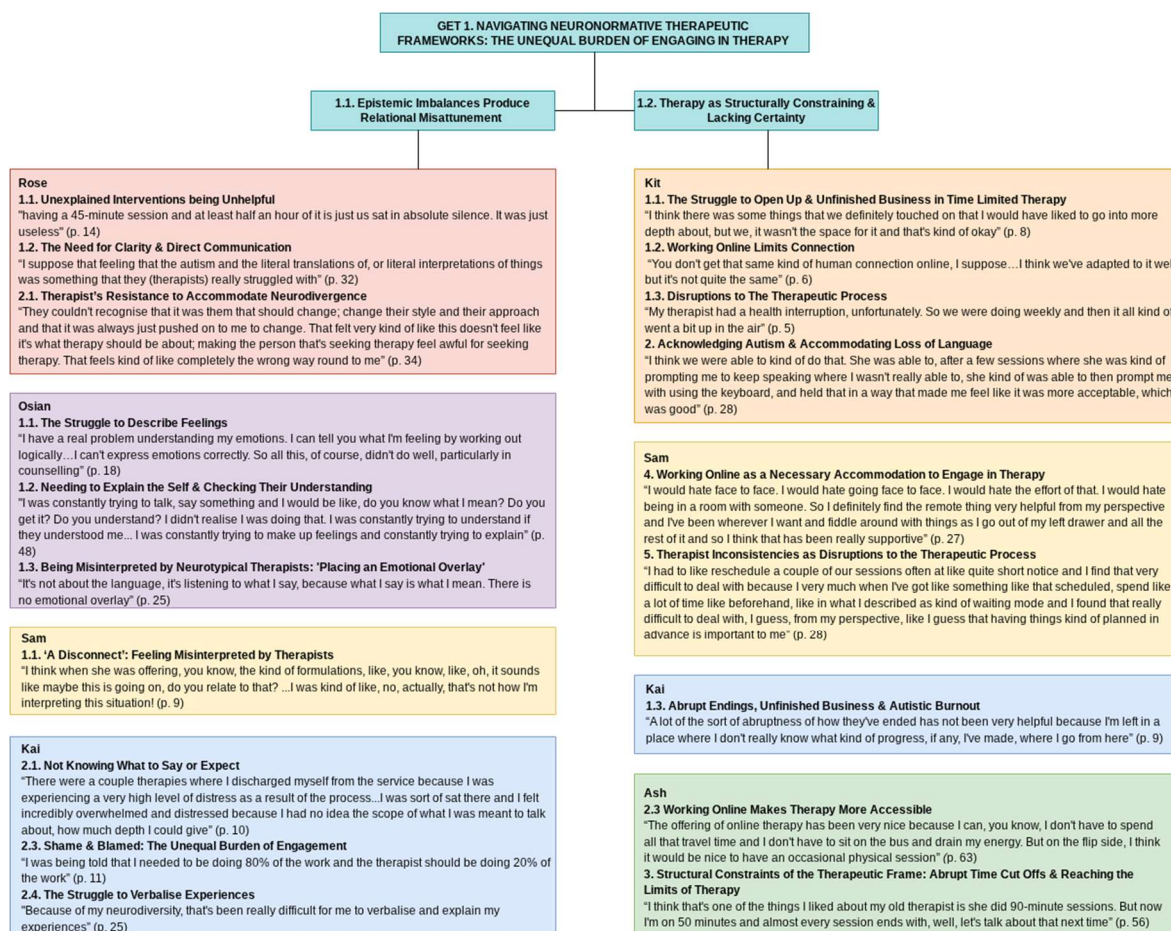


Figure 2. GET 1 formulation from PETs

1.1. Epistemic Imbalances Produce Relational Misattunement

This subordinate theme describes how participants experienced an imbalance or mismatch in knowledge, understanding or methods of communication with their therapist, signifying an epistemic imbalance. These mismatches acted as relational barriers, creating misattunement within the therapeutic relationship.

Some participants described feeling uncertain and uninformed about what to expect, say or regarding the purpose of certain techniques used.

I was sort of sat there and I felt incredibly overwhelmed and distressed because I had no idea the scope of what I was meant to talk about, how much depth I could give. (Kai, p. 10)

They would ask me a question and it was a relatively closed question to my mind. And so I answered the relatively closed question. And then I sat there, and they sat there and didn't say anything... It was just useless and it made me feel like there was some kind of deficit in me because the counselling just wasn't working. (Daisy, p. 14-15)

Such accounts reflect a sense of stagnancy and lack of communication between participants and their therapists, demonstrating how a lack of clarity, transparency or shared understanding about the therapeutic process contributed to feelings of confusion, discomfort, shame and significant distress, which lead to their disengagement.

Consequently, the importance of having such clarity appeared paramount for both Kai and Daisy: *"I need a lot of clarity in order to feel safe and understood and I've very often lacked that"* (Kai, p. 29); *"Apparently people have said that was them using silence as a tool in therapy. I'm like, it's a pretty ineffective tool if I don't know what they want from it"* (Daisy, p. 14). Daisy concluded *"I suppose that feeling that the autism and the literal translations or literal interpretations of things was something that they [therapists] really struggled with"* (p. 32).

For others, similar communication mismatches were apparent. Sam stated *"I think when she was offering...formulations, like, oh, it sounds like maybe this is going on, do you relate to that?...I was kind of like, no, actually, that's not how I'm interpreting this situation"* (p. 9). Sam concluded: *"It wasn't affirming or inclusive, it was just that there was a kind of disconnect, I guess"* (p. 10). Similarly, Osian explained: *"It's not about the language, it's listening to what I say, because what I say is what I mean. There is no emotional overlay"* (p. 25). For Kai, it was about the

language: *"there was so much vagueness with a lot of the therapy I had... like the language that was used, for example, low mood, felt so like diminutive and confusing because it didn't match what I was experiencing"* (p. 12). Together, these accounts illustrate how therapists' interpretations and language used frequently failed to reflect participants internal lived experiences which left them feeling confused, unheard, misunderstood and fundamentally unseen within the therapeutic space.

Participants difficulties with verbalising their experiences and alexithymia appeared to compound such misunderstandings and experiences of distress.

It definitely makes me flare up with sort of forms of autistic burnout as well, like after therapy or that has felt really difficult because I haven't been understood or I didn't know what to expect. Like I find it then very hard to speak in that session or to properly look after myself afterwards. (Kai, p. 41)

Similarly, Osian reflected on their difficulties with understanding and expressing emotions: *"I would be like, do you know what I mean? Do you get it? Do you understand? I didn't realise I was doing that. I was constantly trying to understand if they understood me"* (p. 21); *"I was constantly trying to make up feelings and constantly trying to explain"* (p. 48). These accounts highlight the continuous cognitive and emotional effort required of participants to attempt to accurately communicate their experiences, feel understood and prevent misunderstanding within the therapeutic space. Likewise, demonstrating how some felt pressure to engage inauthentically to meet therapist's expectations surrounding emotional expression.

Additionally, some participants experienced this effort as imbalanced, with the burden of achieving shared understanding and engagement placed primarily on them as the client. This dynamic appeared to be normalised and reinforced by therapists. Kai explained: *"I was being told that I needed to be doing 80% of the work and the therapist should be doing 20%"* (p. 11). Similarly, Daisy described the perceived attitude held by therapists: *'We don't need to change. We've done the training. We are trained therapists, so if you're not getting something out of this, it's because you're doing it wrong'* (p. 35). For Kai, voicing their concerns about the suitability of the therapy resulted in their experience being dismissed and efforts to engage being questioned: *"Can you just try? Can you just put your reservations to the side, put it in a box and put it to the side and just try and engage? and then when*

I haven't, it's been like, 'did not engage with treatment' as if it's again my fault" (p. 43). For both Kai and Daisy repeated experiencing of such barriers led them to feel blamed for their struggles to engage, ashamed and questioning the utility of therapy entirely: *'maybe there's something inherently wrong with me if I keep going through all these treatments, but there's no real sign of me feeling better" (Kai, p. 9).*

You do kind of think it must be me that's the problem because I've been now to several of these people and they're all treating me the same and they're all treating me as the problem and that doesn't feel nice and it doesn't feel friendly or useful. So why am I subjecting myself to these people constantly? (Daisy p. 27)

Collectively, these findings demonstrate how participants' neurodivergence was often insufficiently acknowledged, with conventional therapeutic practices and expectations appearing at odds with core facets of neurodivergent experience like alexithymia, communication differences and difficulties with verbalising experiences. This made attempts to engage significantly more cognitively and emotionally demanding, contributing to relational misattunement, reduced authentic engagement and limited therapeutic efficacy. Crucially, therapists appeared to hold greater knowledge and power within the therapeutic process whilst expecting unequal effort from participants to engage, providing limited clarity or transparency and demonstrating little motivation to address this imbalance. This suggests an oppressive mechanism through which epistemic imbalances were maintained by therapists to the detriment of their clients.

1.2. Therapy as Structurally Constraining and Lacking Certainty

This subordinate theme reflects how therapy was frequently experienced as shaped by structural and practical features of the therapeutic frame, which appeared to impact certainty, safety, and therapeutic depth.

For some participants the standard 50-minute session length was experienced as restrictive, appearing to interrupt their natural style of information processing. Ash described the ending of sessions: *"the time cut offs can be very abrupt" (p. 55)* and compared this to past experiences *"I think that's one of the things I liked about my old therapist is she did 90-minute sessions. But now I'm on 50 minutes and almost every session ends with, let's talk about that next time" (p. 56).*

To add, the impact of attending therapy through an online medium was noted by participants.

I would hate face to face. I would hate going face to face. I would hate the effort of that. I would hate being in a room with someone. So I definitely find the remote thing very helpful from my perspective and I've been wherever I want and I fiddle around with things as I go out of my left drawer...so I think that has been really supportive. (Sam, p. 27)

The offering of online therapy has been very nice because I can, you know, I don't have to spend all that travel time and I don't have to sit on the bus and drain my energy. But on the flip side, I think it would be nice to have an occasional physical session. (Ash, p. 63)

Such accounts highlight how online therapy enhanced accessibility by creating conditions that reduced cognitive load, promoted familiarity and comfort, provided opportunities for more authentic engagement, including stimming behaviours. Likewise, the importance of flexibility and choice in the mode of service delivery.

Relatedly, both Kit and Ash described the benefit of being able to use the text chat function online to support their engagement and accommodate their loss of language in sessions, however the application of such accommodations appeared inconsistent:

I think we were able to kind of do that. She was able to, after a few sessions where she was kind of prompting me to keep speaking where I wasn't really able to, she kind of was able to then prompt me with using the keyboard, and held that in a way that made me feel like it was more acceptable, which was good. (Kit, p. 28)

Despite these advantages, Kit also described working online as '*quite tricky*' (p. 6), in which the quality of connection that could be achieved felt diminished; "*You don't get that same kind of human connection online, I suppose...I think we've adapted to it well, but it's not quite the same*" (p. 6). Such accounts demonstrate how for some working online facilitated therapeutic engagement but for others acted as a barrier to the therapeutic relationship.

Practically, unexpected changes appeared to disrupt the therapeutic process. Kit described how their weekly sessions "*all kind of went a bit up in the air*" (p. 5) due to their therapists unexpected health interruption. Kai described a similar situation: "*my private therapist who I had been seeing for a year, had a medical emergency and I had to just stop seeing him with no sort of warning*" (p. 8). Further, Sam reflected on the impact of having several of their sessions rescheduled at short notice:

When I've got like something like that scheduled, I spend like a lot of time like beforehand, in what I described as kind of 'waiting mode' and I found that really difficult to deal with...having things kind of planned in advance is important to me. (Sam, p. 28)

Such accounts evidence how these disruptions and scheduling inconsistencies appeared to introduce instability into the therapeutic process, creating uncertainty, discomfort, and for some meaning additional time and energy spent anticipating the session had been wasted.

Generally, therapy appeared to be experienced as somewhat fragmented and unpredictable, particularly within time-limited programmes which were '*not really enough to shift quite closely held and long-term habits*' (Kit, p. 13). For both Kit and Kai, there remained unfinished business. Kit stated: "*I think there was some things that we definitely touched on that I would have liked to go into more depth about, but it wasn't the space for it and that's kind of okay*" (p. 8). Likewise, Kai described their therapeutic experiences as being "*cut short or stopped dramatically*" (p. 8), "*with no concrete resolved ending*" (p. 9). They further concluded: "*A lot of the sort of abruptness of how they've ended has not been very helpful because I'm left in a place where I don't really know what kind of progress, if any, I've made, where I go from here*" (p. 9). This further suggests a lack of continuity of care, certainty or resolution to the therapeutic process.

Collectively, accounts illustrate how standard features of the therapeutic frame, including session length and time-limited therapies, alongside unexpected changes and scheduling inconsistencies undermined predictability and continuity within the therapeutic process. These features appeared to conflict with neurodivergent processing styles and need for consistency and certainty, limiting therapeutic depth and leaving many participants feeling uncertain, dissatisfied and with needs unmet. Additionally, online therapy was experienced as both facilitating and constraining to the therapeutic process. Although it represented a necessary accommodation for some participants, others felt this constrained the development of the therapeutic relationship.

2. “A PART OF ME NEEDS TO KEEP STAYING HIDDEN”: NEGOTIATING NEUROQUEER IDENTITY AND SAFETY

This superordinate theme reflects participants experiences of having to negotiate parts of their neuroqueerness in therapy; the extent to which this was disclosed, acknowledged and what happened as a result.

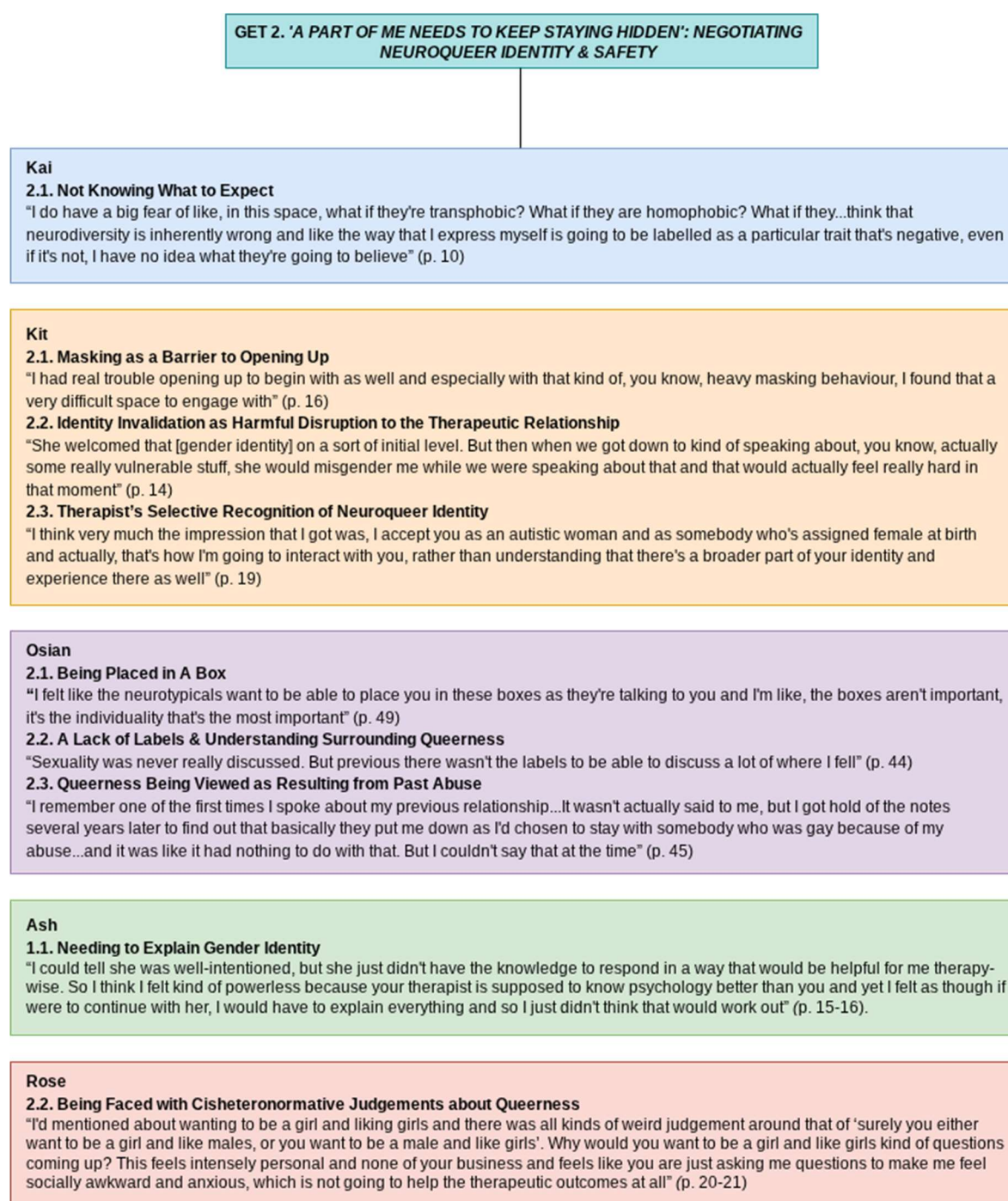


Figure 3. GET 2 formulation from PETs

Some participants explained entering therapy not feeling safe enough to disclose their identity, fearing identity stigma, invalidation or pathologisation.

I do have a big fear of like, in this space, what if they're transphobic? What if they are homophobic? What if they...think that neurodiversity is inherently wrong and like the way that I express myself is going to be labelled as a particular trait that's negative, even if it's not, I have no idea what they're going to believe. (Kai, p. 10)

Likewise, Osian explained how *'there was a lot of things I couldn't really say'* (p. 20) regarding their queerness; *"Sexuality was never really discussed"* (p. 43) and they were *"careful, I think, about stepping outside the social normalities"* (p. 44). Although they felt this was because *"previously there wasn't the labels to be able to discuss a lot of where I fell"* (p. 44). For Kit, their autistic identity was disclosed, acknowledged and their therapy was extended: *"I had real trouble opening up to begin with as well and especially with that kind of, you know, heavy masking behaviour, I found that a very difficult space to engage with"* (p. 16). Such accounts demonstrate how both identity concealment and masking were implemented as protective strategies to manage personal safety within the therapeutic space, whilst simultaneously acting as a barrier to authentic engagement.

Participants also linked such experiences to therapist's lack of competence surrounding their neuroqueerness. For example, Kit explained their therapist's awareness of masking: *"I think she was kind of aware of it, but not necessarily of the impact that it might have on our sessions in terms of kind of digging a little bit deeper"* (p. 29). Similarly, Kai expressed: *"people aren't trained or don't have the experience knowing what to say to someone who has the heaviness of queer trauma or the confusion of being neurodivergent trying to understand emotion"* (p. 27). Evidently, this lack of competence limited shared understanding and the level of therapeutic depth that could be achieved.

Further, Ash reflected on their therapist's response to disclosing their gender identity:

I could tell she was well-intentioned, but she just didn't have the knowledge to respond in a way that would be helpful for me therapy-wise. So I think I felt kind of powerless because your therapist is supposed to know psychology better than you and yet I felt as though if I were to continue with her, I would have to explain everything and so I just didn't think that would work out. (p. 15-16)

This lack of knowledge about queerness appeared to shift the power dynamics and expectations of the therapeutic relationship in a way that would have been unhelpful

for Ash, requiring them to educate their therapist, which resulted in them ending the therapy entirely. Kai experienced a similar pressure:

When you talk to a professional who maybe hasn't got the most training or experience or knowledge of queerness or neurodiversity, you're almost put into a position where you have to educate that person and there's very little room for nuance when you're educating. (p. 23)

Relatedly, Daisy described being faced with cisheteronormative judgements when discussing their queerness:

I'd mentioned about wanting to be a girl and liking girls and there was all kinds of weird judgement around that of 'surely you either want to be a girl and like males, or you want to be a male and like girls'. Why would you want to be a girl and like girls? kind of questions coming up. This feels intensely personal and none of your business and feels like you are just asking me questions to make me feel socially awkward and anxious, which is not going to help the therapeutic outcomes at all. (p. 20-21)

Evidently, such questions were perceived as harmful, intrusive and unhelpful to the therapeutic process, creating significant discomfort for Daisy. For Osian, disclosing their queer relationship also appeared to result in harm, in which stigmatising misinterpretations were made by their therapist without consulting them:

I remember one of the first times I spoke about my previous relationship...It wasn't actually said to me, but I got hold of the notes several years later to find out that basically they put me down as I'd chosen to stay with somebody who was gay because of my abuse...and it was like it had nothing to do with that. But I couldn't say that at the time. (p. 45)

Additionally, For Kit, their therapist's lack of competency surrounding queerness meant their neuroqueerness was selectively and superficially acknowledged. Their therapist appeared more comfortable working with other parts of their identity, like their autism and faith, rather than their queerness, despite its relevance to Kit's therapeutic goals. Kit explained how they "*welcomed that [gender identity] on a sort of initial level*" (p, 14) but when speaking about "*some really vulnerable stuff, she would misgender me...and that would actually feel really hard in that moment*" (p. 14). They further reflected:

As somebody who masks and I recognise that in myself, it's already really hard for me to bring everything of myself to that session. So feeling that there's a

part of me that actually needs to keep staying hidden was actually quite difficult and damaging, especially to that relationship of therapist and attendee, that's not right. (p. 21)

Despite their therapist's initial acceptance of Kit's gender identity, this could not be meaningfully translated into practice and resulted in significant harm and rupture within the therapeutic relationship.

I think very much the impression that I got was, I accept you as an autistic woman and as somebody who's assigned female at birth and actually, that's how I'm going to interact with you, rather than understanding that there's a broader part of your identity and experience there as well. (Kit, p. 19).

Such experience evokes the sense that Kit had little choice or control over how they were perceived; despite disclosing their identity, their therapist ultimately determined its importance within the therapeutic space. In a similar way, Osian described: *"They want to be able to place you in these boxes as they're talking to you"* (p. 49). Both experiences reflect a pressure to fit their identity into simplified, more easily digestible terms to align with therapist's normative frame of reference and level of understanding. Therapists appeared unable to holistically engage with neuroqueer identities, approaching this as something which required clearly defining and separating out.

Together, these accounts evidence how participants used identity concealment and masking to manage personal safety within therapy, although these strategies acted as a barrier to authentic expression. When neuroqueer identities were disclosed, therapists' lack of competency shaped interactions, determining the extent to which these were acknowledged. This resulted in significant experiences of harm, including misgendering, intrusive questioning about queerness based on cisheteronormative assumptions, and stigmatising misattributions linking queerness to experiences of abuse. These experiences appeared to exacerbate feelings of unsafety and create ruptures within the therapeutic relationship.

3. NEUROQUEER UNDERSTANDING AND ACCOMMODATION AS TRANSFORMATIVE TO THE THERAPEUTIC PROCESS

This theme captures features of therapeutic experiences which enabled participants to meaningfully engage in therapy and perceive this as safe and helpful. In contrast

to earlier unhelpful and harmful experiences, most participants described transformative therapeutic experiences when working with neurodivergent and/or queer-affirming therapists.

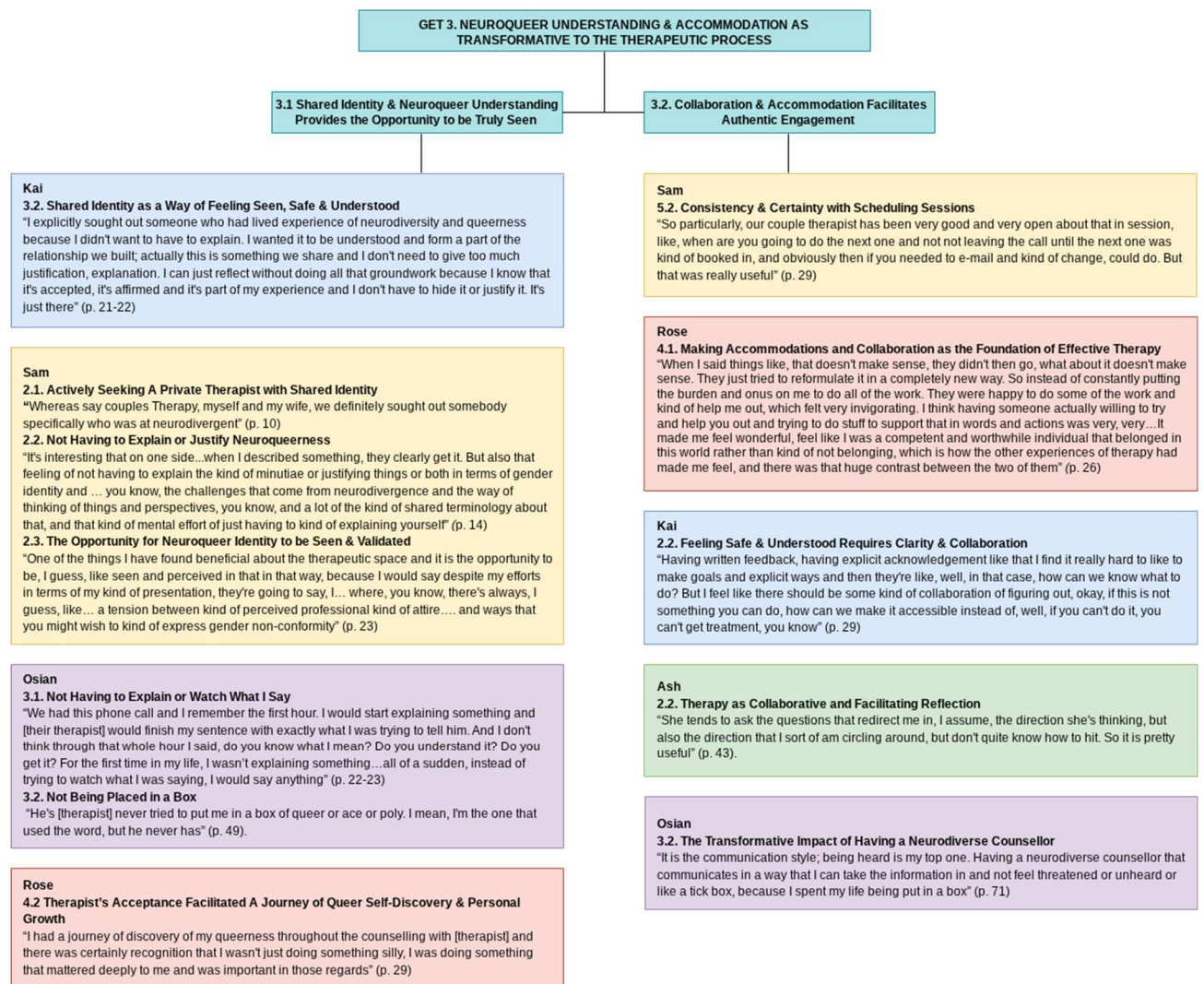


Figure 4. GET 3 formulation from PETs

3.1. Shared Identity and Neuroqueer Understanding Provides the Opportunity to Be Truly Seen

This subtheme illustrates how therapy was experienced by most participants as helpful and effective when there was shared identity and understanding of neuroqueerness between themselves and their therapist. Following earlier unhelpful or non-affirming therapeutic encounters, several participants described intentionally seeking a therapist who held shared neuroqueer identities.

I explicitly sought out someone who had lived experience of neurodiversity and queerness because I didn't want to have to explain. I wanted it to be understood and form a part of the relationship we built; actually this is something we share and I don't need to give too much justification, explanation. I can just reflect without doing all that groundwork because I know that it's accepted, it's affirmed and it's part of my experience and I don't have to hide it or justify it. It's just there. (Kai, p. 21-22)

It's interesting that on one side...when I described something, they clearly get it. But also that feeling of not having to explain the kind of minutiae or justifying things or both in terms of gender identity and ... you know, the challenges that come from neurodivergence and the way of thinking of things and perspectives... a lot of the kind of shared terminology about that, and that kind of mental effort of just having to kind of explaining yourself. (Sam, p. 14)

I would start explaining something and [therapist] would finish my sentence with exactly what I was trying to tell him. And I don't think through that whole hour I said, do you know what I mean? Do you understand it? Do you get it? For the first time in my life, I wasn't explaining something...all of a sudden, instead of trying to watch what I was saying, I would say anything. (Osian, p. 22-23)

Showing up with someone who's already done that work of unpacking and understanding what it's like to experience queerness, I felt a lot more comfortable to talk about the parts of queerness that I didn't yet understand in myself, like my gender. (Kai, p. 23)

Such accounts reflect a sense of feeling deeply understood combined with the relief of not having to explain their neuroqueerness. The increased certainty about therapist's identity appeared to cultivate a deeper sense of safety and openness in which participants could assume acceptance rather than having to anticipate and navigate misunderstandings or judgement. The removal of these kinds of emotional and cognitive burdens, or '*groundwork*'; the effort required to establish shared understanding before meaningful work could begin, which previously dominated and constrained the therapeutic space, enabled the focus of therapy to shift to more nuanced self-exploration in which their multiplicity could be meaningfully acknowledged and accepted. Sam explained how therapy provided "*the opportunity to be seen and perceived in that way*" (p. 23) and how holding shared identity with their therapist meant they understood that "*identity is not necessarily correlated with gender performance, Yay!*" (p. 24). Osian described their neurodiverse counsellor possessing a similar fluid and accepting perspective on their sexuality; "*He's never tried to put me in a box of queer or ace or poly. I mean, I'm the one that used the word, but he never has*" (p. 49). Such accounts illustrate how shared identity created

a space where their queerness, particularly gender identity, could be validated and meaningfully explored.

For Daisy despite not knowing their therapist's identity, having a therapist who had had appropriate neurodivergent-affirming training and an understanding of queerness appeared transformative to her process. She described her therapist as possessing “*non-judgement, acceptance and just being a really wonderful ally*” (p. 21). As a result, therapy was experienced as “*a journey of discovery of my queerness throughout the counselling*” (p. 29) in which Daisy’s process of transitioning could be explored. Her therapist recognised: “*I wasn’t just doing something silly, I was doing something that mattered deeply to me and was important*” (p. 29). She reflected on the impact of this:

I was taken from a place of being very broken down and feeling useless and like I was a burden on society to feeling like I was happy to interact with society again and happy to start living a little bit again, whereas I'd been very much sort of just shut away for quite a period of time (p. 22).

Evidently, having a therapist who understood Daisy’s queerness enabled her to compassionately reframe internalised shame and self-judgement surrounding her identity. Deeply validating and affirming this part of her experience allowed her to re-engage with society.

Together, these accounts highlight the importance of shared identity and understanding in facilitating the therapeutic process. This cultivated a deeper sense of acceptance, non-judgement and safety, enabling more open and authentic expression. This also removed the burden of participants needing to explain, educate or justify their neuroqueerness and enabled more nuanced exploration of their identities.

3.2. Collaboration and Accommodation Facilitates Authentic Engagement

This subtheme reflects how therapy was experienced as more accessible and effective when therapists collaborated with participants to implement necessary accommodations to address barriers to engagement.

Many participants described the value of therapists adapting the therapeutic process to accommodate their individual needs, demonstrating flexibility and a

willingness to modify the therapeutic frame. Sam described how their therapist routinely scheduled their next session before ending each appointment, explaining that they were “*very good and very open about that in session, like, ‘when are you going to do the next one’ and not leaving the call until the next one was kind of booked in*” (p, 29). This proactive approach enhanced certainty and accommodated Sam’s changing schedule. Similarly, Daisy described the impact of adapting the therapeutic process to meet her needs:

So, [therapist] and I had a conversation for about 45 minutes; He'd phoned up and booked it a week in advance. So, I had time to think about things and had time to think about what I wanted to ask, and I had time to summarise my fears about it and my experiences previously. So that was really useful and feeling really listened to in those initial sessions and then shaping what happened in the subsequent sessions based on what I'd said in that initial session and the follow through of asking me about my needs and then enforcing the need to actually look after those needs felt very affirming - that someone did actually care about me and what I said rather than just ignoring. (p. 43-44)

This kind of prioritisation and responsiveness to Daisy’s needs appeared to cultivate trust, allowing her to feel deeply listened to and cared for. In contrast, for Kai, unhelpful therapy experiences consolidated their need for certain accommodations:

Having written feedback, having explicit acknowledgement like that I find it really hard to like to make goals and explicit ways and then they're like, well, in that case, how can we know what to do? But I feel like there should be some kind of collaboration of figuring out, okay, if this is not something you can do, how can we make it accessible instead of, well, if you can't do it, you can't get treatment. (p. 29)

Such accounts illustrate the importance of flexibility and adapting standard practices to reduce barriers to engagement.

Similarly, tailoring interventions to suit participants' communication styles and way of thinking appeared to be foundational to experiencing therapy as beneficial. Some participants described their therapeutic experience as “*almost entirely*” (Ash, p. 42) and “*very*” (Daisy, p. 27) collaborative, noting their therapist's willingness to reframe and clarify interventions when needed.

She tends to ask the questions that redirect me in, I assume, the direction she's thinking, but also the direction that I sort of am circling around, but don't quite know how to hit. So it is pretty useful. (Ash, p. 43)

When I said things like, that doesn't make sense, they didn't then go, what about it doesn't make sense. They just tried to reformulate it in a completely new way. So instead of constantly putting the burden and onus on me to do all of the work. They were happy to do some of the work and kind of help me out, which felt very invigorating. I think having someone actually willing to try and help you out and trying to do stuff to support that in words and actions was very, very...It made me feel wonderful, feel like I was a competent and worthwhile individual that belonged in this world rather than kind of not belonging, which is how the other experiences of therapy had made me feel, and there was that huge contrast between the two of them (Daisy, p. 26)

It is the communication style; being heard is my top one. Having a neurodiverse counsellor that communicates in a way that I can take the information in and not feel threatened or unheard or like a tick box, because I spent my life being put in a box (Osian, p. 71)

These accounts demonstrate the importance of therapist actively working to adapt techniques to ensure shared understanding. By shifting expectations surrounding therapeutic engagement, sharing the burden of engagement, participant experiences of shame and pathologisation were reframed and transformed into feelings of competency and liberation. The overall impact of these experiences appeared to be profound and crucial for therapeutic engagement. For example, Ash explained *"I feel like I can only really do it this way. Like if my therapist had told me to read these things, I would have said, no, I can't do that"* (p. 42). Both Daisy and Osian used metaphor to articulate the transformative experience of affirming therapy after previous non-affirming experiences:

It was like you had been trying to walk buried up to your chest in mud and not getting very far, you were suddenly then just able to walk and it was like, oh, is this what it's like for everyone else? (Daisy, p. 45)

It was like passing your driving test and being given a Robin Reliant. You're absolutely over the moon, you've got your wheels, you can get everywhere and then someone gives you a jag and you go, what the hell was I doing with the Robin? (Osian, p. 42)

Collectively, participants experienced therapy as most effective when it moved beyond rigid, standardised therapeutic approaches to adopt more person-centred practices which meaningfully acknowledged and accommodated their neurodivergence. Rather than placing the burden solely on participants to engage, this was willingly shared and barriers to engagement were meaningfully addressed and collaboratively resolved. Here, therapy was experienced as deeply validating

and supportive, cultivating a deep sense of safety and trust that enabled participants to engage more authentically and to feel truly heard and understood.

Chapter 5: Discussion

This chapter contextualises the present study's findings within the existing literature to examine how neuroqueer individuals experience psychotherapy. Together, findings inform a conceptual framework that identifies key processes through which neuroqueer clients may experience therapy as affirming or non-affirming. The theoretical and practical implications of the findings, along with subsequent training recommendations are discussed. The chapter concludes with reflexive considerations, methodological limitations and directions for future research.

Neuronormative Therapeutic Frameworks and Accommodating Neurodivergence

Most participants experienced incompatibilities between traditional therapeutic practices and core facets of their neurodivergence, including information and emotional processing, and communication differences. This extends existing research within autistic populations suggesting that standard therapeutic approaches often fail to adequately accommodate neurodivergence (Camm-Crosbie et al., 2019; Brede et al., 2022; Jones, Hamilton and Kargas, 2025). Participants frequently described feeling misunderstood and misinterpreted by therapists, reflecting Milton's (2012) double empathy problem, which explains how difficulties in understanding arise from differences in reciprocal communication and meaning-making across neurotypes. Participants identified communication, reframing interventions to suit their communication style, providing greater context when needed as strategies to help reduce these communication barriers. Such adaptations may help to bridge neurotype differences by reducing ambiguity and facilitating shared understanding. The present findings complement and extend related work demonstrating that unclear explanations and vague language can leave neurodivergent participants feeling confused, overwhelmed, or disengaged (Babb et al., 2021; Darazsdi and Bialka, 2023; Mazurek et al., 2023; Hersh, Mery and Dawson, 2024).

Beyond communication, participants identified aspects of the therapeutic frame, including session lengths, time-limited interventions and practical disruptions, as barriers to the process, conflicting with participants' needs for certainty, sufficient processing time and continuity. These experiences appeared to contribute to feelings of uncertainty, reduced psychological safety and unfinished therapeutic work,

extending evidence that autistic adults may require greater flexibility in therapy structure and timing, with standard session formats limiting therapeutic work (Jubenville-Wood et al., 2023; Mazurek et al., 2023; Kilgallon, 2025). Consistent with this, direct communication, explicit goal setting and predictable structures have been shown to reduce anxiety and facilitate engagement for neurodivergent clients (Maddox et al., 2020; Jubenville-Wood et al., 2023). Participants similarly advocated for collaborative adaptations, including discussing needs and goals before therapy, providing clear expectations about the therapeutic process, and offering written summaries following the completion of therapy. Such recommendations support calls to increase transparency, ensuring clarity and information dispersal, and altering contracting procedures to consider reasonable adjustments where needed (Jones, Kargas and Hamilton, 2025).

Additionally, online therapy was experienced as both facilitative and constraining. For some, it functioned as a necessary accommodation, increasing accessibility and reducing barriers associated with travel, sensory demands and navigating unfamiliar environments (Harris et al., 2022; Gilmore et al., 2023). However, others experienced online formats as limiting opportunities for relational connection and therapeutic attunement (Hume, 2022; Pappagianopoulos et al., 2025). Participants emphasised the importance of flexibility and choice between online and in-person modes of service delivery. This aligns with research demonstrating considerable variation in how neurodivergent individuals experience and benefit from therapeutic adaptations, reinforcing the importance of tailoring therapy based on individual needs (Paynter, Sommer and Cook, 2025).

Importantly, participants' accounts highlight the implicit expectation to conform to neuronormative standards of therapeutic engagement and the unequal effort required of clients to engage. Therapists were often perceived as unable or unwilling to adapt therapeutic practices to accommodate neurodivergent needs, with difficulties engaging in or benefitting from therapy being understood as client difficulties rather than as arising from a mismatch between clients' needs and the therapeutic environment. This contributed to experiences of blame, shame and feeling unsupported, with responsibility to resolve barriers to engagement placed on the client alone. Combined with communication differences and unequal knowledge about the therapeutic process, these experiences appeared to create an epistemic imbalance in which therapists' perspectives were privileged over clients'

understanding of themselves, their needs and the therapeutic process (Crichton, Carel and Kidd, 2017; Catala, Faucher and Poirier, 2021). From an anti-oppressive perspective, this reflects an oppressive dynamic in which unequal distributions of epistemic authority and responsibility for engagement were reinforced by therapists, to the detriment of their neurodivergent clients. More affirming practices therefore appear to require greater cultural humility, involving ongoing reflection on power dynamics, professional knowledge and assumptions within the therapeutic relationship (Zhang et al., 2022). This also requires a redistribution of epistemic authority, where shared understanding is prioritised and barriers to engagement are collaboratively addressed and accommodated.

Masking and Identity Concealment

Crucially, participants appeared to use masking and identity concealment as protective strategies to manage interpersonal risk and enhance personal safety within therapy (Hull et al., 2017; Cage and Troxell-Whitman, 2019). Consistent with emerging work conceptualising unmasking and identity disclosure as parallel processes (Rosati, Miscioscia & Anzani, 2026), participants who employed these strategies described uncertainty regarding therapist's positionality towards their neuroqueerness, often anticipating stigma, invalidation or pathologisation. This aligns with research conceptualising masking as a socially and relationally motivated survival strategy which may be shaped by autism-related stigma and experiences of interpersonal trauma, reflecting attempts to minimise the risk of further harm while maintaining interpersonal connection (Cook et al., 2021; Perry et al., 2022; Zhuang et al., 2023; Evans, Krumrei-Mancuso and Rouse, 2024). Relatedly, neurodivergent clients may require stronger experiences of relational attunement and validation before feeling sufficiently safe enough to unmask within therapy (Hume, 2022; Jones, Hamilton and Kargas, 2025). Similarly, identity concealment has been associated with fear, psychological strain, and poorer mental health outcomes, whereas disclosure tends to be linked to improved wellbeing when safety and acceptance are present (Wainipitapong et al., 2025).

From a Minority Stress perspective, these strategies can be understood as proximal stressors arising from past or anticipated distal stressors (Meyer, 2003; Botha and Frost, 2020). Although such strategies may facilitate short-term

interpersonal safety, they may simultaneously constrain the openness, authenticity and relational depth necessary for therapeutic change (Evans, Krumrei-Mancuso and Rouse, 2024). These findings extend existing understandings of masking by highlighting how neuroqueer clients actively negotiate safety within therapeutic relationships and how uncertainty regarding therapist's acceptance of their identity may shape their capacity to engage authentically.

Neuroqueer Understanding and Shared Identity

Participants consistently described therapists' lack of understanding about neurodivergence and queerness as a significant barrier to the therapeutic process. This cultivated a range of negative experiences, from feelings of relational disconnection or misattunement, to harmful experiences of identity invalidation like misgendering, cisheteronormative assumptions and the pathologisation of neurodivergence. These experiences left participants feeling distressed, deeply unheard and unseen in the therapeutic space, echoing previous findings of neurodivergent and LGBTQ+ individuals' experiences in psychotherapy and healthcare settings (McNamara and Wilson, 2020; Brede et al., 2022; Di Marco, Troop and Wood, 2025; Mezzalira et al., 2025). Consistent with Minority Stress Theory, these distal stressors also cultivated additional proximal stressors, including hypervigilance, increased efforts to prevent misunderstanding and the burden of explaining or educating therapists about their neuroqueerness (Meyer, 2003; Hendricks and Testa, 2012; Bishop, Crisp and Scholz, 2022; Turville, 2024).

Conversely, participants described positive therapeutic experiences with therapists who demonstrated neuroqueer understanding, whether through shared lived experience or affirmative practice. Therapists with shared neuroqueer identities appeared to facilitate psychological safety, trust, authentic expression and more nuanced discussions surrounding identity, potentially through the reduced need to participants to explain or justify their neuroqueerness (Arora et al., 2022; Rosati et al., 2022; Leitch and McGeough, 2023). This complements research suggesting that neurotype alignment may facilitate social ease and therapeutic engagement by reducing the cognitive demands associated with compensatory social strategies (Milton, 2012; Livingston, Shah and Happé, 2019; Crompton et al., 2020a, 2020b; Miller, Rees & Pearson, 2021). However, even when participants did not know their

therapists' identities, neuroqueer understanding, non-judgement and acceptance remained central to positive therapeutic experiences. This reflects broader evidence across LGBTQ+ and neurodivergent populations demonstrating the importance of perceived acceptance, and of feeling heard, believed and understood in facilitating engagement and client empowerment (Bishop, Crisp, and Scholz, 2022; Brede et al., 2022; Leitch and McGeough, 2023; Jones, Hamilton and Kargas, 2025). Taken together, findings suggest that effective therapy for neuroqueer populations required therapists to cultivate shared understanding, whether through lived experience or training, and cultural humility in which clients' identities and experiences are deeply respected and valued (Arora et al., 2022; Orlowski et al., 2025).

Minimising Minority Stress and Cultivating Psychological Safety through Neuroqueer Understanding and Collaborative Accommodation

This work extends existing minority stress literature to consider how traditional therapeutic frameworks may function as systemic sources of distal stress for neuroqueer individuals through embedded normative assumptions surrounding gender, sexuality and neurocognitive functioning. Consequently, this creates an environment in which interpersonal distal stressors, including misattunement, invalidation and pathologisation, can be reproduced and pressure to conform to social norms is reinforced (Meyer, 2003; Milton, 2012; Chapman and Botha, 2023). This aligns with evidence from LGBTQ+ populations demonstrating how cisheteronormative assumptions and implicit bias within therapeutic practices can undermine clients' willingness to engage and sense of safety within therapy (McDowell et al., 2020; Levenson, Craig and Austin, 2023). Such experiences may contribute to proximal stress processes, including hypervigilance, anticipation of rejection or misinterpretation, identity concealment and masking (Cage and Troxell-Whitman, 2019; Botha and Frost, 2020; Pearson and Rose, 2021). Together, such processes create additional cognitive and emotional burdens for neuroqueer clients, reflected in participant accounts of exhaustion and autistic burnout following therapeutic experiences (Raymaker et al., 2020; Osborne et al., 2026). Ultimately, such experiences act as barriers to the therapeutic process.

Conversely, shared neuroqueer understanding and collaboratively accommodating neurodivergence appeared to disrupt these stress processes by

meaningfully addressing barriers to engagement and cultivating psychological safety, trust, authentic expression. This aligns with humanistic understandings of therapeutic growth, in which experiences of empathy, authenticity, unconditional positive regard create the foundation for safe relational connection and psychological change (Rogers, 1957; Levenson, Craig and Austin, 2023).

Collectively, findings suggest that psychological safety represents a core mechanism through which effective therapy is facilitated for neuroqueer clients, consistent with evidence highlighting its central role in therapeutic engagement and change (Flückiger et al., 2018; Podolan & Gelo, 2024). More specifically, findings complement the transtheoretical model of safety regulation, which conceptualises therapeutic safety as a dynamic, co-regulated process shaped by interpersonal interactions, external conditions, social systems and cultural norms (Podolan and Gelo, 2024; Podolan, 2026). From this perspective, safety and regulation emerge relationally through attunement, affirmation, consistency and predictability within the therapeutic environment. This reinforces the need to reframe therapeutic safety and engagement as co-created processes requiring shared responsibility between client and therapist. The relationship between central findings, minority stress and psychological safety is represented in Figure 5.

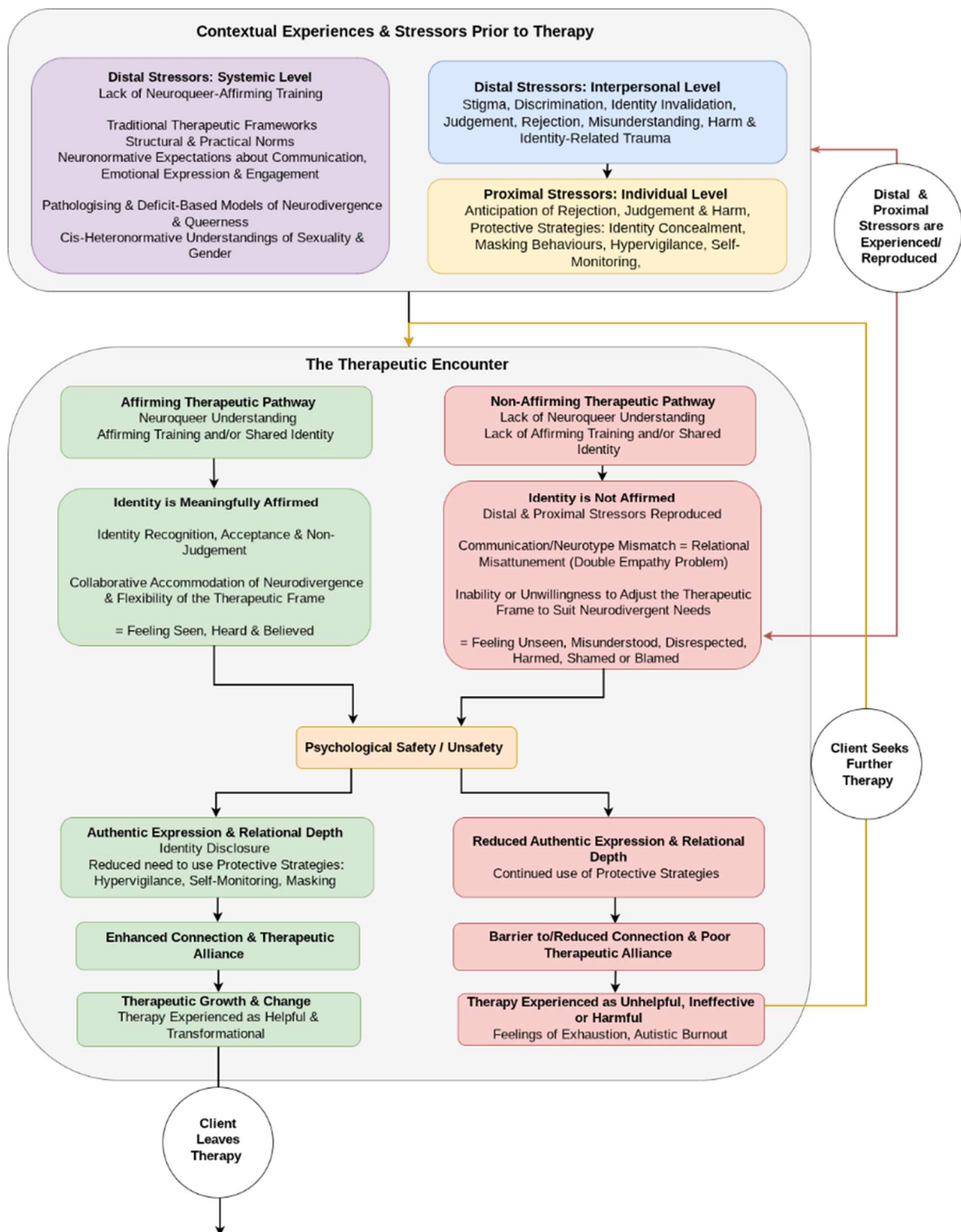


Figure 5. A conceptual model illustrating the role of psychological safety and minority stress in affirming and non-affirming neuroqueer therapy experiences.

Practice Implications and Training Recommendations

Together, findings highlight the need for greater cultural humility, reflexivity, anti-oppressive and identity-affirming practice within psychotherapy. When neuroqueer identities are not meaningfully acknowledged and accommodated, this may enable harmful experiences of marginalisation, invalidation and epistemic inequality to be reproduced within the therapeutic relationship. Practice should therefore prioritise psychological and relational safety through explicit identity acceptance, understanding and collaborative adaptation, consistent with identity-affirming and person-centred and (Rogers, 1957; Chapman and Botha, 2023).

Further, findings emphasise the necessity of questioning and queering traditional therapeutic power dynamics by prioritising shared understanding and epistemic equality through collaboration, greater transparency about the therapeutic process, and flexible adaptation of the therapeutic frame to meet individual needs (Leadbitter et al., 2021; Jones, Hamilton and Kargas, 2025; Pappagianopoulos et al., 2025). Such approaches align with queer commitments to challenging normative expectations and the redistribution of power within relationships (Nadal and Scharrón-del Río, 2021; Ciric et al., 2026).

Notably, most participants described negative and non-affirming experiences within NHS mental health services within the last five years, echoing concerns that affirming approaches have yet to be systemically integrated into psychotherapy training and practice (Chapman and Botha, 2023; Burger and Pachankis, 2024). In contrast, positive experiences involved therapists who had undertaken specialist training or who were in private practice with neurodivergent and/or queer identities. These findings highlight the importance of embedding neuroqueer-affirming practices within core psychotherapy training. Equally, qualified practitioners should engage in further professional development to strengthen either competence for working with neuroqueer individuals.

Psychotherapy training should include education on anti-oppressive practice, including critical examination of oppressive structures, like capitalism, ableism, racism, classism, heterosexism, cisnormativity, and how these intersect to shape experiences of marginalisation, social and health inequalities and experiences within healthcare settings (Timothy and Umana Garcia, 2020). This should accompany

education on Minority Stress Theory, Intersectionality, and identity-affirming practices and Queer Theory.

Given that participants described difficulties finding therapists with expertise in both neurodivergence and queerness, training should explicitly address the intersections between these identities. As all participants identified as gender minorities, particular attention should be given to transgender and non-binary experiences and sources of resilience for these populations (Testa et al., 2015; Morris, Lindley and Galupo, 2020). Identity-affirming practices should encourage a culturally sensitive and person-centred exploration of client identities based on client determined relevance to the therapeutic process, avoiding inappropriate neglect or overemphasis (Anders and Kivlighan, 2023; Chapman and Botha, 2023).

Crucially, training should also include education on neurodiversity, depathologising approaches to care and practical guidance on how to adapt therapy to accommodate differences in communication, sensory needs and information and emotional processing (Cooper, Loades and Russel, 2018; Chapman and Botha, 2023; Jones, Hamilton and Kargas, 2025). Such adaptations may include modifying initial assessment procedures to consider reasonable adjustments, offering flexible modes of service delivery, extending session lengths where appropriate, and ensuring that organisational policies support such flexibility and address barriers to access (Cooper, Loades and Russel, 2018).

Given the increased likelihood of prior experiences of marginalisation and trauma amongst neuroqueer populations, a trauma-informed approach appears essential (Reuben, Stanzione and Singleton, 2021; Levenson, Craig and Austin, 2023; Marchi et al., 2023). Therapists should be supported to recognise how minority stressors may manifest within the therapeutic relationship and understand masking and identity concealment as adaptive responses to unsafe relational environments rather than indicators of resistance or poor engagement (Hull et al., 2017; Botha and Frost, 2020; Pearson and Rose, 2021). Training should equip therapists with the skills to cultivate psychological safety, support authentic disclosure and unmasking when desired. Similarly, whilst training should seek to prevent identity-related experiences of harm like microaggressions, therapists must also be taught how to effectively address and repair these kinds of relational rupture when they occur (Morris, Lindley and Galupo, 2020).

Finally, training should proactively create opportunities for conversations

about personal identity, privilege, therapeutic power dynamics and structural inequalities. Incorporating principles of cultural humility, trainees should be encouraged to critically reflect on the normative assumptions they may hold surrounding sexuality, gender and ability, along with how their own positionality and professional power may contribute to the reproduction of harm and social norms within the therapeutic space (Zhang et al., 2022).

Reflexive Considerations, Methodological Limitations and Future Directions

The interpretation of findings was inevitably shaped by the researcher's neuroqueerness and therapeutic experiences in several ways. Experiences of identity invalidation, feeling misunderstood by authority figures and justice sensitivity heightened their caution about the interpretations made due to the risk of reproducing previous harms, especially given their dual position of researcher and therapist. Although the researcher shared aspects of participants' identities, they are cis-gender and high-masking, thus did not hold shared experience as a gender-diverse person and may have been perceived by participants as possessing a differing neurotype. These differences, combined with the inherent power dynamics of the researcher-participant dynamic, are likely to have influenced the interview process and co-construction of meaning.

The researcher also critically reflected on the use of Interpretative Phenomenological Analysis (IPA) within neurodivergent populations. IPA emphasises close engagement with linguistic features like tone, pauses in speech and non-verbal cues, however this level of interpretation felt inappropriate at times (Smith, Larkin and Flowers, 2021). For many neurodivergent individuals, observable expressions and interpretations of non-verbal cues may not consistently align with internal experiences due to differences in communication style, emotional expression and masking strategies (Milton, 2012; Hull et al., 2017; Pearson and Rose, 2021). Thus, attempts to derive meaning from changes in speech patterns, body language and expression risked over-interpretation and obscuring participant meanings. Likewise, the use of open-ended questions, although necessary to prevent biasing answers, meant most participants required additional clarification and context on the purpose of the questions to understand what was being asked of

them. Together, this suggests IPA may require adaptation to accommodate neurodivergent differences in communication, information processing and meaning making.

To add, several methodological limitations should also be considered. First, the idiographic and interpretative nature of IPA, combined with the small UK-based sample used, limits the transferability of findings. Instead, this work offers theoretical and contextual insights which complement existing literature on LGBTQ+ and neurodivergent psychotherapy experiences. Future research should implement larger, more diverse samples across different geographical locations and employ methodologies better suited to generalising findings across populations, such as reflexive thematic analysis or mixed methods designs.

Second, there was considerable heterogeneity in participants therapy experiences, including variation in publicly and privately accessed support, therapeutic modality, duration and recency of experiences. In some cases, participants were uncertain of the modality used, while accounts ranged from within recent months to others occurring years or decades earlier. Similarly, some participants had spent decades in therapy, others had only experienced brief time-limited interventions. Such variation is likely to have influenced how experiences were processed and interpreted, and thus the present findings. Therefore, investigations which control for such variation, examining more specific therapeutic contexts and modalities, as well as considering the duration of therapy would help to clarify how these factors shape neuroqueer experiences.

Finally, demographic features, including race, ethnicity and socioeconomic status were not systematically collected. Although participants were invited to discuss whether other social identities beyond neuroqueerness shaped their therapeutic experiences, these factors were not consistently reported. However, some participants reflected on the influence of their ethnicity, cultural background and racial and socioeconomic privilege in their ability to access effective therapy. Additionally, the sample was predominantly autistic and non-binary, thus findings are unlikely to capture the diversity of experiences across other neurotypes, queer identities and within the broader neuroqueer community. Given the established impact of structural inequalities on access to and experience of mental health support, future research should intentionally recruit more diverse and intersectional

samples. This should include greater representation across race, ethnicity, socioeconomic background, neurotypes beyond autism, a wider range of LGBTQ+ identities, while systemically recording a broader range of demographic characteristics. Such efforts would support a more comprehensive and intersectional understanding of neuroqueer individuals' experiences of psychotherapy.

Chapter 6: Conclusion

This study explored the therapy experiences of individuals who identify as both neurodivergent and queer, or “neuroqueer”. Using IPA, this work sought to gain a more in-depth understanding of how neuroqueerness shapes psychotherapy experiences and the complex realities of individuals who hold these multiple marginalised identities. Adopting a critical, intersectional perspective, the study aimed to identify barriers and facilitators to the therapeutic process, considering any systemic, relational, and cultural factors that may be involved.

Findings indicate that the effectiveness of therapy was contingent on the extent to which neuroqueer identities were acknowledged, understood and accommodated within the therapeutic space. This work also demonstrates how therapy can be experienced as healing or harmful for neuroqueer people, depending on the extent to which broader oppressive systems of power and traditional therapeutic structures are challenged or reinforced. Key barriers to effective therapy included distal stressors like experiences of identity invalidation, pathologisation, lack of therapist knowledge of neuroqueerness and an inflexibility to adapt the process to accommodate neurodivergence. In contrast, affirming relationships were facilitated through neuroqueer understanding, shared identity and collaborative adaptation to the therapeutic process which cultivated psychological safety. This work extends existing minority stress theory to consider how normative frameworks are systemic level sources of distal stressors and provides a conceptual model through which effective therapy can be facilitated for neuroqueer individuals.

In sum, the present work highlights the necessity of identity-affirming, person-centred, trauma-informed and anti-oppressive approaches to psychotherapy when working with neuroqueer individuals. More broadly, this calls for a cultural shift in therapeutic practice towards the critical examination and queering of traditional therapeutic frameworks and relational dynamics. Such practices require greater cultural humility and a redistribution of power through collaborative approaches that prioritise shared understanding and the cultivation of client safety, authenticity and agency.

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Appendices

Appendix 1. Advisory Group Information Sheet

Advisory Group Information Sheet

Research Title: *Navigating Neuroqueerness in the Therapy Room: An Interpretative Phenomenological Analysis exploring neuroqueer client experiences of therapy*

Purpose of Research

The purpose of this research is to explore the lived therapeutic experiences of individuals who identify as both neurodivergent and queer, recently termed 'neuroqueer'.

'What is it like to be a neuroqueer client in therapy?'

Research shows that both queer and neurodivergent people are at risk of experiencing higher levels of mental health difficulties compared to their cisgender, heterosexual, and neurotypical counterparts, due to the stigma, discrimination, and exclusion they face. Other work highlights that being a part of multiple marginalised groups may have a cumulative negative effect on a person's mental health.

The significant overlap between neurodivergence and queerness has been highlighted and led to the coining of the term 'neuroqueer' to describe this. However, to date, little is known about how these overlapping identities and how they may shape the experience of therapy.

Existing affirmative models of therapy which aim to help support people from these groups have been developed based on research involving other populations within the LGBTQIA+ community and specific neurotypes; mostly autistic people. Further research centering the voices of neurodivergent, queer and neuroqueer people is necessary in order to ensure equal and effective mental health support for these groups.

The researcher identifies as neuroqueer. This work stems from their passion for and commitment to social justice and their personal experiences as a neuroqueer client in therapy.

Study Aims: What does this research hope to achieve?

1. To explore the lived experiences of individuals who identify as both neurodivergent and queer (*'neuroqueer'*) within the context of psychotherapy, using Interpretative Phenomenological Analysis (IPA).
2. To deepen understanding of how intersecting identities of neurodivergence and queerness shape clients' therapeutic experiences, needs, outcomes and the overall therapeutic process.
3. To identify key barriers and facilitators that influence access to and engagement with psychotherapy for neuroqueer individuals, considering systemic, relational, and cultural factors.

The hope is that this work can help to inform more inclusive, person-centred and intersectionally affirming models of psychotherapy in order to contribute to more equitable mental health care for neuroqueer people.

Study Objectives: How will this research attempt to achieve this?

1. To conduct semi-structured interviews exploring the lived experiences of neuroqueer therapy clients (general therapeutic experiences, environmental factors, facilitators and barriers to effective therapy)
2. To transcribe, code, and analyse the interview data using the principles and procedures of IPA.
3. To critically examine and interpret how neuroqueer individuals make sense of their psychotherapy experiences.

Purpose of the Advisory Group

Current recommendations for conducting neuro-inclusive and phenomenological research (like interpretative phenomenological analysis; IPA) involving minority identity populations, strongly encourages attempting to include members of these groups at all stages of the research process whenever possible in order to ensure accurate representation (Dark, 2024; Smith, Larkin and Flowers, 2021).

In order to honour this, an advisory group (also referred to as 'experts by experience') will be constructed. This will be a small group of people who have personal lived experiences similar to the demographic of interest, i.e. are queer and/or neurodivergent.

The group will play a consultative role, providing feedback regarding the clarity, accessibility, cultural sensitivity and appropriateness of the proposed materials, particularly the interview questions, before participant interviews are conducted. This will help refine interview questions and ensure that the research materials are inclusive, accessible, and ethically sound.

Your Involvement: What will be expected of you?

- Review the draft materials and interview questions: prior to the advisory group meeting (included below)
- Attend a one-off advisory group meeting online via Microsoft Teams which will last roughly 60 minutes.
- During the meeting, provide feedback about:
 - a. Whether the proposed methods and materials are appropriate for the intended participant group; if any alterations could be made
 - b. The clarity, tone and appropriateness of the interview questions
 - c. How the overall ethical quality of this research could be strengthened; if there is any potential for unintended bias or exclusion
- You will not be asked to share any personal or sensitive experiences
- At the end of the meeting, members will be debriefed on how their data will be used, their right to withdraw, what to expect after the meeting and additional support and information available if needed.

Your Data: How will this be stored and used?

Participation in the Advisory Group is **voluntary**. You are not being asked to participate as a research subject, but rather as an *advisor* contributing your expertise to improve the study design.

This means that no personal or identifying data will be collected about you beyond what is necessary for communication and acknowledgment of your contribution (if you consent to this).

Any information shared during the advisory group meeting will not be used in the main body of the final research.

The advisory group meeting will take place online; audio and visual information will be electronically recorded via Microsoft Teams.

All information you provide throughout the entirety of the research process; before, during and after the advisory meeting will be kept entirely **confidential** and **stored securely** in accordance with General Data Protection Regulations (GDPR), the Data Protection Act (2018), and the data management and privacy policies of UWTSD and Microsoft Teams. Only the researcher and supervisor will have access to this information.

You have the right to refuse to answer any questions during the meeting and are free to leave the meeting at any point without providing a reason/penalty.

You also retain the **right to withdraw** from the study **at any point** during the research process. You may request the removal of your data for **up to one week following the advisory group meeting** after this point, data withdrawal is no longer feasible.

All data collected will be permanently destroyed once the research has been completed and the researcher's degree is awarded.

Further information on data protection and privacy can be found here:

Microsoft Teams Privacy Policy: <https://www.microsoft.com/en-gb/microsoft-teams/security>

UWTSD Guidance of Data Management: <https://www.uwtsd.ac.uk/library/research-data-management/>

Your Next Steps

If you are happy to participate in this research, please complete the consent form and send this back to the researcher as soon as possible.

Please send these completed documents back to the researcher as soon as possible.

If you have any questions or comments about any part of the research, you can contact the researcher or their supervisor directly, or you can follow the complaints procedure listed here: <https://www.uwtsd.ac.uk/external-complaints>

Appendix 2: Advisory Group Consent Form

Advisory Group Consent Form

Research Title: Navigating Neuroqueerness in the Therapy Room: An Interpretative Phenomenological Analysis exploring neuroqueer client experiences of therapy

Thank you for considering participating *as a member of the advisory group* as part of this research. **Please read this form carefully and provide an initial in each box to indicate your agreement as appropriate.**

Once this is completed, please return this form to the researcher via email. If you have any questions prior to your participation please contact the researcher, Caitlin Payne via 2218988@student.uwtsd.ac.uk or the supervisor, Dr. Beverly Cole via beverly.cole@uwtsd.ac.uk

	Please Tick
I have read and understand the information provided about this research	
I understand that my participation in this research is voluntary	
I understand that I am being invited to provide feedback as a member of the pre-interview advisory group, not as a participant of this research	
I understand that this research is being carried out by a UWTSD student as part of their final year Master's dissertation and is bound by the UWTSD and BACP ethical guidelines.	
I understand that the advisory group meeting will take place online; this will be electronically recorded (audio and visual) via Microsoft Teams and that this data collected will be securely stored in accordance with General Data Protection Regulations (GDPR), the Data Protection Act (2018), UWTSD policy and Teams privacy policy.	
I understand that all information I provide will be kept confidential and that no personal or identifying data will be collected about me beyond what is necessary for communication and acknowledgement of my contribution	

I understand that if I agree to take part, I am able to leave the meeting at any point without providing a reason/without penalty	
I understand that I have the right to withdraw my data at any point up until one week after the advisory group meeting has occurred and that should this be the case my feedback will not be used.	
I understand that the feedback I provide will be used to help refine the research materials and interview questions.	
I understand that I can raise concerns about the research, if necessary, at any point during the research process and have the necessary contact information	
I understand that at the end of the meeting I will be debriefed and provided with the opportunity to discuss any issues with the researcher.	
I understand that findings from this research may be the subject of journal articles/conference presentations and/or any other related educational or research work.	
I understand that all feedback collected will be destroyed once the research project is finalised and the researcher's degree is awarded.	
I would like to be sent the research findings and any subsequent published works relating to this paper when it is available	

I, **(Add participant name)** agree to participate as a member of the advisory group for this research conducted by *Caitlin Payne*, Department of Psychology and Counselling, University of Wales Trinity Saint David, under the supervision of *Dr Beverly Cole*

Participant Signature: _____

Date: _____

Researcher Name: _____

Researcher Signature: _____

Please note that if you are unable to provide an electronic signature then the **receipt of this completed form via your email address will be taken as a form of your written consent.**

Appendix 3: Advisory Group Debrief Sheet

Advisory Group Debrief Sheet

Thank you for taking part in this advisory group.

Your feedback is extremely valuable in ensuring that the design of this study is accessible, respectful, and inclusive.

Purpose of Research

This research aimed to:

1. Explore the lived experiences of individuals who identify as both neurodivergent and queer (*'neuroqueer'*) within the context of psychotherapy, using Interpretative Phenomenological Analysis (IPA).
2. Deepen understanding of how intersecting identities of neurodivergence and queerness shape clients' therapeutic experiences, needs, outcomes and the overall therapeutic process.
3. Identify key barriers and facilitators that influence access to and engagement with psychotherapy for neuroqueer individuals, considering systemic, relational, and cultural factors.

This research is in response to the current underrepresentation of neuroqueer voices in psychotherapeutic research and the limited literature acknowledging and exploring how queerness and neurodivergence may intersect to uniquely shape therapeutic experiences.

Enhancing our understanding of the complex realities faced by those who hold multiple marginalised identities is essential for informing more inclusive, person-centred, and intersectionally affirming psychotherapeutic practice. Such insight supports the development of more equitable mental health care for neuroqueer people.

Purpose of the Advisory Group

The group will play a consultative role, providing feedback on the research design and materials, in order to ensure that these are inclusive, accessible and ethically sound prior to the interview process and data collection.

What Happens Next?

- Your feedback will be reviewed and used to refine the interview schedule and materials
- The final version of the schedule will then be used in the main study with participants.
- Your names will not appear in any reports, and no personal information will be shared.
- If you would like to receive a summary of how your feedback informed the materials, please contact the researcher to request this.

Additional Comments and Feedback

If you wish to withdraw your feedback or you have any further comments that you would like to share, please contact the researcher via email ***no later than one week after*** the advisory group meeting has occurred.

You will be aware that this study has received ethical approval from the UWTSD Research Ethics Committee. If you have any questions or comments about any part of the research, you can contact the researcher or their supervisor directly, or you can follow the complaints procedure listed here:

<https://www.uwtsd.ac.uk/external-complaints>

Researcher Name: Caitlin Payne

2218988@student.uwtsd.ac.uk

Supervisor Name: Dr Beverly Cole

beverly.cole@uwtsd.ac.uk

Appendix 4: Study Information Sheet

Study Information Sheet

Research Title: *Navigating Neuroqueerness in the Therapy Room: An Interpretative Phenomenological Analysis exploring neuroqueer client experiences of therapy*

You are invited to take part in the current research study which aims to explore the therapeutic experiences of people who identify as both neurodivergent and queer (also known as 'neuroqueer').

'What is it like to be a neuroqueer client in therapy?'

Your participation in this research is voluntary. Before you decide on whether you wish to participate it is important for you to understand the following:

- Why this research is being conducted
- What this research hopes to achieve
- How this research aims to achieve this
- What is required of you as a participant

This will be provided in the following **Information Sheet**.

A **consent form** and **participant criteria questionnaire** will also have been sent to you.

If you have any further questions after reading this, please contact the researcher through the contact information below.

This master's level research is supervised by Dr Beverly Cole and has been approved by the University of Wales Trinity Saint David's (UWTSD) Research Ethics Committee. This research is bound by the ethical guidelines of the British Psychological Society (BPS) and The British Association for Counselling and Psychology (BACP).

Researcher Name: Caitlin Payne

Email: 2218988@student.uwtsd.ac.uk

Supervisor Name: Dr Beverly Cole

Email: beverly.cole@uwtsd.ac.uk

Study Purpose: Why is this research being conducted?

The purpose of this research is to explore the lived therapeutic experiences of individuals who identify as both neurodivergent and queer, recently termed 'neuroqueer'.

“What is it like to be a neuroqueer client in therapy?”

Research shows that both queer and neurodivergent people are at risk of experiencing higher levels of mental health difficulties compared to their cisgender, heterosexual, and neurotypical counterparts, due to the stigma, discrimination, and exclusion they face. Other work highlights that being a part of multiple marginalised groups may have a cumulative negative effect on a person's mental health.

The significant overlap between neurodivergence and queerness has been highlighted and led to the coining of the term 'neuroqueer' to describe this. However, to date, little is known about these overlapping identities generally or how they may shape the experience of therapy.

Existing affirmative models of therapy which aim to help support people from these groups have been developed based on research involving other populations within the LGBTQIA+ community and specific neurotypes; mostly gay and autistic people. Further research centering the voices of neurodivergent, queer and neuroqueer people is necessary in order to ensure equal and effective mental health support for these groups.

The researcher identifies as neuroqueer. This work stems from their passion for and commitment to social justice and their personal experiences as a neuroqueer client in therapy.

Study Aims: What does this research hope to achieve?

1. To explore the lived experiences of individuals who identify as both neurodivergent and queer (*'neuroqueer'*) within the context of psychotherapy, using Interpretative Phenomenological Analysis (IPA).

2. To deepen understanding of how intersecting identities of neurodivergence and queerness shape clients' therapeutic experiences, needs, outcomes and the overall therapeutic process.
3. To identify key barriers and facilitators that influence access to and engagement with psychotherapy for neuroqueer individuals, considering systemic, relational, and cultural factors.

The hope is that this work can help to inform more inclusive, person-centred and intersectionally affirming models of psychotherapy in order to contribute to more equitable mental health care for neuroqueer people.

Study Objectives: How will this research attempt to achieve this?

1. To conduct semi-structured interviews exploring the lived experiences of neuroqueer therapy clients (general therapeutic experiences, environmental factors, facilitators and barriers to effective therapy)
2. To transcribe, code, and analyse the interview data using the principles and procedures of IPA.
3. To critically examine and interpret how neuroqueer individuals make sense of their psychotherapy experiences.

Your Involvement: What will be expected of you?

Pre-Interview

As a participant, you are expected to familiarise yourself with the materials provided in this research pack.

This includes:

1. Reading the **information sheet**
2. Completing the **consent form**
3. Completing the **participant recruitment questionnaire**
4. Send the completed documentation back to the researcher as soon as possible

5. Reading the **interview schedule** to carefully consider questions in advance of the interviews.

After this documentation has been reviewed by the researcher, they will be in contact to inform you of your suitability. If you are suitable, a date and time for the interview will be suggested.

Due to the sensitive nature of the topics that will be discussed it is possible that strong or unsettling emotions may arise during the process. The researcher encourages you to reflect on the personal ways in which you can prepare before, during and after the interviews to ensure your own emotional safety and comfort.

For example:

- Scheduling time to rest before or after the interview
- Engaging in personal self-care practices
- Thinking about what accommodations you may need to comfortably engage in the interview process, such as requesting to take breaks when needed, making your environment comfortable as possible
- Scheduling a session with a trusted therapist if needed

Interview

You will engage in a semi-structured interview involving questions about your therapy experiences. This is a space for you to share *whatever you feel comfortable to, at your own pace*. Interviews will be conducted via Microsoft Teams, at a mutually agreed time between yourself and the researcher. Interviews are expected to last roughly one hour.

The interviews will be electronically recorded using Microsoft Teams for the purpose of transcription and analysis.

You have the right to not answer any questions during the interview and are free to leave the interview at any point without providing a reason. Should this be the case, information collected from your interview will not be used in the research.

The full **interview schedule** has been emailed to you as part of this pre-interview information pack.

Debriefing, Support and Signposting

After all questions have been covered, there will be a 10-minute cooling off period. During this time, the researcher will provide a verbal debrief, outlining how your data will be used and stored, your right to withdraw, and what to expect following the interview. Further support and signposting information will also be discussed.

This period is designed to ensure that the interview has not caused any harm or distress, and to give you the opportunity to raise any concerns or ask any further questions about the research.

The researcher is a neuroqueer therapist with training in supporting people through complex emotional experiences. If you feel you require additional time and space to reflect on any thoughts or feelings that have arisen from the interview, this can be accommodated within the debrief period.

If you have any questions or comments about any part of the research, you can contact the researcher or their supervisor directly, or you can follow the complaints procedure listed here: <https://www.uwtsd.ac.uk/external-complaints>

Post-Interview

You will be sent a **debrief document**, including the information discussed during the debrief period in the interview. You will also be provided with a **signposting document** containing relevant resources and support options that may be helpful to you moving forward.

Additional Comments and Feedback

You are allowed to contact the researcher to provide any additional comments **up to two weeks** after your interview has been conducted.

Your Data: How will this be stored and used?

All information you provide throughout the entirety of the research process; before, during and after interviews, will be kept entirely **confidential** and **stored securely** in accordance with General Data Protection Regulations (GDPR), the Data Protection Act (2018), and the data management and privacy policies of UWTSD and Microsoft Teams. Only the researcher and supervisor will have access to this information.

Any information shared during the interviews will be anonymised using **pseudonyms** in the main body of the final research and any contextually identifiable information will be removed.

You have the right to not answer any questions during the interview and are free to leave the interview at any point without providing a reason. Should this be the case, information collected from your interview will not be used in the research.

You also retain the **right to withdraw** from the study **at any point** during the research process. You may request the removal of your data for ***up to one month following your interview***; after this point, the analysis process will have progressed to a stage where data withdrawal is no longer feasible.

All data collected will be permanently destroyed once the research has been completed and the researcher's degree is awarded.

Further information on data protection and privacy can be found here:

Microsoft Teams Privacy Policy: <https://www.microsoft.com/en-gb/microsoft-teams/security>

UWTSD Guidance of Data Management: <https://www.uwtsd.ac.uk/library/research-data-management/>

Your Next Steps

If you are happy to participate in this research, please complete the **consent form** and **participant criteria questionnaire** included in order to confirm your consent and to ensure you meet the participant criteria for this research.

Please send these completed documents back to the researcher as soon as possible.

The information you provide will be reviewed and the researcher will aim to provide a response via email ***within one week*** of receiving these documents.

Appendix 5: Participant Recruitment Questionnaire

Participant Recruitment Questionnaire

Please read the following information:

The term '**queer**' is an umbrella term used to describe when a person's sexuality or gender does not align with heterosexual norms or traditional ideas of gender, and constitutes as a sub-population within the LGBTQIA+ community.

The term '**neurodivergent**' refers to people who diverge from dominant cultural standards of 'normal' neurocognitive functioning. This can include differences in attention, executive functioning, learning and memory, language, perceptual-motor control and social cognition. This can encompass but is not limited to clinical diagnosis such as autism, attention deficit hyperactivity disorder (ADHD), dyslexia, dyspraxia, dyscalculia and Tourette's syndrome.

The term '**neuroqueer**' is used to describe people who identify as both neurodivergent and queer.

This label recognises the interconnected nature of neurodivergence, disability, gender, and sexuality, and describes a way of being that challenges both neuronormativity and heteronormativity.

Participant Criteria

1. Participants **self-identify as 'neurodivergent'** and/or have a **clinical diagnosis** of a specific neurotype, such as autism, ADHD, dyslexia, dyspraxia, Tourette's etc.
2. Participants **self-identify as 'queer'** regarding their gender and/or sexual identity(s)
3. Participants have been a **client in psychotherapy for at least six sessions or more**
4. Participants are **over the age of 18**

Based on these definitions, please answer the following questions:

Please highlight your chosen answer in colour or bold font

1. What is your age?

2. What are your preferred pronouns?

3. Do you self identify as ‘neurodivergent’? Yes / No

4. Do you have a clinical diagnosis of a specific neurotype? Yes / No
(e.g. Autism, ADHD, Dyslexia, Dyspraxia etc.)

If yes, please specify your diagnosis:

5. Do you identify as ‘queer’? Yes / No

6. Do you identify as ‘neuroqueer’? Yes / No

7. Before this research, have you been a client in psychotherapy for at least six sessions or more Yes / No

If yes, to the best of your knowledge, please answer the following questions:

8. What type (modality) of therapy have you received?

9. How long ago did you attend therapy? 0 - 1 years/ 1 - 2 years/ +2 years

10. How long did you attend therapy for? (e.g. number of sessions or general time frame)

11. Are there any reasonable adjustments that the researcher can make in order to ensure that you are able to comfortably engage during the interview process?

For example, environmental considerations such as low lighting, preferred amount of eye contact, request for breaks at certain points, your preferred way of answering the questions (e.g. systematically in order of presentation or no order), request for just audio data to be collected/have cameras off during interview.

Thank you for sharing this information

Appendix 6: Study Consent Form

Study Consent Form

Research Title: Navigating Neuroqueerness in the Therapy Room: An Interpretative Phenomenological Analysis exploring neuroqueer client experiences of therapy

Thank you for considering participating in this research. **Please read this form carefully and provide a tick or ‘/’ in each box to indicate your agreement as appropriate.**

Once this is completed, please return this form to the researcher via email. If you have any questions prior to your participation please contact the researcher, Caitlin Payne via 2218988@student.uwtsd.ac.uk or the supervisor, Dr. Beverly Cole via beverly.cole@uwtsd.ac.uk

	Please Tick
I have read and understand the information provided about this research	
I understand that my participation in this research is voluntary	
I understand that this research is being carried out by a UWTSD student as part of their final year Master’s dissertation and is bound by the UWTSD and BACP ethical guidelines.	
I understand that interviews will take place online and be electronically recorded (audio and visual) via Microsoft Teams and that this data collected will be securely stored in accordance with General Data Protection Regulations (GDPR), the Data Protection Act (2018), UWTSD Data Protection and Storage Protocol, UWTSD Data Management Policy and Microsoft Teams privacy policy.	
I understand that I am able to request for my interview to be conducted without the camera on so that only audio data will be collected	
I understand that all information I provide will be kept confidential and will be anonymised through the use of pseudonyms in the final dissertation	

I understand that if I agree to take part, I am able to decline or not answer any questions I am not comfortable with or can leave the study at any point without providing a reason.	
I understand that I have the right to withdraw at any point up until one month after my data has been collected and that should this be the case, information from my interview will not be used.	
I also understand that direct quotations from the interview may be used within the final dissertation work.	
I understand that I can concerns about the research, if necessary, at any point during the research process and I have the necessary contact information	
I understand that at the end of the interview I will be debriefed and will have the opportunity to discuss any issues with the researcher.	
I understand that findings from this research may be the subject of journal articles/conference presentations and/or any other related educational or research work.	
I understand that all data collected will be destroyed once the research project is finalised and the researcher's degree is awarded.	
I would like to be sent the final research findings and any published works relating to this paper when it is available	

I, **(Add participant name)** agree to participate in the research conducted by *Caitlin Payne*, Department of Psychology and Counselling, University of Wales Trinity Saint David, under the supervision of *Dr Beverly Cole*

Signature: _____

Date: _____

Researcher Signature: _____

Date: _____

Please note that if you are unable to provide an electronic signature then the **receipt of this completed form via your email address will be taken as a form of your written consent.**

Appendix 7: Interview Schedule

Interview Schedule

Preamble (~ 10 Minutes)

- Start Video Call
- Welcome Greeting and Introductions
- Advise participants of recording/transcription of interview, request consent and press record

The researcher will then:

- Remind participants of the content in the information sheet: the purpose of study, data protection and storage, right to withdraw etc.
- Ensure participant understanding, provide opportunity to ask questions and request informed verbal consent
- Discuss reasonable accommodations and check in with participant needs (e.g. sensory factors like lighting, noise level, use of stim toys, movement or breaks needed etc) and suggest grounding technique(s) if needed

Please share what you feel is important, meaningful and relevant about your experience.

Section A: Your Identity

1. How do you identify?

Section B: Your Experience of Therapy

2. Could you tell me about your therapy experiences so far?
--

3. Was there anything about your therapy experience that you found particularly helpful or beneficial?

4. Was there anything about your therapy experience that you found particularly unhelpful or harmful?
--

5. Do you feel your identity impacted your experience of therapy? If so, how?
--

6. Do you feel there are any other aspects of your identity that impacted your therapy experience?

Section C: Accommodations, Recommendations and Final Comments

7. Do you have any thoughts about anything which could have been done to make your therapy experience more accessible, inclusive or helpful for you as a neuroqueer person?

8. Is there anything we haven't discussed that feels important to share?
This could be referring back to one of the questions we have covered, something else relating to your experience as a neuroqueer client in therapy, general feedback on this research and/or how you've found the interview process.

Debrief, Check-in and Closing Statements (~ 10 Minutes)

The researcher will:

- Check in with the participant: how they are feeling and if they require additional time to reflect upon anything that has come up for them during the interview process and/or suggest grounding exercise if needed
- Verbally debrief participant: talking through the purpose of study, data protection and storage, their right to withdraw and the next steps in the research process, i.e. feedback after interviews
- Remind the participant that a signposting document, along with a written debrief form will be sent after the interview has ended.
- Thank the participant for their time and contributions
- Stop Recording
- End Interview/Video Call

Appendix 8: Study Debrief Sheet

Study Debrief Sheet

Research Title: Navigating Neuroqueerness in the Therapy Room: An Interpretative Phenomenological Analysis exploring neuroqueer client experiences of therapy

Thank you for participating in this research. Your time and contributions are greatly appreciated.

Purpose of Research

This research aimed to:

1. Explore the lived experiences of individuals who identify as both neurodivergent and queer (*'neuroqueer'*) within the context of psychotherapy, using Interpretative Phenomenological Analysis (IPA).
2. Deepen understanding of how intersecting identities of neurodivergence and queerness shape clients' therapeutic experiences, needs, outcomes and the overall therapeutic process.
3. Identify key barriers and facilitators that influence access to and engagement with psychotherapy for neuroqueer individuals, considering systemic, relational, and cultural factors.

This study was undertaken in response to the current underrepresentation of neuroqueer voices in psychotherapeutic research and the limited literature acknowledging and exploring how queerness and neurodivergence may intersect to uniquely shape personal therapeutic experiences.

Enhancing our understanding of the complex realities faced by those who hold multiple marginalised identities is essential for informing more inclusive, person-centred, and intersectionally affirming psychotherapeutic practice. Such insight supports the development of more equitable mental health care for neuroqueer people.

Your Data: How will this be stored and used?

All information you provide throughout the entirety of the research process; before, during and after interviews, will be kept entirely **confidential** and **stored securely** in accordance with General Data Protection Regulations (GDPR), the Data Protection Act (2018), and the data management and privacy policies of UWTSD and Microsoft Teams. Only the researcher and supervisor will have access to this information.

Any information shared during the interviews will be anonymised using **pseudonyms** in the main body of the final research and any contextually identifiable information will be removed.

You also retain the **right to withdraw** from the study **at any point** during the research process. You may request the removal of your data for **up to one month following your interview**; after this point, the analysis process will have progressed to a stage where data withdrawal is no longer feasible.

All data collected will be permanently destroyed once the research has been completed and the researcher's degree is awarded.

Further information on data protection and privacy can be found here:
Microsoft Teams Privacy Policy: <https://www.microsoft.com/en-gb/microsoft-teams/security>
UWTSD Guidance of Data Management:
<https://www.uwtسد.ac.uk/library/research-data-management/>

What Happens Next?

Additional Comments and Feedback

You are able to contact the researcher to provide any additional comments **up to two weeks** after your interview has been conducted.

If engaging in this research process has left you needing more support and/or information, please see the **support and signposting document** provided.

If you have any questions or comments about any part of this research, you can contact the researcher or their supervisor, or you can follow the complaints procedure listed here: <https://www.uwtsd.ac.uk/external-complaints>

Researcher Name: Caitlin Payne

Email: 2218988@student.uwtsd.ac.uk

Supervisor Name: Dr Beverly Cole

Email: beverly.cole@uwtsd.ac.uk

Appendix 9: Support and Signposting Document

Support & Signposting

Immediate Support (24/7)

Samaritans: Immediate confidential support for people feeling distress, overwhelmed or needing to talk to someone. Phone: 116 123

SHOUT Crisis Textline: A 24/7 Text-based support organisation
Text: SHOUT to 85258

NHS 111: Select Option 2. Provides access to mental health crisis services.

General Mental Health Support

Mind: Charity provided mental health information, resources and guidance on accessing support. <https://www.mind.org.uk/information-support/>

The Mix: Inclusive support and resources for young people aged 25 and under. Includes discussion boards, support groups, counselling, chat, text, and helpline services. Also provides information about a range of topics like mental health, neurodivergence, sex and relationships.
Text: 85258 for urgent mental health support <https://www.themix.org.uk/>

Rethink Mental Illness: Includes advice and information services, helplines, community support, peer groups and advocacy services. <https://www.rethink.org/>

LGBTQIA+ Support & Information

Switchboard LGBT+ Helpline: Provides confidential support around gender, sexuality, mental health and relationships
Phone: 0300 330 0630 www.switchboard.lgbt

MindOut: a mental health service run by and for lesbian, gay, bisexual, trans, and queer (LGBTQ) people. Includes: including live chat, peer groups, and crisis support. www.mindout.org.uk

Stonewall: Providing information, rights-based guidance, and signposting for LGBTQ+ communities. www.stonewall.org.uk

Mermaids: Charity supporting trans, non-binary and gender diverse children, young people and their families since 1995. Offers helpline, webchat and text chat services.
Phone: 0808 801 0400 <https://mermaidsuk.org.uk/>

Not A Phase: A trans-led grassroots charity committed to uplifting and improving the lives of trans+ adults, through awareness campaigning, social projects and funding trans+ led initiatives. <https://notaphase.org/about/>

Neuro-Inclusive Support & Information

National Autistic Society: Offers guidance and support on mental health, education, work and wellbeing. Include an online directory for local and national services supporting neurodivergent people, as well as an online community. <https://www.autism.org.uk/>

NeuroTribeUK: Offers neurodivergent-affirming therapy and training. <https://neurotribe.uk/>

The Brain Charity: Offers mental health support, counselling, practical help for people with neurological conditions such as autism, ADHD and Tourettes, and their families, including a phone befriending service. <https://www.thebraincharity.org.uk/>

ADHD Adult UK: A charity for adults with ADHD run by adults with ADHD. Provides evidence-based advice, coaching, guides, diagnostic guidance and tools for adults with ADHD. <https://www.adhdadult.uk/>

Tourettes Action: support and research charity working to improve the lives of people living with Tourette's Syndrome. Offers local and online support groups, workshops and resources <https://www.tourettes-action.org.uk/>

Neurodivergent Insights: A blog created by a neurodivergent (AuDHD) psychologist, Dr. Neff, who creates mental health and wellness resources with neurodivergent people in mind. They also have a podcast called '*Divergent Conversations*'.

Information on Neuroqueerness

Neuroqueer Blog

Created by Dr. Nick Walker; author, educator and psychologist partially responsible for coining the term 'neuroqueer'. Their blog includes a series of essays, books and videos about neurodivergence, queerness and neuroqueerness. <https://neuroqueer.com/>

Reporting Unethical & Malpractice

Based on the nature of the topics discussed in the interview, you may wish to raise concerns and report a therapist on the basis of unethical or malpractice. This process depends on the professional body the therapist works under. Please find below a list of UK based professional bodies and links to their complaints procedures.

British Association for Counselling and Psychotherapy (BACP)

<https://www.bacp.co.uk/about-us/protecting-the-public/professional-conduct/how-to-complain-about-a-bacp-member/#:~:text=I'd%20like%20to%20make,Park%2C%20Lutterworth%2C%20LE17%204HB.>

UK Council for Psychotherapy (UKCP)

<https://www.psychotherapy.org.uk/ukcp-members/complaints/how-to-make-a-complaint/>

National Counselling and Psychotherapy Society (NCPS)

<https://ncps.com/complaints/complaints-concerns-procedure>

Health and Care Professions Council (HCPC)

<https://www.hcpc-uk.org/globalassets/resources/guidance/how-to-raise-a-concern.pdf>

NHS Based Services

In England: <https://www.england.nhs.uk/contact-us/feedback-and-complaints/complaint/#:~:text=If%20you're%20not%20happy,can%20also%20report%20fraud%20anonymously.>

In Wales:

<https://www.gov.wales/nhs-wales-complaints-and-concerns-putting-things-right>

Advocacy Services

VoiceAbility

<https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy>

Citizens Advice

<https://www.citizensadvice.org.uk/about-us/contact-us/>