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Therapy and counselling experiences of queer adults in Germany

Sonja Bröning[1] | Agostino Mazziotta[2]

[1]Department of Psychology, Faculty of Human Sciences, Medical School Hamburg (MSH), University of Applied Sciences and Medical University, Hamburg, Germany

[2]Department of Social Work, FH Münster, University of Applied Sciences, Münster, Germany

Correspondence
Sonja Bröning, Department of Psychology, Faculty of Human Sciences, Medical School Hamburg (MSH), University of Applied Sciences and Medical University, Am Kaiserkai 1, 20457 Hamburg, Germany.
Email: sonja.broening@medicalschool-hamburg.de

Abstract

Background: Mental health professionals play a crucial role in either alleviating or exacerbating stress among queer clients.

Aims: Drawing on minority stress theory, we conducted a study to examine the experiences of lesbian, gay, bisexual and/or consensually non-monogamous clients with current or recent psychotherapy or counselling experiences in Germany.

Method: A convenience sample of 492 queer individuals participated in an online survey, providing insights into their most recent experiences with psychotherapy or counselling and evaluating the success of these processes. Among the participants, 92% identified as lesbian, gay, bisexual, or another non-heterosexual identity, while 8% identified as heterosexual. Additionally, 54% reported being in consensually non-monogamous relationships, and 23% identified as gender-diverse.

Results: The majority (92%) had prior experience with psychotherapy, with over half reporting their last session within the last month. The remaining 8% reported counselling experience. Most participants rated their recent psychotherapy or counselling process as successful. Exemplary practices were more common than inappropriate ones. While overt discrimination by mental health professionals was rare, subtle inappropriate behaviours were still prevalent. Affirmative and actively reassuring practices were strongly linked to subjective therapy success.

Conclusion: The study's findings warrant cautious optimism regarding a non-discriminative stance in German mental health professionals while highlighting the need for further research, training and guidelines for therapists and counsellors.

KEYWORDS
consensual non-monogamy, counselling, gender, sexual and romantic diversity, psychotherapy, sexual minority adults

1 | INTRODUCTION

Mental health professionals play a crucial role in either alleviating or exacerbating stress among queer[1] clients. Within the German healthcare system, these professionals engage with queer clients either through psychotherapy—a service provided by clinically trained psychotherapists who treat diagnosed mental health disorders—or through psychological counselling, which encompasses a broader

range of psychological support offered in various settings, including community centres, churches and other organisations. Little is known about the experiences of these clients with mental health practitioners in Germany and how these experiences influence their evaluation of the therapeutic process. To address this research gap, we examined the psychotherapy and counselling experiences of queer individuals. Drawing on Meyer's stress model (Meyer, 1995, 2003), we aimed to identify key success factors and areas for improvement for health practitioners. Our research specifically focussed on individuals who identify as non-heterosexual and/or engage in consensual non-monogamy.

'Sexual minority populations' encompass a diverse group of individuals with various sexual orientations, including lesbian, gay, bisexual, pansexual, asexual, queer and fluid identities (American Psychological Association, 2021). In Germany, approximately 3%–4% of the population identifies as lesbian, gay or bisexual (Briken et al., 2021), with higher estimates in younger age groups (Scharmanski & Heßling, 2021). Notably, more women identify as bisexual, while more men identify as gay. The prevalence of individuals referring to themselves as 'not exclusively heterosexual' is higher, ranging from 11% to 22% in women and from 10% to 14% in men (Pöge et al., 2020). Internationally, a growing number of individuals identify as bisexual (Chandra et al., 2013). In the United States, approximately 21% of 'Generation Z' citizens (born between 1997 and 2003) identify as lesbian, gay, bisexual or trans* (Jones, 2022), with the majority referring to themselves as bisexual.

A substantial portion of sexual minority adults engages in various types of consensually non-monogamous relationships, such as 'monogamish', 'open', 'swinging' or 'polyamorous' relationships (Grunt-Mejer & Campbell, 2016; Hosking, 2013; Levine et al., 2018). While types of consensually non-monogamous relationships vary, they share the commonality that all partners involved explicitly agree to having multiple intimate partners, if they wish, though they are not obligated to do so. The prevalence of consensually non-monogamous relationships varies, with around 4%–5% estimated for the general population in the United States (Conley et al., 2013), but ranging from 32% to 45% among individuals identifying as 'gay', 5%–35% among individuals identifying as 'lesbian' and 22%–48% among individuals identifying as 'bisexual' (Haupert et al., 2017; Levine et al., 2018). There is also overlap between individuals who identify as sexual and/or relational minorities and those who identify as gender minorities, including trans*, genderqueer and non-binary identities (Van Anders, 2015).

Minority stress theory (Brooks, 1981; Meyer, 1995, 2003) suggests that psychological risk arises among individuals from sexual minorities due to heteronormativity, resulting in discrimination and victimisation. Although high-intensity aggression against queer people is declining in Western countries, stigmatising attitudes and microaggressions persist (Nadal et al., 2016; Woodford et al., 2014). According to an EU Fundamental Rights Agency survey (2020), 36% of individuals from a sexual minority reported experiencing harassment in the year prior to the survey. These forms of stigmatisation can impact self-worth and lead to psychopathology (Hatzenbuehler et al., 2013; Plöderl & Fartacek, 2009). Strong evidence points to elevated mental health vulnerabilities among these populations (Flentje et al., 2020; Plöderl & Tremblay, 2015; Reynish et al., 2023; Wittgens et al., 2022). These vulnerabilities are associated with minority stressors that operate through a variety of structural, interpersonal and intrapersonal processes, depriving queer individuals of equal access to health-protective resources. As Burton et al. (2019, p. 1) summarise, 'family and peer rejection, along with societal prejudice and discrimination, can compromise mental health by prompting chronic vigilance for sexual-orientation-based rejection, heightened internalized homophobia, maladaptive coping responses, and altered physiological stress reactivity'.

Romantic minorities, defined here as persons in consensually non-monogamous relationships, also experience stigma and discrimination (Rodrigues et al., 2021). Monogamy is the prevailing cultural norm in many Western countries, leading to negative perceptions of individuals in consensually non-monogamous relationships as 'amoral' or 'deficient' (Thompson et al., 2018). However, research does not clearly show that people in consensually non-monogamous relationships have lower well-being or impaired mental health than those in monogamous relationships. Studies indicate that consensually non-monogamous relationships can be a valid and satisfying

Implications for practice and policy

- Minority stress theory suggests that psychological risks among queer individuals arise due to hetero-mononormativity, leading to discrimination and victimisation. Mental health professionals play a crucial role in either alleviating or exacerbating this minority stress.
- Our community sample of 492 queer adults in psychotherapy and counselling offers reasons for cautious optimism. Overt forms of discrimination were rare, and exemplary practices were more frequently reported than inappropriate ones. However, a substantial number of participants still reported experiencing inappropriate behaviour or subtle forms of discrimination.
- To effectively support queer clients, therapists and counsellors should create an affirming and supportive environment. They should adopt an attitude of 'informed naivety', which involves striving to understand clients on their own terms while possessing a fundamental understanding of diversity in gender, sexuality and relationships.
- There is a need for improved preparation and training for mental health practitioners regarding queer clients, as sexuality-related topics are significantly underrepresented in standard psychotherapeutic and counselling curricula.

relationship option with no significant differences in relationship satisfaction or attachment security (Brewster et al., 2017; Conley et al., 2017; Rubel & Bogaert, 2015). Nevertheless, heterosexual individuals openly engaging in consensually non-monogamous relationships may face victimisation for challenging the prevalent monogamous ideal (Grunt-Mejer & Campbell, 2016; Séguin, 2019). For sexual minority individuals, adopting a consensually non-monogamous lifestyle may subject them to additional stigma, as having multiple sexual partners can be misinterpreted as evidence of possessing lower moral standards or engaging in sexually risky behaviour (Stults et al., 2023).

1.1 | Therapy and counselling for queer clients

Affirmative therapy models for queer clients aim to enhance their coping skills in relation to minority stress while affirming and validating their minority identity as equally valid as any cis/hetero experience. One example is ESTEEM, a programme grounded in cognitive behavioural therapy that includes motivational enhancement, interoceptive and situational exposure, cognitive restructuring, mindfulness and self-monitoring elements (Burton et al., 2019). Affirmative therapy for queer clients has been shown to be effective (O'Shaughnessy & Speir, 2018; Pachankis et al., 2022), but it is not yet widespread. Queer clients frequently report unmet mental healthcare needs, more so than the general population (Gaspar et al., 2021; Steele et al., 2017). The gap between the elevated need for mental health care and the lack of satisfactory services sensitive to minority stress has been repeatedly addressed (Turpin et al., 2024), as have the barriers to seeking this care due to stigmatisation both within and outside healthcare settings (Silveri et al., 2022).

Mental health care in Germany is primarily provided by psychotherapists, psychiatrists, eligible medical doctors, psychiatric hospitals, psychosomatic clinics and psychiatric outpatient clinics (Melcop et al., 2019). Social workers and other professions provide counselling for queer clients in clinics, but, more importantly in the context of walk-in centres and institutions, sometimes specifically address the needs of queer clients. While public awareness of queer affirmative therapy and counselling has been rapidly increasing in recent years in Germany, research in this area is sparse, except for some small, qualitative studies (Lampalzer et al., 2019). In fact, there is very limited scholarship that shares client experiences and perceptions of therapy, particularly including bisexual and lesbian individuals in any contexts outside the United States.

This study addresses this research gap by investigating how queer clients evaluate their experience with German-speaking mental health practitioners in a larger, community-based sample. Based on the existing literature, we assume that mental health practitioners may still hold stigmatising views towards queer individuals (Shin et al., 2021; Spengler et al., 2016) and exhibit inappropriate behaviours towards queer clients (Liddle, 1996, 2000). Liddle (1996) and Schechinger et al. (2018) found that inappropriate behaviours were linked to lower therapy success and satisfaction.

2 | METHOD

We conducted a cross-sectional survey, with closed and open questions. Participants were recruited through various channels, including social media, word of mouth, a sexuality podcast and community-based organisations. Data were collected between November 2021 and January 2022. Eligible individuals were adults who identified as non-heterosexual (e.g. lesbian, gay, bisexual, asexual and queer) and/or engage in a consensually non-monogamous relationship (e.g. open, swinging or polyamorous) and had experienced psychotherapy and/or some form of counselling (e.g. church counselling, institutional or private counselling). All participants provided written informed consent before completing the online survey. The institutional ethics committee of the Medical School Hamburg approved the study (MSB-2021/160).

The questionnaire consisted of three sections: (a) sociodemographic information; (b) experiences and evaluation of current therapeutic process; and (c) additional measures not relevant to the current manuscript, which will be reported elsewhere. We combined and translated the measures used in Liddle's as well as Schechinger and colleagues' studies (Liddle, 1996; Schechinger et al., 2018). Participants rated the applicability of 13 observable exemplary and inappropriate practices (e.g. 'Engaged with LGBQP orientation when relevant'; 'Refused to continue after indicating LGBQP') to their last or current therapist/counsellor on a scale from 1 (*not at all applicable*) to 4 (*very applicable*). We focussed on experiences with their most recent or current therapist/counsellor to minimise recall bias.

We also measured therapy/counselling success using two self-constructed items: 'How useful was the therapy/counselling process for your issue'? And 'how likely is it that you would recommend your therapist/counsellor to someone else'? Responses were on a 5-point Likert scale, ranging from 1 (*not at all useful/definitely not*) to 5 (*very useful/definitely yes*). These items were highly correlated (Pearson's $r = .78$), and therefore combined into a single measure of 'subjective therapy/counselling success'.

All data analyses were performed by using SPSS version 24.0 (IBM Corp., Armonk, NY). A significance level of $p < .05$ was used for all analyses. We analysed frequencies, means (*M*) and standard deviations (*SD*s) of the demographic characteristics and helpful as well as inappropriate behaviours and used correlations to compute the strength of their association with therapy success.

3 | RESULTS

3.1 | Participants

A total of 492 individuals (see Table 1 for sample characteristics) completed the survey, ranging in age from 18 to 64 years ($M = 29.27$; $SD = 8.62$). The majority were in their 20s or early 30s. Among the participants, 87% had the highest German school qualification, and 91% held German citizenship. Regarding gender identity, 65% identified as (cis)female, 12% as (cis)male and 23% as genderqueer,

TABLE 1 Sample characteristics ($N = 492$).

Gender	Sexual orientation	Relationship form[a]	Point(s) of contact with health system
65% (cis)female	30% lesbian	46% monogamous (sexuality + intimacy only with one partner)	92% psychotherapy
12% (cis)male	8% gay		26% inpatient treatment with therapeutic components
12% non-binary	31% bisexual	31% polyamorous (sexuality + intimacy with several partners)	30% counselling center
5% genderqueer	8% heterosexual	13% open relationship/ swinging (sexuality with several partners)	11% private counselling
2% trans*	23% other		10% church counselling
4% other		10% other	9% other

[a]71% of participants indicated being in a relationship.

non-binary, trans* or other (e.g. 'agender', 'genderfluid' and 'questioning'). While gay men were underrepresented, there was a substantial number of women with bisexual orientation. About 23% did not identify with any provided labels and choose the option 'other' (e.g. 'pansexual', 'queer', 'omnisexual' and 'panromantic'). We did not actively recruit individuals identifying as a gender minority, including trans* persons, or persons with differences of sex development, due to methodological considerations (e.g. mandatory therapy for gender transition in Germany warranting different research questions about therapy experience).

Seventy-one per cent of participants indicated being in a relationship. Descriptive analyses revealed large diversity in relationship structures, with 46% describing their relationship as monogamous, 31% as polyamorous, 13% as open and 10% of respondents did not feel any of the provided labels fit their relationship structure. Among those who selected 'other', self-descriptions included 'planning an open relationship', 'relationship anarchy' and 'open for polyamory'. All participants had prior experience with therapy and/or counselling, seeking help for various reasons, such as mental health, particularly depression, trauma, and anxiety, and issues related to transitioning, identity, relationships or job problems.

3.2 | Therapy/counselling processes

Table 2 presents details about the therapy/counselling services received. Most participants had been with their therapist for over 10 sessions, and in 74% of cases, the sessions occurred within the last 6 months. About 79% of therapists/counsellors were described as female, 20% as male and 1% as 'other'. The broad majority had received psychotherapy (92%), and only 8% reported having solely experienced counselling. Figure 1 illustrates the frequency of exemplary and inappropriate therapist/counsellor practices. Overtly inappropriate behaviours, such as 'refusal to continue therapy/counselling', 'pushing to renounce LGBQP orientation' or 'pressuring to come out', were rarely observed in recent therapy/counselling sessions. Exemplary practices were more common, especially 'engaging in LGBQP topics when relevant for the therapeutic process' and 'helping clients feel good about being LGBQP'. However, automatic assumptions about monogamy and heterosexuality, along with a lack of basic knowledge regarding community issues, were still evident. Participants reported a high subjective usefulness of therapy ($M = 4.11$; $SD = 1.08$), and the majority would recommend their therapist/counsellor to others ($M = 2.84$; $SD = 1.23$). For explorative purposes, we examined how strongly exemplary and inappropriate practices were associated with subjective therapy/counselling success. As shown in Table 3, strong correlations were evident for practices related to understanding, validating and affirming queer clients.

4 | DISCUSSION

In an online survey, we examined perceptions of exemplary and inappropriate therapist/counsellor practices among 492 queer clients. Like previous studies conducted in North America (Liddle, 1996; Schechinger et al., 2018), our findings offer reason for cautious optimism, as exemplary practices were more frequently reported than inappropriate ones. Nevertheless, a substantial number of queer individuals reported inappropriate behaviour by mental health practitioners.

Subtle forms of discrimination were reported quite frequently, such as attributing psychological problems to the queer status (22%). More overt forms of discrimination were rarer, such as pressuring clients to 'come out' (11%), viewing their sexual orientation or consensually non-monogamous relationship as bad, sick or inferior (15%), or refusing therapy/counselling after disclosure of queer status (6%). By comparison, a recent study from China revealed that more than half of the participants felt openly devalued by their therapist (Liu et al., 2022), highlighting culturally different stances towards queer clients.

While consensual non-monogamy is not extensively studied, acceptance may still be rarer in this field (Henrich & Trawinski, 2016;

TABLE 2 Therapy/counselling characteristics ($N = 492$).

Timing of last session	Total number of sessions	Gender of therapist/counsellor	Age of therapist/counsellor	Importance of therapist/counsellor's knowledge and skills regarding sexual and relational diversity for choosing current mental health expert
58% within the last month	6% 1–2 sessions	79% female	7% <age 30	13% very important
16% within the last half year	9% 2–5 sessions	20% male	37% ages 30–40	17% important
17% within the last 2 years	13% 5–10 sessions	1% "other"	26% ages 40–50	21% partially important
12% longer ago than 2 years	71% more than 10 sessions		21% ages 50–60	23% not very important
			6% >age 60	24% not important at all
			4% unknown	

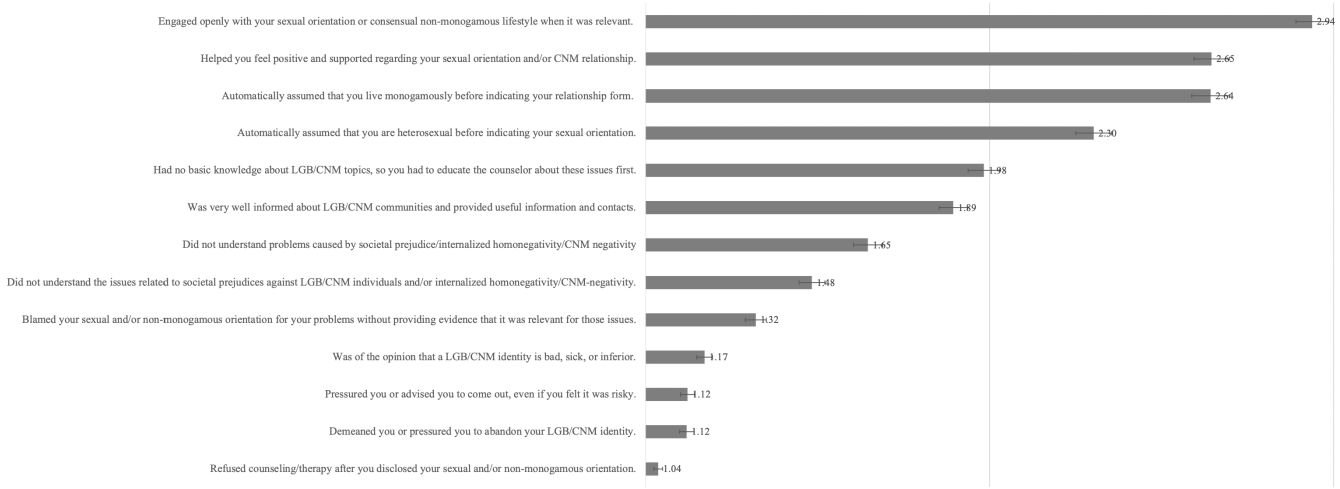

FIGURE 1 Mean (standard error) of exemplary and inappropriate practices of mental health practitioners as perceived by sexual, gender and relational minority clients. Participants indicated for each practice how much the behaviour was applied to their last or current therapist/counsellor (1—*not at all applicable*; 4—*very applicable*). CNM, consensual non-monogamous; LGB, lesbian, gay and bisexual.

Moors et al., 2021). Implicit forms of stigmatisation, such as automatic hetero-, mononormative assumptions, appeared quite frequently. In about 40% of cases, therapists did not understand the problems of societal prejudice against queer individuals and internalised homonegativity/consensual non-monogamy negativity. Other studies have shown that healthcare providers and counsellors lack awareness of consensually non-monogamous relationships and may negate or trivialise queer-related problems (Bieschke & Matthews, 1996; Henrich & Trawinski, 2016; Israel et al., 2008; Vaughan et al., 2019).

About one-third of therapists/counsellors were perceived as having limited or no knowledge about queer topics, and as failing to acknowledge the importance of queer identities. Schechinger et al. (2018) found comparable results. Some practitioners also failed to openly address these issues or adequately support romantic diversity. Even though 46% of participants did not find their therapist's knowledge and competence in working with queer clients important when selecting these practitioners, they may have reconsidered this as therapy progressed. In Ford and Hendricks' study (2003), only 42% of therapists reported having explored sexual minority issues. Conversely, other studies highlight the therapist's expertise as essential (Atkinson et al., 1981; Liddle, 1996; Schechinger et al., 2018), and as a significant influence on therapeutic success (Dorland & Fischer, 2001; O'Shaughnessy & Speir, 2018; Quiñones et al., 2017).

The data indicate that only about half of the therapists or counsellors helped their queer clients feel good about themselves. While overt stigma may be diminishing, the lack of implicit affirmation, positivity and acceptance is still evident in many cases. This may manifest through subtle cues, such as avoiding certain topics or using language that is not neutral towards sexual orientation and monogamy.

Overall, satisfaction with therapists and counsellors was widespread in our convenience sample. Nearly half of all participants rated the process as 'very useful' (49%), and an additional 25% rated it as 'fairly useful'. A similar percentage would probably or surely recommend their therapist to others. This finding can be interpreted

TABLE 3 Correlation of exempary and inappropriate practices with therapy/counselling success as perceived by queer adults.

Exemplary and inappropriate practices	Correlation
Exemplary practices	
Helped you feel positive and supported regarding your sexual orientation and/or CNM relationship.	$r = .64$
Engaged openly with your sexual orientation or consensual non-monogamous lifestyle when it was relevant.	$r = .55$
Was very well-informed about LGB/CNM communities and provided useful information and contacts.	$r = .44$
Inappropriate practices	
Did not recognise the significance of your non-heterosexual and/or consensual non-monogamous relationship and/or did not appropriately support these relationships.	$r = -.52$
Did not understand the issues related to societal prejudices against LGB/CNM individuals and/or internalised homonegativity/CNM-negativity.	$r = -.49$
Blamed your sexual and/or non-monogamous orientation for your problems without providing evidence that it was relevant for those issues.	$r = -.49$
Had no basic knowledge about LGB/CNM topics, so you had to educate the counsellor about these issues first.	$r = -.43$
Was of the opinion that a LGB/CNM identity is bad, sick or inferior.	$r = -.41$
Automatically assumed that you are heterosexual before indicating your sexual orientation.	$r = -.40$
Demeaned you or pressured you to abandon your LGB/CNM identity.	$r = -.38$
Automatically assumed that you live monogamously before indicating your relationship form.	$r = -.32$
Pressured you or advised you to come out, even if you felt it was risky.	$r = -.28$
Refused counselling/therapy after you disclosed your sexual and/or non-monogamous orientation.	$r = -.20$

Note: All correlations listed here are statistically significant ($p < .05$).

Abbreviations: CNM, consensual non-monogamous; LGB, lesbian, gay, and bisexual; *r*, Pearson's correlations.

from various angles. On the one hand, the presence of inappropriate behaviours or the absence of exemplary ones does not seem to eliminate therapy effectiveness for many queer clients. On the other hand, queer clients might be accustomed to facing some degree of stigma and devaluation, leading them to 'mask' their identity or cope with it in various ways to receive therapeutic help. Such 'masking' behaviours could weaken the therapeutic alliance (Flückiger, 2018), potentially resulting in less sustainable long-term effects, which may not be discernible with our cross-sectional design. Clear links were found between exemplary and inappropriate practices and self-assessed therapy success. Therapists were most successful when they displayed affirmation, openness and helped clients feel good about their queer identity. Openly exploring clients' sexual orientation and consensually non-monogamous lifestyle when relevant also contributed to positive outcomes. On the contrary, not recognising or supporting clients' gender, sexual and/or relational identity, lacking understanding of societal prejudice and attributing mental health problems to queer status negatively affected therapy success. It is important to note that our study focussed on ongoing or not-yet-cancelled therapy processes, in which explicitly derogatory behaviours were rare. The nuances in these generally well-received therapeutic processes can make a difference, turning 'average' therapy into something truly meaningful and empowering.

Integrating queer attributes into a positive self-concept while conducting a therapeutic process that is aligned with clients' goals appeared to be especially helpful. Other studies have also shown associations between exemplary practices and the psychological well-being of queer clients (Alessi et al., 2019; Pachankis et al., 2015, 2022; Schechinger et al., 2018). Alessi et al.'s (2019) study found that therapeutic alliance mediated the relationship between helpful therapist behaviour and well-being in queer clients. Subtle devaluations, also known as 'microaggressions', can undermine the therapist–client relationship. They negatively impact therapy satisfaction and self-acceptance and may discourage individuals from seeking further psychological help. Unchecked inappropriate behaviours or microaggressions can exacerbate the stigma experienced in other contexts (Rodrigues et al., 2021; Stults et al., 2023).

4.1 | Limitations and recommendations for future research

To our knowledge, the current study is the most comprehensive investigation of therapy and counselling experiences of queer clients in Germany. However, the external validity of the presented results should be considered in the light of our convenience sample, which

is predominantly young, educated and gender-skewed, with a large proportion of (cis)women. This distribution aligns with Schechinger et al.'s (2018) study, in which 62% identified as female and 25% as male. The inclusion criterion of 'experience in therapy and counselling' may have contributed to this bias, as women tend to be more open to seeking psychological help. It is worth noting that older studies on therapy of queer clients have reported fewer positive outcomes. Males identifying as sexual minorities have reported poorer mental health outcomes and more unmet mental health needs due to barriers rooted in heterosexism and homonegativity (Gaspar et al., 2021). In those studies, women and individuals in consensually non-monogamous relationships were underrepresented, highlighting the relevance of the study at hand (O'Shaughnessy & Speir, 2018). Bisexual women may have more unmet mental health needs than heterosexual (cis)gender women (Steele et al., 2017) and experience greater sexual minority stress and lower social support than lesbian women (Baldwin et al., 2017).

Even though only a small percentage of participants reported having only experienced counselling, not psychotherapy, we cannot be sure whether the 'most recent experience' focussed on in this study is a psychotherapeutic or counselling process. Therefore, our research does not represent one professional group (such as clinical psychotherapists), and future research must compare mental health professionals' counselling processes in more detail. Additionally, we did not include other professional groups, such as medical doctors and psychiatrists, limiting comparisons with previous research. Around 78% of therapists or counsellors in our study were women, so the findings may not directly apply to therapists of other genders. Information on sexual orientation of therapists and counsellors was not available for the study.

Another limitation is the scope of therapeutic experience we examined. We focussed on participants' most recent therapy experience. As a result, 73% of cases had sessions within the last month or six months, reducing recall bias. While this approach was successful in assessing current satisfaction, we lack insight into earlier therapeutic processes that might have been affected by inappropriate behaviour and led to unsuccessful attempts.

Even though we had not actively sought to recruit gender-related minority members, our sample included a substantial percentage of persons also identifying, for example, as 'genderqueer'. We cannot be sure how prejudice on gender minorities may have influenced therapists' behaviours in our sample.

The cross-sectional nature of the study prevents us from establishing causality, particularly regarding the role of client characteristics which can predict therapy success. For example, individuals with stronger affirmation of their sexual identity may perceive fewer instances of sexual prejudice in counsellors (Spengler et al., 2023).

Intersectional minority stress and other characteristics, such as differences in help-seeking attitudes between urban and rural populations, may also influence therapy outcomes. Measures other than self-report would provide further validation of these outcomes. There is a need for longitudinal, mixed-method research that allows for stronger causal conclusions regarding factors that might affect therapy and counselling processes and outcomes for queer clients. Recently, new measures are becoming available that will aid this research by providing a more comprehensive view on therapists' practices with queer clients (Turpin et al., 2024).

Finally, each minority group faces unique challenges, mental health problems and experiences. Future research is needed to explore the impact of differential client and context characteristics, as well as intersectional minority stress, on the effectiveness of mental health services (Reynish et al., 2023).

4.2 | Implications for practice

To effectively support queer clients, therapists and counsellors should create an affirming and supportive environment, adopting an attitude of 'informed naivety' that aims to comprehend clients on their own terms while possessing a fundamental understanding of diversity in gender, sexuality and relationships, along with the associated dynamics.

Psychotherapists and counsellors should prioritise reducing implicit inappropriate behaviours, such as making assumptions and neglecting to validate issues related to societal stigma. Simultaneously, they should strive to increase exemplary behaviours, such as being well-informed and affirming.

Based on our findings, as well as on former work in the field, training for mental health professionals should be extended to guide therapists and counsellors in adopting an approach that is:

1. Stigma-informed: This includes understanding of various forms of societal stigma, discrimination and microaggression (O'Shaughnessy & Spokane, 2013) and being aware of the potential impact of these experiences on a client's unique situation (Bidell & Whitman, 2013; Hutzler et al., 2016).
2. Affirmative: This refers to possessing and conveying a positive, supportive attitude towards queer clients, encouraging the development of a positive identity and recognising that some queer clients may find belonging to a specific category beneficial for their identity, while others may prefer not to label themselves when categories feel restrictive and limiting (Ghavami et al., 2011). Affirmative practice also includes teaching coping skills and promoting awareness of internalised forms of negativity (Browning et al., 1991).
3. Resource-, community- and subgroup-informed. This means being knowledgeable about resources and community support available to queer clients, particularly considering that these clients may often not have supportive families of origin (Nichols, 2020), and being familiar with various issues that can arise with different client groups, such as understanding the impact of machismo on self-esteem in gay clients and potential reinforcement from certain aspects of gay culture. Also, it is necessary to be aware of the 'double jeopardy' of stigma faced by bisexual clients from both the larger culture and some parts of the queer community (Nichols, 2020), and to understand the significance of

intersectionality, including race-ethnicity, as well as its influence on the identities of queer individuals (Kavanaugh et al., 2020; Tierney et al., 2021).

4. Self-reflective: Acknowledging implicit homonegativity and non-monogamy negativity prevalent in society (including within the therapist and counsellor), recognising own privileges, demonstrating openness to criticism, openly addressing inadvertent microaggressions and empowering the client to confront subtle forms of devaluation and facilitate relationship repair (Quiñones et al., 2017; Spengler et al., 2016).
5. Context and language sensitive: These factors play a significant role in either perpetuating or reducing implicit stigma. Elements in the waiting room, assumptions on the website and symbols present can contribute to implicit stigma (Spengler et al., 2020). Inclusive language should be used, therapists should ask about names and pronouns, avoid assumptions about gender identity, sexual orientation or relationship status and use neutral terms, such as 'spouse', instead of gender-specific terms, such as 'husband' (Nichols, 2020).

4.3 | Final remarks

Our study on recent therapy and counselling experiences of queer individuals provides valuable insights into the evolving landscape within Germany. Despite increasing public awareness of queer issues, stigma and prejudice continue to pose psychological risks for queer people. Mental health professionals have a crucial role in supporting queer clients in effectively dealing with discrimination and marginalisation. Being well-equipped for this task is essential in their efforts to help clients heal and thrive in the face of intolerance. The findings from our community sample of 492 queer adults offer reason for cautious optimism: overt forms of discrimination were rare, and exemplary practices were more frequently reported than inappropriate ones. However, inappropriate behaviour or subtle forms of discrimination were still frequently reported by a substantial number of queer clients. There is a need for improved preparation and training for mental health practitioners regarding queer issues (Brandt et al., 2022), as sexuality-related topics are significantly underrepresented in standard psychotherapeutic and counselling curricula.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest or competing interests to declare that are relevant to the content of this article.

DATA AVAILABILITY STATEMENT

The study was not pre-registered. Data are available from the authors upon reasonable request.

ETHICAL APPROVAL

This study was approved by the Ethics Approval Board of the Medical School Hamburg.

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ORCID

Sonja Bröning https://orcid.org/0000-0001-9803-9779

ENDNOTE

[1] 'Queer' is an inclusive term that embraces all LGBTIQ* identities and signifies a stance that challenges binary/categorial conceptions of gender and sexuality. It reflects a perspective that recognises sexual orientation and gender identity as fluid and evolving. While 'queer' was historically used as a slur, it has been reclaimed by the LGBTIQ* community to express pride, defiance and solidarity. Despite the shared experiences of navigating complex identity processes and facing discrimination, those who identify as queer represent a highly diverse group. Importantly, not everyone within the LGBTIQ* spectrum identifies with the term 'queer'. Therefore, it is essential to respect and use the self-identifications that individuals personally choose and find meaningful.

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AUTHOR BIOGRAPHIES

Sonja Bröning is a tenured professor for developmental psychology at the Medical School Hamburg and a certified mediator, couple/family and sexual therapist. Her research interests lie at the crossroad of intimate relationships, sexuality and diversity. She is inspired by her students, and her work as a practitioner in the area of close relationships.

Agostino Mazziotta is a tenured professor of diversity and community work at the Applied University in Münster. He is a certified couple and sexual therapist and the Editor-in-Chief of ‘*Blickpunkt EFL-Beratung*’, a journal dedicated to couple and family counselling.

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