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Rima Hawkins & Silva Neves

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# Queering the 7-eyed model of clinical supervision

Rima Hawkins and Silva Neves 

Private Practice, London, UK

## ABSTRACT

In this essay, we argue that the 7-eyed model of clinical supervision (as well as most models in psychotherapy) are in need of “queering.” What we mean by “queering” is to make the model adaptable to the wider work with gender, sex, sexuality, erotic, and relationship diversities (GSERD) in clinical supervision. It is applicable to supervisors and/or supervisees and the clients who identify outside the societal heteronormative, mono-normative, and cisgenderist norms. Psychotherapy and psychology, and by extension, clinical supervision, have been criticised for being white, middle-class, heteronormative, and euro-centric. This article will provide a framework and guidance for clinical supervisors on how to adapt the 7-eyed model to diverse populations.

## LAY SUMMARY

The field of psychotherapy is generally embedded in white and heteronormative assumptions. These assumptions also apply to clinical supervision. This paper explains how we can adapt the 7-eyed model of clinical supervision to be more effective for clients and supervisees who are outside of the societal norms and marginalised, to foster an anti-oppressive practice.

## ARTICLE HISTORY

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## Introduction

Clinical supervision is compulsory for therapists practicing in the UK who belong to a membership professional organisation such as UKCP, BACP, and COSRT, and therefore, both supervisor and supervisee have an ethical responsibility towards clients' wellbeing. It is well acknowledged that clients have complex intersectionality which includes gender, sex, sexuality, erotic, and relationship diversities (GSERD), yet the clinical trainings in these areas are notoriously poor.

The acronyms GSRD and GSERD are used interchangeably in academic literature because they essentially mean the same things: gender, sex and relationship diversity, both including erotic diversity. The term GSRD originates from Meg-John Barker (2019) and Dominic Davies (<https://pinktherapy.org>). In some literature, the term developed into GSERD to make the erotic diversity visible within the acronym (Twist et al., 2022). The term GSRD is used most often in literature and clinical training

(Neves & Davies, 2023), but the use of GSERD is growing. The authors accept both terms given they hold the same meaning. In this article, we use both GSRD (GSRD therapy and GSRD competences) and GSERD as wider context. We acknowledge that this article is written by authors based in the UK where the term GSRD is best known.

The definition of GSRD/GSERD includes (Neves & Davies, 2023; Twist et al., 2022):

*Gender*: all gender spectrum including transgender, agender, bigender, cisgender, crossdressers, genderqueer, gender-fluid, and nonbinary. It also includes First Nations/indigenous genders that have been erased by colonisation.

*Sex*: all diversity of biological sex including intersex characteristics.

*Sexuality*: all sexual orientation/identities including lesbian, gay, bi+, pansexual, asexual, grey, and demi sexual, heterosexual, queer.

*Erotic*: includes erotic orientations such as celibate people, those engaging in BDSM, kink, and fetish.

*Relationship diversity*: people in the aromantic spectrum, people involved in power relationships (Dom/sub, BDSM/kink), sex work relationships, people in multi-partnered relationships such as swingers, consensual non-monogamous people, polyamorous people, and those in monogamous or monogam-ish relationships.

In some clinical discourse, GSRD/GSERD has traditionally been a synonym of the acronym LGBTQ+ but, in its essence, the term represents the diversity of all people, including heterosexual people. The important difference when we discuss GSERD is that it requires specific awareness, skills, and knowledge in working with people whose identity and sexual behaviours fall outside of the dominant heteronormative, mono-normative, and cisgenderist culture. Barker (2019) asserts the GSRD knowledge is also helpful to people who fit in with heteronormativity because they may be stuck in following strict “rules” that don’t suit them (i.e. a heterosexual man who struggles to process his emotions because the masculinity script tells him he should not feel sad or “weak”).

The term “Queer” was used negatively in the past as a homophobic slur. It has since been reclaimed by the LGBTQ+ communities and now refers to the broad identifications within the LGBTQ+ communities. The verb “queering” is also used as challenging societal norms that privilege the dominant narratives (Czyzewska, 2022). In this article, we use Queering the 7-eyed model of clinical supervision to challenge the pervasive blind spot of our profession in terms of diversities.

For clarity, in this article, we use the following terms:

“Client” refers to the service users or patient of counselling and psychotherapy.

“Sessions” is the clinical work of the supervisee with their clients.

“Supervisee” refers to the therapist who is directly involved in the clinical care of the client.

“Supervisor” is the professional clinician offering clinical supervision of the supervisee.

“Supervision” is the clinical discussion between the supervisee and supervisor.

“Consultant” is the professional clinician who offers supervision of the supervisor as part of the required professional accountability structure.

“Consultation” is the clinical discussions between the supervisor and the consultant.

The purpose of queering the 7-eyed model of clinical supervision is to support and challenge the perceptions and common assumptions of the frame of reference of

individuals whether they are supervisee, supervisor, and consultant. Here is a brief example of a common assumption due to the lack of GSERD knowledge and curiosity:

Tom (supervisee) discussed with Jerry (supervisor) that his client Mimo felt isolated as an immigrant. Despite Tom's encouragement to reach out to his community living in the UK, Mimo has been reluctant to do so. Jerry thinks that Mimo is "resistant to therapy." Both Tom and Jerry are trying to find the appropriate clinical formulation as to what might contribute Mimo being resistant to therapeutic interventions about community building in order to reduce isolation. The shared blind spot of Tom and Jerry is that neither have been curious about Mimo's sexual orientation because the only identity they perceived about Mimo was one of being an immigrant due to political reasons in his country of origin. If Tom and Jerry had some awareness of GSERD as part of Mimo's intersectionality, and enquired about that part of Mimo's identity, they might have realised that Mimo identified as a gay man, and therefore, he did not want to reach out to his community for fear of homophobia within his own community. Therefore Mimo's perceived resistance to a therapeutic intervention was actually a protection for himself. Another common blind spot could be that the privilege of heterosexuality in both the supervisee and supervisor may have disabled them both from being aware of the anti-LGBTQ+ laws of Mimo's country of origin and its psychological impact.

### **Defining and understanding supervision**

The term supervision has been in use in managerial practice where it has come to mean not just overseeing but also concern with standards and measurement of effectiveness. In a clinical setting, this meaning differentiates the equality or collaborative aspects in the relationship and emphasises the difference in power dynamics. Bāk (2023) argues that clinical supervision in psychotherapy needs to be relational. He also states that the supervisor and the supervisee are equal in their common focus to make the process for the client safe and therapeutic. At the same time, the relationship can be unequal because the supervisor has a responsibility to hold the therapist accountable in order to safeguard the interests of the client, and, if necessary, put those interests above the supervisee's. This is in particular with trainee supervisees where the power difference extends to evaluating competencies. The supervisory process can be compared to Eric Berne's (1964) Transactional Analysis model of adult-to-adult or parent-to-child dynamics or Donald Winnicott's (1965) "good enough mother" where the good enough therapist can survive the negative emotions of the client through the strength of being held within and by the supervisory relationship.

The verb "queering" requires making the commitment to establish and maintain an anti-oppressive practice. Berne's model and Winnicott's conceptualisation can both inform us in introducing an ethical practice to clinical supervision by helping us identify the power dynamics as well as the supervisory holding that is needed. Here are two examples of using both Berne's and Winnicott's ideas in identifying oppression.

### **Relational dynamics in clinical supervision**

Berne's Parent-Adult-Child model (P-A-C) is a helpful frame in distinguishing the power dynamics within relationships with identifying ego states of Parent, Adult, and

Child. It is the responsibility of the supervisor to identify and acknowledge the power differentials of certain roles (e.g. when working with trainee psychotherapists), and, in the instance of the supervisor identifying as heterosexual, and therefore, in a powerful position of a dominant culture who may unconsciously take the role of the “critical parent” and minoritise the supervisee pushing them into an “adaptive child” role.

Julie (supervisor) dismissed Bo (supervisee) when they brought up a concern about their client’s gender dysphoria. Julie told Bo that they were having “woke thoughts” based on no evidence and that if Bo’s client struggled with their body, it could be treated with psychoanalysis rather than the gender-affirming interventions that Bo learned in their training. When Bo was unhappy about Julie’s opinion, Julie stated clearly that she had 20 years of experience while Bo was only a trainee, and therefore, was told to follow Julie’s instruction if Bo wanted to pass their course.

In Winnicott’s opinion, the “mother” is able to withstand or rise above the child’s attack when there is release of emotions. In that moment, the child knows that they can be held by the mother’s unconditional love.

Peppy (supervisee) identifies as cisgender and heterosexual. She discusses a client, Pete, who identifies as a cisgender gay man. Pete had been very angry with Peppy, saying that they felt misunderstood by her. Pete perceived Peppy as “cold” because she would not answer personal questions about her from Pete. He said: “you don’t care about me.” Pete previously mentioned feeling distressed in his childhood because his mother was “cold and did not care about him.” As soon as Pete came out as gay, his mother abandoned him and never spoke to him again. Even though Peppy could identify that Pete was projecting his anger towards his mother onto her, she felt overwhelmed by Pete’s intense emotions. Peppy told her supervisor: “I don’t know what to do, I feel deskilled.” In the overwhelming moments, Peppy was in a rush to find an intervention, or a technique that would calm Pete’s emotions down. Peppy’s supervisor reminded her that Pete needs holding in his current distress rather than rationalised. It is only when Peppy can hold Pete that the layers of anger may be explored, including the relational wounds, homophobia, and the grief of abandonment from his mother. Peppy attempting to offer solutions at the time of distress reminded Pete of his childhood: he could not just be, he had to somehow be “nice” and fit into his mother’s world, repressing his sexuality and core sense of self. Once Peppy understood the Winnicott’s concept of the “good enough mother,” she was able to create a distance from Pete’s anger towards her by being fully present to his distress, which ultimately soothed Pete.

A practice centred in anti-oppression includes mindsets of cultural and diversity sensitivity. Ratts et al. (2015) contributed to developing “Multicultural and Social Justice Counselling Competencies” (USA), stressing on supervisors developing cultural self-awareness, which involves getting to know themselves as social and cultural individuals. The supervisor has a responsibility to educate themselves about cultural differences and continue to develop an awareness of intersectionality. According to “The Discrimination Model” (Bernard & Goodyear, 2018), clinical supervisors are encouraged to develop a more direct and purposeful approach with their supervisees in challenging their dominant ways of thinking. The model discusses the three different foci in supervision: (1) intervention; (2) conceptualisation; (3) personalization, and three possible roles of the supervisor: (1) educator; (2) counsellor; (3) consultant.

## **Becoming a GSRD-informed supervisor**

Becoming a supervisor comes with having enough clinical experience as a therapist, learning to work with ethical guidelines, feeling robust in our competence so that we can hold the supervisee's ethical and moral dilemmas. Becoming a GSRD-informed supervisor requires the same level of clinical expertise as well as specific core competences.

The GSRD Therapy core components are (Neves & Davies, 2023):

### ***Practicing a commitment to social justice***

Taking an anti-racist, feminist, Queer, and LGBTQ+ affirmative philosophy throughout the therapeutic work. Helping clients deconstruct the negative impact of amata-normativity, heteronormativity, mononormativity, cisgenderism, sexism, patriarchy, capitalism, and colonial thinking that affect all people, including heterosexual people (Czyzelska, 2022). Promote advocacy and be an ally to all marginalised and oppressed groups (Turner, 2024). Offering psycho-education.

### ***Demonstrating cultural humility and cultural competence***

Committing to keep developing our awareness of self and clinical competencies. Committing to training for ongoing maintenance of cultural competence (Barker, 2019). Staying humble with the enthusiasm to keep learning. Gaining specific knowledge of various marginalised populations such as LGBTQIA+, kinksters, sex workers, and those of diverse racial backgrounds. Not making assumptions based on appearance.

### ***Understanding the specific adverse effects of oppression***

A thorough understanding of the diverse ways oppression functions in society and how it affects a wide range of people differently, including marginalised people (Winter & Charura, 2023). Helping clients develop more resources for self-care and well-being.

### ***Being trauma, grief, and shame informed***

Enhancing psychological resilience. Understanding the physiological and psychological effects of individual, collective, and cumulative trauma (Kelly et al., 2020; Nadal, 2019). Reducing symptoms of post-trauma stress for survivors of abuse, attacks, discrimination, and conversion practices (Kort, 2018; Semlyen & Rohleder, 2023; Todd, 2016). Having a thorough understanding of grief, including loss due to change (Kübler-Ross & Kessler, 2005; Samuel, 2017). Understanding shame, its effects and how to mitigate it (Etherson, 2023).

### ***Knowing contemporary sexology***

Gaining and keeping updated with the specialist knowledge of gender, sex, sexuality, erotic, and relationship diversities, including knowledge of sexual fantasies, desires,

and behaviours. Understanding the biological, psychological, and social processes of sex. Taking care in not over-pathologising clients' sexual behaviours with pseudo-diagnosis (i.e. "sex addiction") (Ley, 2012; Neves, 2021)

### ***Integrating core GSRD theories***

Incorporating knowledge of minority stress (Meyer, 2003), intraminority stress (Pachankis et al., 2020), social safety, micro-aggression, intersectionality (Dunlop & Lea, 2022), erotic diversity (Twist et al., 2022). Employing a strengths-focused affirmative practice within your therapeutic modalities. Affirming clients' self-determination.

### ***Fostering Joy***

Through an affirmative stance, we focus on self-worth through compassion-focused approaches (Gilbert, 2013). Fostering joy and pride in our diversities, building community connections and harnessing micro-affirmations in the therapeutic relationship is key for positive validations.

In the 1970s, Noel Burch (Curtiss & Warren, 1973) introduced the conscious competence ladder (also called the conscious competence matrix, the learning matrix, and the four stages of learning). These are: (1) unconscious incompetence; (2) conscious incompetence; (3) conscious competence; (4) unconscious competence. Putting the GSRD components into practice throughout a therapist's career, from being a trainee, becoming a therapist and developing as a supervisor, means not only bringing learning and knowledge into practice but also developing "unconscious competence" through an ongoing reflective process. This requires us to have cultural humility to question our values, beliefs, assumptions, and thought processes.

As demonstrated in case examples above, due to the field of psychology and psychotherapy being traditionally heteronormative, mono-normative, and cisgenderist (Nichols, 2021), it is easy for practitioners to be in unconscious incompetence with the lack of GSERD knowledge, and, by definition, not knowing that they are in need of GSERD training. They may likely receive supervision from a supervisor who is equally in unconscious incompetence. As well as cultural humility, the learning process requires courage and a safe space to be able to challenge attitudes and skills through a process of reflection and clinical supervision (which may need to come from a GSERD-informed consultant).

### **An overview of the 7-eyed model of supervision**

In 1985, Peter Hawkins and Robin Shohet developed the "*The 7 Eyed Model of Supervision*" which is one of the most well-known and widely used supervision models (Hawkins & McMahon, 2020). It was originally developed to get a deeper understanding of differences in supervisory styles and concluded that they were linked to where supervisors chose to focus their attention.

## **Eye 1**

### ***Focus on the client***

What the supervisee discusses about what the client brings in therapy. In this eye, the supervisor and supervisee discuss client's content, formulations, conceptualisation of client's distress, the psychological understanding of the client, how they hold themselves and what is their perception of the therapist, and their worldviews.

## **Eye 2**

### ***Focus on the supervisee's interventions***

The supervisee and supervisor discuss how the supervisee decides what interventions are appropriate, and why. The supervisor enquires if the interventions are for the client's benefits. The supervisee and supervisor discuss the supervisee's enquiries: are they done to help the supervisee or help the client? The supervisee and supervisor have an ongoing dialogue about the sources of the interventions depending on the supervisee's frame of reference.

## **Eye 3**

### ***Focus on client-therapist relationship***

The supervisee and supervisor are curious about the therapeutic relationship that is co-created by the therapist and client in the here-and-now. This could contribute to the therapeutic change that is required in the relationship, for example, when there are ruptures and repairs. The supervisee and supervisor have an ongoing dialogue identifying transference and countertransference between the therapist and client. This focus also gives perspective to the supervisee and validates the importance and usefulness of the therapeutic relationship.

## **Eye 4**

### ***Focus on therapist's process***

This is an opportunity to invite the supervisee to self-reflect on their own processes, including thoughts, emotions, sensations and behaviours in response to their client. It is a space to develop awareness of their processes and invaluable data that it provides, as an opportunity to learn about the client and the supervisee themselves. It also helps the supervisee understand the hindrances and possible collusions. With this eye, the supervisor and supervisee can discuss professional limitations, continuous professional developments and the self-care needs of the supervisee.

## **Eye 5**

### ***Focus on supervisee- supervisor relationship***

This is an exploration of what the relationship is, the meaning of it, and what is being played out unconsciously within that professional relationship. It is an

opportunity to identify and discuss parallel processes, and gaining information of the mirroring in the relationship that may be helpful to the supervisor and the supervisee, and in turns, with the client. The supervisee and supervisor can develop the professional relationship through ruptures and repairs, and is dependent on the supervisee sharing their vulnerability, which is also dependent on the co-created quality of the professional relationship.

## **Eye 6**

### ***Focus on supervisor's process***

With this eye, the supervisor self-reflects on their own individual process, the parallel processes, and the mirroring that is happening within the multiple professional relationships. The supervisor can acknowledge their own thoughts, emotions, sensations and behaviours in response to the supervisee and the content they bring. With this eye, the supervisor must be careful not to make interpretations about the supervisee, as they need to have the ability to own their process.

## **Eye 7**

### ***Focus on the wider context***

This eye looks at the current and historical background of the client, supervisee and supervisor for the purpose of clinical conceptualisation, framework and holding. This eye includes the contextual environment in which the therapy and supervision take place, whether it is within an organisation or private practice. Furthermore, this eye looks at ethical framework, regulating bodies, professional and personal relationships in the wider system, and the influences they have on the supervisor, supervisee and their clients. More recent literature added an eighth eye concerning the transpersonal context which includes questions like the meaning and value of life, common humanity, and emerging higher purpose such as I-self connection. This eye recognises that world crises are an opportunity for growth.

## **Anti-oppression in the “queering” of the 7-eyed model**

The field of GSRD Therapy theories and practice is slowly developing. It seems imperative that therapists need to work on their own biases and prejudices about GSRD issues such as sexual orientation, gender identity, power, class, and other intersectionalities that give individuals narratives about themselves. Therapists and clients who are able to self-define, feel included, respected, have less shaming and pathologising attitudes can make a safe space to connect with minority groups (Hagler, 2020). Assumptions are often made about clients, therapists, and supervisors on what is visible. Assumption takes away curiosity but permission to explore creates space for growth. Assumptions usually stem from fear. Unless a safe confidential space is created, disclosure from clients to therapists and therapists to supervisors can become a challenge (Shohet & Shohet, 2020; Wadley & Siegel, 2019). Previous experience of shame, trauma, internalised oppression or minority

stress contextually plays out reducing the healing and growth possibilities (Rothschild, 2006). Whilst we teach therapists to know their limitations, does it occur to supervisors what their limitations may be working with culturally diverse population?

As aforementioned, the “queering” of psychotherapeutic models includes adopting an anti-oppression stance, therefore, we need to pay attention to race as a broader intersectionality agenda. McKenzie-Mavinga (2016) in her book *The challenges of Racism in Therapeutic Practice* describes multiculturalism and how intersecting identities influence individual personal development. When there is no space for exploration of racism or oppression the fear of being misunderstood can be internalised. The topic of racism is uncomfortable for many therapists and supervisors and often the conversation is redirected or shut down (DiAngelo, 2018). The experience of trauma and recovery from racism should not be underestimated. There are animal studies showing how transgenerational trauma can affect generations (Hime et al., 2021). DeGruy (2017) coins the term *Post Traumatic Slave Syndrome*. Her book explores the huge implications of slavery and modern slavery on individuals. She notes the difficulty in discussing these topics without painful and distressing emotions for people from Black cultures. Minority stress (Meyer, 2003) is a well-established concept within GSERD groups and its repercussions on the marginalised population, be it racism, gender, religion, sexual orientation, or abilities. McKenzie-Mavinga (2016) not only addresses racism but also homophobia. She explains that homophobia exists in Black and Asian culture which is influenced by slavery and colonialism.

White supervisors and supervisees may experience white fragility (DiAngelo, 2018) when race is identified and acknowledged due to cultural incompetence. For example, Lux (white supervisee) discusses her Black client, Mercy, with Laura (mixed-heritage supervisor). Mercy is reporting the difficulty of coming out as a bisexual person in her Black community in the UK. Her specific issue is that she considers herself diasporic, however, her community is very religious and keen to hold onto their values of their cultural ethnicity. Laura explores with Lux the complexity of the co-existence of race, culture, and sexuality and how this impacts on Lux and Mercy. Lux responds to Laura saying “I’m colour-blind, I treat everyone the same and equal.” The main focus of Lux’s work with Mercy has been about the difficulty of coming out as a bisexual woman in her community, so Lux privileged the coming out process while dismissing the racial tension that inhabits Mercy’s everyday life. Lux felt defensive towards Laura, missing the important similarities in the re-enactment of Mercy’s experience of her skin colour Vs being integrated in the UK, and therapy with Lux who is white.

The experience of having a space and a voice to talk about racism and being queer in supervision can break the societal silence imposed by white fragility. Supervision can be a place where the therapist may experience attention to areas that have not had space before. It opens up discussions which can lead to a better relationship with clients, especially those who also come from marginalised communities (McKenzie-Mavinga, 2016).

Oppression, microaggression, internalisation of negative, and distressing experiences are different due to individual lived experiences but the overall impact may be similar. Minority groups are used to violence and hate (Turner, 2021). It is common

for LGBTQ+ people to normalise it (i.e. “*oh well, it is what it is! Whatever!*”). This needs challenging in supervision when both client and therapist are from minority groups and avoiding addressing trauma (in collusion) thus normalising it. Unless challenged, this may become internalised in the supervisory relationship. Conscious and unconscious impact of violence may include developed tolerance and emotional resilience to create capacity to survive (Levine, 1997).

## The Queer 7-eyed model of clinical supervision

Queering the 7-eyed model of clinical supervision requires specific clinical thinking informed by GSERD knowledge.

### Queer Eye 1

Focusing on the clients, their intersectionality, their relationships with their sexuality, gender identity, intimate relationships, as well as their experiences of homophobia, biphobia, transphobia. Their sense of safety where they live. Their stories of “coming out.” Their experiences of being othered. How they navigate the heteronormative, mononormative and cisgenderist world (Hays, 2016).

### Queer Eye 2

Exploring the strategies and interventions used by the supervisee. Are they using interventions that are based on heteronormative or mononormative therapy theories? Is the supervisee aware that GSERD’s clients’ mental “wellness” is directly linked to societal oppression? Is the supervisee using interventions designed for post-trauma when their clients may be in ongoing trauma/minority stress? (Czyzelska, 2022)

### Queer Eye 3

What is the relationship between the client and supervisee when the client identifies as Queer and the supervisee identifies as heterosexual. Or when the supervisee identifies as Queer and the client identifies as heterosexual. There may be specific transference and countertransference with different combinations of sexual orientation and gender identity differences, including the sense of power and authority, and what assumptions both supervisee and clients make about *perceived* and/or *known* sexual orientation and gender identity. For example, the gay male supervisee may experience an emotional reaction with a heterosexual male client if the client reminds the supervisee of their school bullies (Allan & Poulsen, 2017).

### Queer Eye 4

The focus on the supervisee is to look at their own world, and their stories to enable them to identify their countertransference and projective identification, especially when it is related to their past experiences of homophobia, biphobia, or/and

transphobia. The supervisee who identifies as LGBTQ+ may also live in an ongoing trauma state because of society's oppression, as well as past trauma. Is the supervisee aware of what is going on for them in the here-and-now? How do they self-care? Do they over-work? Do they under-charge? What is their current life like? Are they in good relationships or not? Do they go to the spaces where they are likely to meet their clients? (Kink spaces, hook-up apps, cruising grounds, etc.) (Bağ, 2023).

### **Queer Eye 5**

The supervisory relationship is to be considered here. If the supervisor and supervisee identify with the same sexual orientation or gender identity, they may be unaware of communal blind spots or they may collude with each other about generalising other populations. For example, if the supervisor and supervisee are both gay cisgender men, they could easily make inaccurate assumptions about the sex lives of lesbians. If the supervisor and supervisee have different sexual orientation or gender identities, there may be a struggle or conflict in who knows best. For example, if the supervisor identifies as a trans person and the supervisee identifies as cisgender working with a trans client, the supervisor could dismiss the supervisee's own formulations or ideas because the trans supervisor may automatically assume they understand that client best. The aspects of power, both overt and covert need to be paid attention to here. If the supervisee and supervisor attend similar non-work events, for example, Pride, or kink spaces, there needs to be a consideration of boundaries.

### **Queer Eye 6**

The supervisor needs to self-reflect on their own competencies, blind spots, and assumptions. One of the core components of GSRD therapy is to demonstrate cultural humility and competence. It is important for a supervisor not to claim they know everything about the people whom they identify with. A bisexual supervisor may have a direct and valuable lived experience of being bisexual and thus may understand what it is like to be bisexual on a deep level, however, it is important that they do not assume that they automatically understand *all* bisexual people. They still need to read books on bisexuality, sexual orientations, LGBTQ+ people, GSRD therapy because our lived experience must not inform the entirety of our clinical knowledge. The supervisor also must reflect on their own blocks and difficulties. For example, if they notice that they keep misgendering one of their supervisees, they need to take this difficulty seriously and examine what is behind this difficulty, with the knowledge that continued misgendering is harmful (Neves & Davies, 2023).

### **Queer Eye 7**

There are several wider contexts that are particularly relevant to GSRD therapy. One is of the heteronormative and mono-normative world that we live in. In supervision, there are valuable conversations to be had about the ripple effect of oppression, homophobia, biphobia and transphobia as ongoing trauma, both in the lives of the supervisor and supervisees (if they both identify as part of GSERD) as well as the

supervisee's GSERD clients. Validating and affirming that we are "all in it together" can be soothing for us all, but at the same time, not to erase the differences within those communities. For example, the invisibility of asexuality is a different struggle from the ones experienced by lesbians. The erasure of bisexuality is not the same as the struggles of gay men. The discrimination against trans people is of a different intensity to the ones against LGB people. The positive countertransference and positive role model of the parallel process from supervisor to supervisee may be a good holding space if the supervisor shows how to be strength-based and resilient faced with the oppressive world (rather than ignoring it), which in turn may transfer to the supervisee, and then their clients. (Turner, 2023).

Another context to be mindful of is the one in which therapy happens: there will be a different dynamic depending on where the supervisee sees their clients. If the supervisee works for an organisation that has poor diversity knowledge, where their sexual orientation and gender identity are not respected, or where they are treated differently and where their identity is perceived as more important than their skills: "*we refer the gay clients to you because you're one of them.*" If the supervisee works in private practice, discussions about what clients they attract, who they choose to see, how they advertise themselves, how much they charge and whether they offer in-person or online therapy are important considerations in terms of the Queerness (or not) of their practice. It is always useful to help supervisees reflect on why they want to work only with one section of the LGBTQ+ and not the other. Or why they want to specialise in one particular area of work such as eating disorders, compulsive sexual behaviours, or trauma, for example, as opposed to have a more diverse practice.

A third context is the one of the supervisor and supervisee's professional network. Does the supervisor and/or supervisee work in isolation? Or are they connected to a solid GSERD network? Do they trust their colleagues? Are there competitions with colleagues? Do they have GSERD friends in the profession?

And a final context to think about, as mentioned above, is the one of the shared living and working spaces. Many GSERD supervisors, supervisees and clients will hang out in the same spaces: gay venues, kink events, Pride events, LGBTQ+ entertainment like theatre or cinema, LGBTQ+ favourite destinations like Gran Canaria. It can be a small world and it is easy to bump into each other. What are the clinical, professional and personal implications of being in shared spaces? (Davies, 2023).

Having explored all the definition of "queering" the 7-eyed model, GSERD and its philosophy of anti-oppression with a focus on gender, sex, sexuality, erotic and relationship diversities, we are now going to offer a case example of how the 7-eyed model of clinical supervision can be adapted to meet the GSERD components described earlier, and to better serve all populations in society in clinical supervision.

Asia (client), whose pronouns are she/her, identifies as trans-femme. Her gender dysphoria started in her early teens. She began to live as a woman at the age of 16. She started to take hormones at 18 years of age, and had successful vaginoplasty when she was 28-year old. She is very happy with her body and vocal feminisation. Her parents are from Indian origin born in the UK. They are supportive and accepting of Asia's gender and have accompanied her on her journey of gender-affirming process. Her parents are financially privileged. Asia went to private school and they bought her a flat when she was 25-year old. Asia trained as a lawyer and she is now

a successful partner in a top law firm. At the age of 30, her relationship broke down with a cisgender man. This relationship was the first long-term relationship she had ever had. The break-up of this relationship left her feeling depressed and the grief of him leaving her has struck her very hard. After the break up, she came to therapy because she experienced low sexual desire and she noticed avoiding starting new intimate relationships. She also withdrew from her friends. Her main exploration in her therapy was to wonder if she had become aromantic and/or asexual.

Areet (supervisee) whose pronouns are he/him, is an Indian psychosexual and relationship psychotherapist who primarily works with Queer people. He identifies as cisgender and bisexual.

Lena (supervisor) whose pronouns are she/her, is a psychosexual and relationship psychotherapist, trauma therapist and a clinical supervisor. Lena is a high profile supervisor in the profession. She identifies as cisgender and a lesbian.

### ***Queer Eye 1: focus on the client***

In supervision, Areet discussed the similar ethnic origin he shared with his client Asia and her parents. He identified that his age and class are similar to her parents. Areet was curious about Asia's sexual orientation in her gender-affirming journey. Areet empathised with Asia's grief. He noticed Asia tended to apologise when she was crying and he told his supervisor Lena that he hadn't mentioned it to Asia. Areet made a joke that it was "very British" to apologise for emotions, calling it the "Victorian stiff upper lip" because she and her parents were born in the UK, however Areet was born in India. Lena questioned if her apologising was cultural from Britain or if there was other reasons. Lena has a trauma therapy background and she was interested in discussing whether the apologising could be a trauma response known as "fawn." Areet did not consider a trauma response but wondered about a cultural element to this behaviour. Lena asked him if he asked Asia how she chose him and why. Areet said that Asia chose him because he was both of Indian origin and explicitly advertising as Queer on his website. Lena then asked Areet to think about the first assumption of the "British" behaviour of apologising that may have deeper cultural meaning between them. Lena asked Areet to be careful about his assumptions and remain more curious about what may seem the same and different between them (this could lead to Queer Eye 3). Areet felt curious about Asia's transitioning journey but as this was not the primary focus, he did not feel comfortable asking Asia any questions about it. Lena enquired what questions Areet usually asks in his assessments when he meets a client disclosing transitioning history. Areet said to Lena that he didn't adapt his assessment questions with trans clients and therefore was none the wiser about Asia's history. Lena asked him to reflect on this because she thought it might be important to understand the substance of Asia's grief which could be influenced by the client's history.

### ***Queer Eye 2: focus on the supervisee's interventions***

One of Asia's primary concerns was her low sexual desire. Areet discussed with Lena that he might want to introduce Sensate Focus (Self sensate) to rekindle sexual desire.

Areet was confused about Asia's possible asexuality given that she had been sexual in the past and that she had presented low sexual desire after a break up and wondered about asexuality in that moment. Areet hypothesised that Asia's asexuality pondering might be a red herring to avoid more grief of her loss of sexual desire after her break up. Lena reminded Areet that sexual orientations are self-identified in the here-and-now and can be fluid. However, she also maintained her trauma focus and asked Areet to consider if the low sexual desire might be a direct symptom of depression due to significant loss. Both Areet and Lena agreed that more comprehensive assessments needed to be done before any psychosexual interventions could take place because of the danger of unintentional conversion practices that are common with asexual people (Russell, 2023).

### ***Queer Eye 3: focus on client-therapist relationship***

In Eye 1, Areet assumed that Asia's apologetic behaviours were due to her being born in the UK. He distanced himself from this because he was born in India. He also identified more with her parents because of being of a similar age and class. Lena pointed out that he might have also made an assumption based on his masculinity as men, too, are raised not to express emotions. The unconscious bias of gender and pervasive shame is common in how all cultures perceive masculinity, femininity, and their relationships with the expression of emotions. The intersectionality of Asia and Areet being somewhat similar and different (Queerness and cultural heritage) needed further exploratory discussions in how they were both seen by each other and the expectations of Asia to be understood and the hopes held by Areet. He disowned his discomfort about his childhood and the cultural messages he received about emotions, and projected it onto Asia's behaviour as being "British." As well as making the differences, he also had some expectations that were similar to Asia's parents in an investment in her wellbeing. Lena asked if the unconscious invitation to be a "new parent" in the therapeutic relationship came from Asia or Areet's desire. Asia's parents are so supportive that Asia's unconscious process may have been to have Areet as a new parent whose role would be to be challenging which connects with the internalised expectations of how parents usually are with their Queer youngsters, thereby bringing guilt (i.e. I've had it good while other queer people struggle with their parents), shame (i.e. undeserved goodness and why am I so upset about my break-up?), and grief (i.e. no opportunity to grieve the loss that transitioning comes with, even though it was the most positive outcome for me) into the conscious space. Given the multilayer aspects of Asia and Areet's intersectionalities, Lena asked Areet to be conscious about the kind of therapeutic role he is engaging with Asia.

### ***Queer Eye 4: focus on therapist's process***

Lena asked what he felt about having Asia as a client. Areet felt relief that Asia was femme passing and therefore was less likely to misgender her. Areet was amazed by Asia's femme looks and told Lena that nobody would ever know that she was assigned male at birth. Lena wanted to explore Areet's feelings about Asia and how they might

impact on the therapeutic relationship. Areet did not want to get things wrong for Asia because she was “very beautiful,” which brought up a discussion on his mindset of the beauty privilege of our society (which is prevalent in the UK and India) and Areet’s own parenting as his beauty was never validated by his parents. He felt he was connecting with being a “father” to Asia because of his age, but Asia already had a supportive father. Usually, Areet’s strength is to “re-parent” his Queer clients who had absent or neglectful parents, but felt this role was redundant with Asia. Lena asked Areet whom he thought he was for Asia. Following exploration in the discussion in this Eye, it transpired that Areet was unconsciously trying to re-parent himself, repairing his own internalised homophobia because his coming out process was done much later than Asia’s and did not go so well.

### ***Queer Eye 5: focus on supervisee- supervisor relationship***

Areet chose Lena for her high profile status because he was seduced by her referent power (the power that is inherent with high status and position). He was both anxious and excited to be accepted as one of her supervisees, and was very eager to be a “perfect” supervisee. Areet and Lena both disclosed their sexual orientation at the beginning of their work. Areet knew Lena had good clinical Queer knowledge based on some of the interventions she made and some articles she wrote. Areet has been working with Lena for four years and she demonstrated very good GSRD competencies helping him with his queer clients, which built a trusting professional relationship. He also projected the “good enough mother” elder onto her even though he assumed they were of similar age. Areet discussing Asia’s femme beauty was an opportunity for Lena to disclose that she also got caught up in the beauty privilege imagining what Asia might look like. At this point, Lena reminded Areet of her sexual orientation and contracted with Areet that they both have to pay attention to their shared blind spot of internalised homophobia which privileges beauty and age within the queer cultural construct. As a result of this conversation in this Eye, Lena felt she could ask Areet to be more explorative with Asia’s transitioning history because they now have a solid supervisory frame that allows shared assumptions to be challenged, as it can easily happen in queer spaces, and welcome vulnerability, so that Asia as an individual does not get lost in clinical thinking.

### ***Queer Eye 6: focus on supervisor’s process***

Lena enjoys working with Areet although she is aware of him putting her on a pedestal due to her status. Lena has been reflecting on how to and when to discuss the referent power between them. She has been avoiding it and brought this to her own consultation. Lena discovered that she enjoys the projected power especially with Queer men because she had experienced being mistreated by gay men. Outside of work, she was a feminist activist and she was particularly interested in the oppressive effect of patriarchy. She was aware that collective trauma, minority stress and internalised homophobia can cause some gay men’s behaviours in being rejecting, and, at the same time, she was aware of her privilege as a cisgender woman whose close relationships

with other women were less attacked than those of gay men. She also remembered being connected to her own vibrant femininity, and society's patriarchy had made her less visible as she aged. Hearing about Asia's low sexual desire and grief reminded Lena of her own grief of loss of sexual desire due to her menopausal symptoms.

In the clinical triad between Lena, Areet, and Asia, Lena is aware that she held the white privilege in this dynamic. Lena wondered about the parallel process of power, where she held the white power and Areet was seduced by her referent power. As Lena and Areet discussed what role he might have in the therapeutic relationship with Asia, Lena wondered if there was a power dynamic also showing up between them. Perhaps Asia did not need another "accepting father," but, as mentioned earlier, Lena questioned Areet about Asia's unconscious invitation to be the missing "challenging parent."

Lena's coming out process was a necessary reminder each time she worked with queer supervisees and those who worked with queer clients because, as a supervisor, she knew it was important to keep her process and emotions on this matter separate. Being aware of her ongoing process of being queer was fundamental to her wellbeing and providing ethical clinical supervision with no unchecked projection. This would not be the case when she worked with heteronormative context.

### ***Queer Eye 7: focus on the wider context***

Both Areet and Lena worked in private practice in London, a wealthy and liberal part of the UK. This is indeed a privilege for both practitioners and the clients that they attract. Although the capital city is large with a significant and diverse queer population, the queer spaces can still seem small. It is, therefore, good practice to discuss between clients, supervisees and supervisors the likelihood to meet in shared queer spaces (Davies, 2023). Working with Asia, Areet did not feel the need to have such a conversation because he tended to go to sexual queer spaces that were for "men-only" or drinking establishments that were mostly frequented by men. However, in both Asian and Queer Asian spaces, the likelihood may be higher than Areet expected. Lena pointed out that by making this statement he connected with his part of his queer intersectionality forgetting the Asian one. When Areet thought about the likelihood of shared Asian spaces, he remembered a past instance when he met one of his queer clients who was not out in an Indian wedding where they both unknowingly had a connection with the bride and the groom.

Lena needed to be aware of Indian beliefs and messages about the Queer world although Asia's parents were very supportive. Lena wondered how much energy is spent in the family protecting themselves against the wider cultural hate towards queer people, and perhaps, was one of the factors of Asia's low sexual desire (the absence of sexual desire for queer relationships feels safer). At the same time, Lena needed to remind herself of her activist role and how it impacted on her therapeutic and supervisory relationships. For example, in her activism, she tended to criticise religion for their general homophobic and transphobic ideas, which sometimes can hinder the process of clients and supervisees who might think she would not accept their religious views. Because of this wider context, she thought that she needed to have explicit conversations about the difference between therapy/supervision and activism.

Part of the wider context is paying attention to the developing queer theories. It is imperative that Lena and Areet continue to have CPDs to update their knowledge of evidence-based and ethical practice. For example, low sexual desire may be mistaken for aromanticism and asexuality, and more research is needed on this topic. As Queer people often identify as neuro-divergent, Lena and Areet have an increasing awareness that they need to be up-to-date with the current neurodiversity knowledge, and more specifically related to Queer people.

Lena and Areet are both members of the College of Sexual and Relationship Therapists (COSRT) so they share the same guiding ethical principles to clinical work. However, Lena also worked with other supervisees who are members of other governing bodies such as BACP and UKCP. In this case, she had to be aware of the ethical guidelines of those organisations and how the culture of these organisations may impact the work with queer people.

In summary, paying attention to the Seven Eyes integrating the exploration of client, therapist and supervisor's processes, projections, transference and countertransference is relevant in all supervision consultations, but when we "queer" the eyes, we can dive deeper in the intricate and multilayered meanings of all those elements. For example, without the GSRD knowledge in Eye 1, Areet might have over-focused on Asia's transitioning process and problematised it when it was not the client's primary concern. However, Lena's careful Queer Eye 1 encouraged Areet not to avoid it as client's histories may inform grief. Without the Queer Eye 2, it would have been easy to launch in psychosexual interventions not paying attention to asexuality. Eye 3 was enhanced with the Queer lens because there was a stronger focus on the complex intersectionalities between the similarities and differences of citizenship, race, age, class, sexuality, gender, and psychological positions in unpacking the conscious and unconscious dynamics of the therapeutic relationship between Areet and Asia. In Eye 4, the Queer lens provided a safe space for Areet to discuss his painful process of coming out and family acceptance, and how his position of "father" in the therapeutic space was for him more than for Asia. This conversation might have been totally missed without the Queer lens. In Queer Eye 5, Lena paid attention to her status as perceived by Areet. Queer people don't often feel like they have good role models or "elders" to show them the way, so discussing Areet's pedestal positioning of Lena makes sense with a Queer Eye. At the same time, Lena and Areet might share a blind spot in their vision of beauty, because they are both attracted to women, and also because physical beauty is especially emphasised in some Queer communities. These conversations might have remained at surface-level, if had at all, without the Queer lens. Queer Eye 6 was an important one for Lena to reflect on several positions she holds. Because of oppression and discrimination, it is common for Queer therapists to also hold an activism role. Sometimes the two roles can complement each other and other times it might create a conflict that the supervisor needs to be aware of to stay fully present in the supervisee's client's materials. The privilege of heterosexuality and being part of the "majority" population does not always allow for this type of reflection. Without the Queer lens, it is easy to miss this important self-reflection. The Eye 7 is an essential one for Queering because therapy for Queer clients (and other minority groups) almost always involves an awareness of society, oppression and how it impacts the client, therapist and supervisor. Without the Queering of this

Eye, much of the clinical materials of clients' distress and therapist's difficulties can be lost.

## Conclusion

Queering the 7-eyed model of clinical supervision to the level of GSRD components require deeper clinical thinking as demonstrated in this article, given that it implies uncovering the blind spots that are inherent in the psychotherapy profession being heteronormative, mononormative, cisgenderist, white, middle class, and euro-centric. It is imperative all supervisors have awareness and considerations of queer issues which is a starting place. We chose the queering of the 7-eyed model because it is one that is expansive and allows multiple layers of exploration with different relationships that are all central and relevant to queer people's lives.

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## ORCID

Silva Neves  <http://orcid.org/0000-0002-5062-6541>

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