Perception of Clinical Authority in LGBTQIA+ Mental Health Service Users: An Exploration Through Projective Storytelling and Experiential Narratives

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Abstract

Background: There is a tendency to use projective assessment to single out intrapsychic vulnerabilities of LGBTQIA+ individuals in mental health literature, without giving due weightage to their marginalized contexts. Additionally, their experiences in accessing mental health services are often nonaffirmative due to dominant pathological discourses in mainstream settings, even though scientific-clinical consensus has been explicit about depathologization.

Objectives: The current study aims to understand implicit perceptions and attitudes toward clinical authority in a sample of 10 self-identified LGBTQIA+ mental health service-users in Kolkata. It also aims to contextualize the same against their lived experiences of mental health-care use.

Methodology: Qualitative method was used in the current study. Data was collected with the help of sociodemographic questionnaire (for identifying social locations of participants), semi-structured interviews (for eliciting lived experiences of clinical relationships in mental health care), and projective storytelling with the help of TAT Cards 1 and 12M.

Results: Analysis of projective storytelling reveals predominantly negative perception of clinical authority with prominent themes of being overpowered by authority, dilemma regarding clinical outcome, passivity, sexual violation, and extreme perceived hostility from environment. Such perception is explainable in the light of lived experiences of discrimination in mental health care, personal vulnerabilities, lack of wholesome interpersonal relationships, and being victims of dominant pathologizing discourses in mental health sciences.

Conclusion: Mental health-care praxis needs to direct its attention to discriminatory experiences of service-users from gender and sexual minorities. Practitioners must be encouraged to develop specific competency in this regard, and be mindful of their own biases and prejudice when interacting with clients.

Keywords
Projective storytelling, LGBTQIA+, mental health service-users, negative perception of clinical authority, lived experiences

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The use of projective techniques for assessment of psychosocial adjustment, personality structure, and dynamics has been longstanding in mental health sciences. The author/s would like to take note of how projective techniques have been employed with respect to theorizing about same-sex attraction. Hooker’s seminal work used projective assessment to dismantle contemporary dominant psychiatric beliefs that all gay men had severe psychological disturbances. Hooker recruited cis gay men from the community instead of clinical cases. She used Rorschach Inkblot Test, Thematic Apperception Test, and Make-A-Picture-Story Test as projective techniques. Hooker’s work is acknowledged to have yielded major influence along with other empirical observations on the
American Psychiatric Association’s 1973 decision to depathologize homosexuality, which was previously enlisted as a sociopathic personality disorder.

Around the same timeline, Lindzey et al² claimed 9 indices of homosexuality on the Thematic Apperception Test which statistically differentiated “overt homosexual” participants from normative controls. “Homosexual” subjects were operationally defined as undergraduate males-assigned-at-birth who admitted engagement in “overt” homosexual experiences, recognized their “sexual deviation,” and were not involved in psychotherapy. The diagnostic utility of these indices reportedly suffered from voluntary manipulation by participants.

The purpose of juxtaposing these research findings against each other is to facilitate a discussion on the philosophy behind employment of assessment tools in research. While Hooker’s work attempted to use projective techniques to advocate for normalizing of same-sex attraction, Lindzey’s work aimed at clinically segregating “overt male homosexuality” for diagnostic utility. This highlights the inherently political nature of scientific research and given the power invested in societal clinical research communication, standpoints of researchers become paramount entry-points in understanding their research premise.

It also needs to be mentioned here that the Rorschach test is often employed as standard psychodiagnostic procedure for determining eligibility for gender-affirmation surgeries. Rorschach protocols of clients with “Gender Identity Disorder” manifest stress control difficulties, loss of adaptability, interpersonal dysfunction characterized by aggressiveness, dependency, and tendencies toward thought dysfunction.³

As mental health sciences (eg, psychiatry, clinical psychology, psychiatric social work, and allied disciplines, which have contributed to knowledge formation in mental health) continue to recognize sexuality and gender as being a spectrum of diverse realities, moving from a paradigm of pathology and deviance to one of affirmation and depathologizing, the deep-rooted heterosexism, homophobia, transphobia, and dominant-value systems implicit in science-making become increasingly apparent. This leads the author/s to speculate that the interpretation of projective techniques has been driven by a dominant heteronormative gaze. A queer-affirmative stance⁴ if applied to such interpretation has to be wary of the following:

- The dominant discourses of pathology that surround queer lives and experiences and how that impact interpretation.
- Avoidance of cis-heteronormative assumptions such as natal-sex-based understanding of gender, compulsory monogamy.
- Acknowledging oppression at the sociostructural level and understanding personality dynamics in context of queer lives, experiences, and support systems.⁵

The Thematic Apperception Test has mostly been employed to elicit intrapsychic vulnerabilities of gender and sexual minorities, where the clinical gaze is directed at LGBTQIA+ individuals as sites of dysfunction/maladjustment. However, there have been relatively scanty attempts to “voice” their experiential realities in a context-embedded fashion using projective techniques.

Interactions of LGBTQIA+ people with mental health professionals are unfortunately still often fraught with pathologizing discourses that reek of professional bias and prejudice fed by dominant-value systems. The main factors associated with dissatisfaction/poor outcome of psychotherapy research and counselling with LGBT clients were ignorance or hostility to their issues by therapists.⁶ In the Indian context, families join hands with mental health professionals to facilitate conversion attempts of queer individuals,⁷,⁸ making the situation grim. Additionally, lack of nationally mandated practice guidelines for LGBTQIA+ clients and ethical bindings leave scope for rampant therapeutic breaches and mis-steps coupled with little systemic accountability.

Keeping this background in mind, the objectives for the present study were framed as follows:

1. To understand implicit perceptions and attitudes toward clinical authority in a sample of 10 self-identified LGBTQIA+ mental health service-users in Kolkata.
2. To contextualize internal representations of clinical authority in the light of lived experiences of mental health-care interactions.

Method

Sample

N = 10 self-identified members of the LGBTQIA+ community, Kolkata-based, ranging within 18 to 30 years, who have had at least 2 interactional sessions with mental health service providers.

The participants lie at multiple intersections of gender-identity and sexual orientation (Table 1). All participants have completed higher secondary education, have functional literacy in English-language, and hail from urban or peri-urban areas within Kolkata district. All of them were willing to share their interactional experiences with the researcher/s and those who were hesitant or reported extreme unpleasant emotionality associated with therapeutic interactions were excluded from the study. Purposive sampling was followed.

Consent

Written informed consent from the participants to participate in the study and have their responses recorded for research purposes was taken by the primary researcher at the beginning of the investigation.
| Age       | Sex-Assigned-at-Birth | Gender Identity (Self-Identified) | Sexual Orientation (Self-Identified) | Educational Status | Occupation (as per Self-Disclosure) | Income Range (Self-Reported) | Self-Sustenance (per Month) for Those Not Living With Natal Family | Extent of Engagement With Mental Health Services | Psychiatric Morbidity |
|-----------|-----------------------|-----------------------------------|-------------------------------------|--------------------|------------------------------------|------------------------------|---------------------------------------------------------------------|-----------------------------------------------|---------------------|
| 18-20 years (60%) | Male = 4/10 (40%) | Trans-woman = 2/10 (20%) | Gay = 1/10 (10%) | Pursuing Under-Graduation (70%) | Unemployed (70%) | ₹30,000-40,000 (10%) | Below ₹10,000 (20%) | Attended 3-5 sessions = 3/10 (30%) | Reported Psychiatric illness (40%) |
| 21-25 years (20%) | Female = 6/10 (60%) | Trans-man = 2/10 (20%) | Lesbian = 1/10 (10%) | Completed Graduation (10%) | Freelancer (10%) | ₹40,000-50,000 (10%) | Preferred nondisclosure (20%) | Attended more than 5 sessions = 7/10 (70%) | No Reported Psychiatric Morbidity (60%) |
| 26-30 years (20%) | Gender Fluid = 3/10 (30%) | Homoflexible = 1/10 (10%) | Pursuing Post-Graduation (10%) | Service (10%) | Above ₹50,000 (40%) | | | | |
| | Cis-man = 2/10 (20%) | Heterosexual = 2/10 (20%) | Pursuing Diploma (10%) | Artist (10%) | | | | | |
| | Cis-woman = 1/10 (10%) | Abrosexual = 1/10 (10%) | | | | | | | |
| | Questioning = 1/10 (10%) | | | | | | | | |
Ethical Clearance

Ethical permission for this study was granted by the Ethical Clearance Committee of the Department of Psychology, University of Calcutta.

Tools Used

1. Sociodemographic questionnaire: To elicit identifying information and sociodemographic knowledge about each participant relevant to the research design, inclusive of educational and occupational history, family history, psychiatric and medical history.
2. Brief interview guide: To explore the nature of interactive experiences with mental health professionals, understand feelings and thoughts regarding interactions, and comprehend routes of negotiating nonnormative gender/sexuality in ongoing interactions.
3. Cards 1 and 12M of the Thematic Apperception Test (TAT): To facilitate participant’s projection of unvoiced themes, feelings, private meanings, and significances surrounding therapeutic interactions (if any) onto stimulus cards depending on the fund of past experience (apperceptive mass) and present wants. The stimulus cards present classical social situations that are deemed relevant to the research framework.

Rationales for selection of the cards:

Bellak\(^9\) suggests that Card 1 of TAT has the potential to assess the total personality of the respondent in terms of self-image alongside relationship with authority figures. It is a powerful predictive base for transference of attitudes, emotions, and sentiments from past interactions with authority onto present clinical relationships. Stories to Card 12M may be indeed reminiscent of a therapeutic relationship, in as much as the couch and supine position may be unconsciously equated with the classical psychoanalytic situation or the generally dependent cliental attitude.\(^8\) In spite of being an exclusive elder male card, it is used here for all the participants. If this card were reflective of the dynamics of a therapeutic relationship, such a theme crosses the boundaries of sex and gender. This card can also be an important gateway to understanding prevailing attitudes toward professionals (through direct or indirect symbolism) and the ability to trust in their goodwill and authenticity.

Procedure

Informed, voluntary consent was obtained from participants by educating them about the nature of the study, risks, and benefits involved, confidentiality of data, and expected outcomes. The researcher met the participants in a congenial and convenient setting chosen by the participants themselves and established rapport to facilitate disclosure of information. Sociodemographic details were obtained with the help of questionnaire.

Face-to-face interviews were conducted with each participant and audio-recorded with consent. The transcripts and emergent themes were reviewed by the participants. The interviewing pattern was responsive, whereby the interview guide was used flexibly and adjusted according to the conversational flow.

The TAT cards were presented to the participants following the standard mode of administration, face down on a platform, while the researcher remained in the background offering minimum interference to the creative flow. Engagement with the stimulus was framed as a story-telling exercise with the following instructions: “I am going to show you some pictures, one at a time; and your task will be to make a story for each. Tell me what has led up to the event shown in the picture, describe what is happening at the moment, what the characters are feeling and thinking. Speak your thoughts as they come to your mind. Do you understand? Well, then, here is the first picture.” A stopwatch was used to measure reaction time and total time for each stimulus card. It is only after the participants felt that they have completed their story, that the researcher enquired into areas that were not covered, through nondirective and nonthreatening questioning.

Analysis of Data

Transcripts were prepared through written articulation of verbal data elicited in interview. They were analyzed for concepts, themes, examples, and topical markers relevant to the research premise. These were labelled as open codes/initial semantic units that emerged from the text and were articulated in language borrowed from interviewee’s expressions (in vivo codes) to remain true to the data source. Thereafter, open codes were differentiated into higher-order categories of increasing precision such as focus codes and axial codes. This enabled a hierarchical organization of the verbal data obtained from interview. Each participant narrative was coded separately and then a summary of axial codes were prepared from cross-participant narratives.

The TAT stories were content-analyzed independently by the authors and an external expert. Inter-rater reliability was maintained and disagreements were settled through discussion. Conventional modes of analysis prescribed by Bellak\(^8\) were used such as the pertinent theme of the story, characters brought forth, the hero of the story and their relationship with other characters, the perceived environment/context, needs, conflicts, resolution, and outcome. If a clinical relationship or metaphor of the same was evoked explicitly, it was studied with intricate details to understand its dynamics as these stories may also bear the imprint of lived realities.

Results

Results from the study are presented in tabular format for precision and clarity.
It can be seen that 60% of participants were early young adults (18-20 years) and about 70% of the participants were unemployed. Additionally, 70% of participants had extensive engagement with mental health services and had attended more than 5 sessions with mental health professionals, though 60% did not report any psychiatric morbidity. A total of 40% of the participants were residing separately from their family of origin and 20% preferred nondisclosure of income range for self-sustenance. All the participants had completed education till higher-secondary, with 70% pursuing under-graduation, 10% having completed graduation, 10% pursuing post-graduation, and 10% pursuing Diploma course after higher-secondary.

Table 2 presents the thematic categories obtained from interview transcripts of participants that are differentiated into axial and focus codes.

Over-arching axial codes that were extracted from the interview transcripts are namely, Tilted Power Dynamics, Invalidation by Professional, Professional Partnering with Familial Injustice, Lack of Professional Competence with LGBT+ issues, Parents as Moderators and Affirmative Experiences. The axial codes are elaborated with focus codes to add descriptive value to each of them.

Table 3 documents the thematic underpinnings of internalized clinical authority as understood from projective storytelling of the participants.

Internalized representations of clinical authority are predominately negative, with distinct themes of: Sense of being overpowered by occupant of clinical role, dilemma of outcome, passivity, sexual violation, and extreme perceived hostility from the environment. These themes are supported by extracts from stories of participants for better clarity and understanding.

Table 4 documents the internalized dynamics of interpersonal relationships as understood from TAT stories of participants.

General interpersonal dynamics in TAT stories of participants reveal the presence of perceived imposition from authority figures, affectational deprivation, and protest against authority. These themes underscore the interpersonal outcomes of being in constant conflict with dominant social norms that are routinely experienced and internalized by gender and sexual minorities.

Lastly, Table 5 provides an estimate of frequency and percentage of occurrence of common personality correlates from TAT stories across the sample.
Table 4. Common Themes Pertaining to Interpersonal Dynamics Reflected in TAT Stories.

| Extracts From Stories With TAT Card Numbers 1 or 12M | Themes Implicated |
|---------------------------------------------------|--------------------|
| “This boy wants to learn the violin, but mother and father do not want him to; they put pressure on the child”. (Card 1) | Perceived imposition from authority figures |
| “My mother keeps pushing me to do things that I do not like, things that other people like.” (Card 1) | |
| “They (singular) does not like playing the violin; after getting scolding, they are sitting quietly and trying hard to familiarize themselves with the instrument.” (Card 1) | |
| “I think that the kid that has been looking at the violin…he is looking very sadly as he is forced to play with it”. (Card 1) | |
| “Maybe, he (father) hates him, but the man wants to get closer to him (his father).” (Card 12M) | |
| “In future he will be touching the face of the woman…. He will feel sane and will find some amount of semblance.” (Card 12M) | |
| “The kid needs help…they seriously need help…they need to be rescued…something is holding them back from the thing that they love the most.” (Card 1) | |
| “If they are alive (the person who is lying) and this man is caressing, maybe this man (the person who is lying) will try to be a better person and be nice to this person.” (Card 12M) | |
| “Maybe this person has come out in their house today…there has been a lot of conflict…everybody is asleep now and this other person has come to pat their head out of affection….maybe this other person cannot accept their child but they cannot also torment the child for this.” (Card 12M) | |
| “If a child does not get support from childhood, they will break off eventually and go their own way” (Card 1) | |
| “On the other hand, there is society, guardian- these barriers, the more they restrain you, the more determined you are to break free, like the strings on the veena, the more you pull them with might, the more harmonious music it makes.” (Card 1) | |
| “Maybe they do not like the violin, they are forced to…. Maybe they just want to break the violin and run away…. I hope they do.” (Card 1) | |

Table 5. Frequency and Percentage of Occurrence of Common Personality Correlates in the Sample.

| Personality Correlates From TAT Stories | Frequency of Occurrence | Percentage of Occurrence |
|---------------------------------------|-------------------------|--------------------------|
| Loose ego-boundaries and personalization of storytelling exercise | 5/10 | 50 |
| Crisis of self-identity | 5/10 | 50 |
| Perceived lack of environmental support | 8/10 | 80 |
| Perception of authority figure as imposing/threatening | 9/10 | 90 |
| Predominant ambivalence in personality orientation | 7/10 | 70 |
| Unresolved conflict between autonomy vs compliance | 4/10 | 40 |
| Need for recognition | 3/10 | 30 |
| Need for succorance | 5/10 | 50 |
| Need for achievement | 3/10 | 30 |
| Need for affiliation | 5/10 | 50 |
| Internalized aggression | 2/10 | 20 |
| Passive orientation | 6/10 | 60 |
| Externalized aggression | 1/10 | 10 |
| Coping with resilience | 2/10 | 20 |
| Unsuccessful conflict resolution | 7/10 | 70 |
| Perception of a hopeful future | 2/10 | 20 |

From Table 5, intrapsychic vulnerabilities of gender and sexual minorities become prominent. A total of 90% of the sample stories reveal the presence of perception of authority figure as imposing and 80% participants demonstrate a lack of environmental support. There is predominant ambivalence in personality orientation as inferred from 70% of the stories and ego-boundaries are easily overwhelmed as reflected in 50% of the projective storytelling protocols. Conflicts in stories are unsuccessfully resolved in 70% of the protocols. The findings are contextualized further in “Discussion.”

Discussion

In order to understand the dynamic internalization of clinical relationships from TAT stories produced by the present sample of LGBTQIA+ participants, it is necessary to contextualize these stories in the light of intrapsychic personality correlates, sociodemographic location of participants, participant narratives from interviews, and existing literature.

Sociodemographic Embeddedness of Participants (Table 1)

In the sociodemographic questionnaire, 70% of the participants reported their family of origin as unsupportive of their gender/sexuality. A total of 40% of the participants are not staying with
their family of origin, 60% of the sample reported absence of queer member/ally in their family of origin and uncongenial home situation, 80% have experienced partner violence/abuse, 80% of the participants perceived their academic environment as discriminatory, and 70% of the present sample is unemployed. Given the multiple stressors that are evident in the sociodemographic situationedness of the participants, their mental health and well-being is bound to be compromised.

A total of 30% of the sample has attended 3 to 5 sessions with mental health professional/s while 70% has attended more than 5 sessions. A total of 40% of the sample reported psychiatric morbidity.

Contextualizing Intrapsychic Vulnerabilities

Intrapsychic vulnerabilities surfaced as a common denominator in TAT stories (Table 5) among the participants. Predominant ambivalence in personality orientation, self-identity crises, perceived lack of environmental support, and threatening perception of authority figures, are all reflective of poor mental health and general well-being. This may be readily attributable in part to internalized negativity due to minority stress, societal prejudice, and discrimination. Such an attribution is not unfounded in sample demographics, considering that 60% of the participants did not report having any significant psychiatric illness, and their interactions with mental health service-providers were sought to navigate concerns of family or their own regarding gender/sexuality. The sociodemographics of the participants substantiate perceptions of impaired relationships with authority figures and lack of environmental support that may produce crises in self-consolidation and conflict of autonomy versus compliance. It is quite natural that these vulnerabilities would be carried over to the interactional space shared with mental health professionals in the form of transference and would reflect diversely in relational engagement. They may contribute to an a priori with which the client enters the clinical space. This is also true of the mental health professional/s who carry their a priori dominant social understandings into the clinical milieu simultaneously. Caution must however be exercised against an over-emphasis on the participant’s intrapsychic vulnerabilities and using it as the sole reference point for looking at clinical interactions. Such an approach has the risk of camouflaging systemic flaws and clinical mis-steps that may further such vulnerabilities. The internalized dynamics of clinical interactions therefore must also be located in narratives of interpersonal unfolding between the participant and mental health professional where the clinician and patient tend to influence each other majorly.

Internalized Representations and Lived Experiences of Client-Professional Dyad

Perceptions of clinical relationships evoked in 60% of participant narratives (either explicitly or in symbolic roles which might mimic culturally viable, traditional sources of help-seeking such as “priest” or “psychic”) are far from positive (Table 3). It is rather saddening that the help-provider in all these stories is projected as being imposing, opportunistic, or exploitative in nature and there is a generic sense of being overpowered. This tallies with recurrent interpersonal dynamics of forced imposition from authority figures, which is counteracted with defensive protest. Underlying these conflicts, remains a deprived affective core, which emits an “inner cry for help” (Table 4).

Taking recourse to Spivak’s perspective of “subalternity,” institutional frameworks (in this case, mental health-care institutions and mental health professionals) may be said to vanguard hegemonic cis-sexist and heteronormative dominance. These influence the way in which “subalterns” (a metaphor that can be extended to the participants of this study after Carroll-Beight) perceive themselves within these systems. The status of subalternity of the LGBTQIA+ participants is maintained in mental health-care systems by leaving them at the mercy of a system where they are not adequately represented. Subalternity becomes an internalized reality for LGBTQIA+ participants in the light of projective test findings of being overpowered by authority, leading to loss of agency and powerfulness, reflecting in passivity, and dilemma of clinical outcome. Participant narratives from interview transcripts also highlight the theme of tilted power dynamics reflected in experiences like being pushed to heteronormative choices, policed in terms of self-expression, or even threatened with social exclusion (Table 2). In fact, it is these power asymmetries and dependability and vulnerability of the participant of minority status who is at the receiving end of health-care delivery that maintains invalidation in multiple capacities from the professional front. Increasing social and professional affirmation of LGBTQIA+ identities have closed the doors for overt prejudice and discrimination, that is replaced by subtler forms. Such invalidation based on group membership can make the participant feel invisible, concomitant with a loss of integrity, and pressure to represent their group. The consequences outline such spatial and temporal immediacies of these acts, leaving behind anger, hostility, and damaged self-esteem in the recipient, being difficult-to-heal “psycho-emotional” wounds. Projection of extreme hostility onto the clinical environment is not unforeseen in light of these experiential realities.

In a clinical relationship, power is wielded over the client by virtue of knowledge, skills, expertise, and socioculturally endowed authority of the clinical role. Lack of professional competence with LGBT+ issues is a recurrent theme in interactional experiences of participants that is also projected as undue assertion of authority in TAT protocols. A hegemonic synergy is observed across institutions of family and mental health-care system, with parents functioning as moderators of clinical interactions and professionals partnering with familial injustice. This mirrors the ethics of clinical interactions and
institutional indignities in mental health-care toward LGBT+ participants. The ambivalence that participants in the present sample experienced with respect to therapeutic outcome and regarding counteraction in such crises, is not an innate vulnerability, but socially induced and maintained by their subaltern status.

In the light of extreme marginality and hegemonic imposition, processes of smooth ego-formation are bound to be disrupted, which explains frequent loosening of ego-boundaries and personalization of storytelling exercise in the TAT. This reiterates the need for these voices to be “heard in-context,” and conveyed to relevant authorities so that a dialogue can be initiated with a transformative focus. A gleam of hope in this direction is provided by affirmative experiences reported by the participants which set the tone for positive systemic change.

**Toward an Integrated Conceptual Framework**

Therefore, the internalized representation of clinical relationships and corresponding meaning-making among the present sample of participants can be imagined along a contextual framework of multiple contributing factors that were highlighted in the current study. Dominant pathologizing discourses in mental health sciences at the macrolevel may spill over into lived interactional experiences with service-users. Further, intrapsychic vulnerabilities due to minority stress and impaired object relations may evoke strong transference within the client-therapist relationship and influence internalization of the same. Additionally, affirmative clinical experiences have the potential to foster hope and resilience and contribute to wholesome and integrated perceptions of clinical relationships with their strengths and flaws.

A schematic representation of the findings is presented for summary in Figure 1.

**Researcher’s Reflexivity**

The primary author’s queer/trans identity and lived experience inform the research premise and there has been a sincere attempt to ensure an affirmative stance throughout the article. Validity concerns are tackled by inter-rater consistency in terms of TAT protocols and independent coding of verbal data by both researchers. The coauthor’s presence as a nonqueer/transperson also kept checks and balances on subjectivity.

**Conclusion**

Internalized dynamics of relationships with mental health service-providers are explored among LGBTQIA+ participants through projective storytelling and semi-structured interviews. Implicitly held perceptions of such interactions are colored by sense of being overpowered by authority, dilemma regarding clinical outcome, passivity, sexual violation, and extreme perceived hostility from environment. Such perceptions are impacted by real-life experiential realities, intrapsychic vulnerabilities, lack of wholesome and integrated object relations, and macrolevel dominant discourses of pathology in mental health sciences. Affirmative clinical experiences have the potential to create positive impact on the psyche and also induce systemic change.

**Limitations**

This study is certainly not without its limitations. The findings should not be generalized beyond the current sample as sample size is small. The sample mostly consisted of individuals from urban, metropolitan, English-speaking background with at least higher secondary education and
certain socio-cultural-economic privileges are inherent in these locations, which may impact lived experience with mental health care. Purposive sampling lacks in methodological rigor as compared to many other sampling methods. This study also could not take into account the experiences of indigenous queer/trans communities that do not align with the Western LGBTQIA+ acronym.

Implications

The clinical significance of this article lies in establishing the utility of projective storytelling as a powerful tool for emotional catharsis that can be used with gender and sexual minorities. It helps to uncover their internalized dynamics with clinical service-providers, which also tally with real-life discriminatory experiences within mental health care. Therefore, the article also underscores the need for development of evidence-based competency and nonprejudiced service delivery specifically for this population in the form of LGBTQ+ counselling. Since the primary researcher identifies as queer/trans, the article further helps make a case for projective interpretation from a nonheteronormative gaze, which runs contrary to the classical way in which gender/sexuality is approached in assessment with TAT.

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Ethical Approval

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Informed Consent

Written informed consent from the participants to participate in the study and have their responses recorded for research purposes was taken by the primary researcher at the beginning of the investigation.

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