SEXUAL ORIENTATION MICROAGGRESSIONS: THE EXPERIENCE OF LESBIAN,

GAY, BISEXUAL AND QUEER CLIENTS IN PSYCHOTHERAPY

by

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(Under the Direction of Edward Delgado-Romero)

ABSTRACT

Existing literature repeatedly illuminates the detrimental effects homophobia and heterosexism have on lesbian, gay, and bisexual (LGB) clients and the psychotherapeutic relationship. There is a growing body of literature that discusses the negative effects microaggressions, subtle, often innocuous messages that communicate a denigrating message to an attended target (Constantine, 2007; Pierce, et al., 1978; Sue, et al., 2007b), have on the therapeutic environment. However, research literature fails to discuss the effects subtle forms of discrimination, specifically sexual orientation microaggressions, have on LGB and queer (Q) clients and the therapeutic relationship; nor is there an established typology of microaggressions directed towards LGBQ psychotherapy clients. The dearth of empirical research on sexual orientation microaggressions is problematic given the LGB community's high utilization of mental health services, and the high probability that sexual minority clients are seen by heterosexual clinicians who most likely, consciously or unconsciously, hold some disparaging views for sexual minorities.

The purpose of this study was to utilize a qualitative methodology to explore the phenomenon of sexual orientation microaggressions with 16 self-identified LGBQ

psychotherapy clients. It was hypothesized that: (a) themes or a typology would emerge to represent sexual orientation microaggressions, (b) the presence of sexual orientation microaggressions within the individual therapeutic environment would have a negative impact on the therapeutic process, and (c) LGBQ individuals experience sexual orientation microaggressions in a variety of formats within the individual therapeutic environment.

Results of this study validated the existence of sexual orientation microaggressions within the therapeutic environment and a typology of eight sexual orientation microaggression themes was constructed. Sexual orientation microaggressions had negative emotive, cognitive, and behavioral consequences for LGBQ clients, and detrimentally impacted the overall therapeutic process. Sexual orientation microaggressions also manifested in a variety of formats, including verbal, nonverbal and environmental transmission. This study extended the empirical research on microaggressions, and implications from this study can be used to advance clinical training and improve the quality of services provided to LGBQ clients.

INDEX WORDS: Microaggressions, sexual orientation, psychotherapy, counseling, gay, lesbian, bisexual, queer

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DEDICATION

I dedicate this dissertation to my family. Completing this dissertation and graduate school have not been solitary efforts. I would not be where I am today without the love and support you have all given me. My hope is that each one of you knows that this work is as much of a reflection of you as it is of me. As well as being supportive, I am grateful that you also made it so easy for me to forget about schoolwork. Thank you!

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Finally, I must thank the group members of Gender Chat, the young man I met at the Augusta Youth Development Campus, and the individuals who participated in this research study. Being a well-intentioned and multiculturally-focused individual, it came as a shock (and horror) to discover the covert biases and heteronormative beliefs I unknowingly held for LGBQ individuals. I entered into my experiences working with LGBQ individuals thinking that I would somehow help LGBQ individuals be LGBQ, but I quickly realized that it was I who would be doing much of the learning. My overall goal from this work is to help seemingly well-informed clinicians, similar to myself, provide the best quality services possible to LGBQ individuals.

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Chapter I

Introduction

This chapter begins with a synopsis of the context and background that frames the study. Following this synopsis is the statement of purpose, the problem statement, general hypotheses, delimitations and definitions of operational terms. Also included in this chapter is a discussion concerning the researcher's assumptions.

This study seeks to explore the phenomenon of microaggressions experienced by lesbian, gay, bisexual and queer (LGBQ) clients in psychotherapy. It is anticipated that the knowledge generated from this inquiry will provide a typology of microaggressions experienced by LGBQ individuals. This research employs a phenomenological methodology to provide a descriptive account of the phenomenon under investigation. Participants in this study include a sample of 16 LGBQ self-identifying individuals who have had at least one individual psychotherapy session with a mental health professional.

Throughout this document, the changes in the use of the acronyms LGB, LGBQ and LG are purposeful and are not meant to be interchangeable. Most existing studies focus on lesbian, gay and bisexual individuals, therefore, when documenting research from preexisting literature, the acronym LGB is used to accurately reflect the populations studied. The acronym LG is used for studies that only included lesbian and gay participants. When describing this current project or when this researcher makes assumptions, the acronym LGBQ is used to reflect the participants in this study.

Background and Context

Unlike other minority populations who tend to underutilize mental health services, sexual minorities, including lesbian women, gay men, and bisexual persons (LGB), are frequent

consumers of mental health services (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). Five to 25 million U.S. individuals are estimated to identify as lesbian, gay, or bisexual (Gelberg & Chojnacki, 1995). Estimates of the percentages of LGB individuals that obtain counseling and psychotherapy range from 25% to 65% (Bell & Weinberg, 1978; Bieschke, et al., 2000; May 1974; Saghir, Robins, Walbran, & Gentry, 1970). Not only is there a high rate of mental health service usage within the LBG community, LGB individuals' use of counseling and psychotherapy has been historically greater than the help seeking behavior of their heterosexual counterparts (Morgan, 1992).

Mental health professionals face several challenges in providing adequate therapy services to LGBQ individuals. First, as most therapists report working with at least one LGB client during their career (Garnets et al., 1991; Liszcz & Yarhouse, 2005), therapists are charged to provide quality service with little or no formal training. Even with the increased number of multicultural courses offered in graduate training departments (Ponterotto, 1996), doctoral trainees and professional practitioners consistently report having inadequate educational training in providing services to LGB clients (American Psychological Association (APA), 2000; Murphy, Rawlings, & Howe, 2002). They are left feeling unprepared to work with LGB clients and LGB issues (Allison, Crawford, & Echemendia, 1994; Barrett & McWhirter, 2002; Buhrke, 1989; Graham, Rawlings, Halpern, & Hermes, 1984; Murphy, et al., 2002), which can have a detrimental effect on the type of services provided to LGB clients (APA, 2000).

Secondly, psychology and counseling are historically rooted in pathologizing sexual minorities. Although homosexuality as a mental illness is no longer categorized in the Diagnostic Statistical Manual (DSM), to some degree there has been a professional lag in practice changes with LGBQ individuals. The continued development and refinement of professional ethics codes

(i.e., American Counseling Association's (ACA) Code of Ethics, 2005; and APA's Ethical Principles of Psychologists and Code of Conduct, 2002) as well as the development of standards of practice (e.g., APA's Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients, 2000) demonstrate a persistent need to discontinue therapy practices that conceptualize LGBQ individuals from deficiency-based and pathological models.

For the mental health professions and society-at-large, much of the justification for the pathologizing of non-heterosexual identifying individuals is indoctrinated in religiosity (Israel & Mohr, 2004). Most religions of the world condemn homosexuality as a sin, amoral, and wrong (Garazini, 1989; LeVay & Novas, 1995). Although homosexuality and same-sex sexual behavior have been present in every culture, religious sanctions have called for the persecution of homosexual individuals and labeled those engaging in such acts as deviants and harmful to society (Morrow & Tyson, 2006; Israel & Mohr, 2004). Mental health professionals and clients alike are exposed to such messages and may develop disparaging views of homosexuality and LGBQ individuals.

Furthermore, even with the United States' growing tolerance for LGB individuals and sensitivity to LGB issues (Butler, 2001), the pervasiveness of homophobia and heterosexism plagues even those with the greatest resistance to perpetuating inequality. It is undeniable that overt forms of discrimination against LGB individuals can exist within the therapeutic environment, as confirmed by the continued advocacy of reparative or conversion therapies by some mental health professionals (i.e., providing counseling and services in an attempt to change the sexual orientation of LGB individuals from homosexual or bisexual to heterosexual. Bieschke, Paul, & Blasko, 2007a; Exodus International, 2008; Haldeman, 1999, 2000, 2002; Spitzer, 2003). However, even mental health professionals who disagree with such practices, are

not immune to continual stigmization of LGB individuals within psychology and the society-at-large. This is particularly problematic for well-intentioned clinicians because with or without the clinician's knowledge, living within a society that continues to perpetuate ideals of heterosexual supremacy and a culture that views any form of divergence from heterosexuality as deviant, will most likely effect the nature of work clinicians do with LGB clients (Barrett & McWhirter, 2002; Mair & Izzard, 2001). As encouraged in professional psychology and counseling nomenclature (i.e., Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients, 2000; Multicultural Counseling Competencies, 1992; and ethics codes), competent practice demands that mental health professionals examine their overt and hidden biases, work to understand their clients' background, and develop skills to work with diverse clients and diverse client issues.

As supported by guidelines and ethics codes, understanding the client means not only being informed about the clients' background, but also having a working understanding of how cultural standards and norms affect clients. It is imperative for clinicians to understand how society's denigration of LGB individuals effects clients' sense of self and the potential fostering of internalized homophobia. For example, most LGB individuals are raised within families that have some religious beliefs, of which many are unsympathetic to the plight of LGB individuals (Schunck & Liddle, 2001). Learning messages that homosexual individuals are condemned to hell or are perverted can cause inner turmoil, confusion, and self-hatred, thus internalized homophobia. Therapists, even those who are well-meaning and sensitive to the worldview of LGBQ individuals, can unintentionally promote internalized homophobia if this dynamic is not understood and explored in the therapeutic setting.

Unintended acts of homophobia and heterosexism within the therapy environment could potentially come across in the form of microaggressions. Microaggressions are subtle, often

innocuous messages that communicate a denigrating message to an attended target (Constantine, 2007; Franklin, 1999; Pierce, Carew, Pierce-Gonzalez, & Willis, 1978; Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007b). Microaggressions may be delivered in the form of snubs, dismissive looks, gestures and tones (Constantine, 2007; Constantine & Sue, 2007; Sue, et al., 2007a, 2007b). To date, the concept of microaggressions and their aftereffects have only been studied on persons/clients of color, specifically African Americans and Asian Americans, commonly referred to as racial microaggressions.

Racial microaggressions are "brief and commonplace verbal, behavioral, or environmental indignities (whether intentional or unintentional) that somehow communicate negative or denigrating messages to people of color" (Franklin, 1999; cited in Sue et al., 2007b, p. 273). When present in the therapy room, racial microaggressions delivered to clients of color can have devastating effects on the quality of treatment, therapeutic relationship and psychological well-being of clients. Clients of color who are exposed to racial microaggressions may prematurely terminate therapy, view their therapists as less multiculturally competent, feel misunderstood by their therapists and racial microaggressions contribute to stronger feelings of frustration and anger in clients (Constantine, 2007; Constantine & Sue, 2007; Sue et al., 2007b).

Adding to the complexity of microaggressions innocuous nature is its complicity for cognitive rationalization. The occurrence of microaggressions can often be easily explained away through nonbiased and valid reasons (Sue et al., 2007b). When people of color confront White individuals for their microaggressive actions, White individuals may view people of color as 'overly sensitive' or 'emotional', which may serve as a cognitive protection for Whites to maintain their sense of reality. For example, Sue and colleagues (2007a) describe the microaggression experience of many ethnic minorities, particularly Asian Americans, as feeling

like perpetual outsiders or foreigners as they are often asked the question, "Where are you from?", as to suggest that they are not from the United States. In his commentary to Sue and colleagues studies, Schacht (2008) espouses that with the United States' increasingly diverse population, asking minority individuals about their origins is acceptable and shows interest in ethnic minorities' backgrounds. Although easily rationalized, such viewpoints dismiss and invalidate the experience of some Asian Americans' perception that such questions feel demeaning and are often unfounded. The repetitive exposure of microaggressions and resultant self-doubt often leads individuals to feel as if they are not a person of worth (Franklin & Boyd-Franklin, 2000).

Microaggression researchers assume that the phenomenon of microaggressions does not solely exist within communities of color; purporting that this dangerous phenomenon exists within the interactions and communications of other marginalized/oppressed groups, including LGB individuals. Considering that client's of color are often receiving services from White therapists (APA, 2009; Bowers & Bieschke, 2005), the microaggression literature has sought to explore the frequent manifestation of microaggressions in cross-cultural therapeutic relationships. Given that most LGBQ individuals receive psychotherapy services from heterosexual therapists, exploration of cross-sexual orientation communication within the therapeutic environment will more than likely uncover the presence of microaggressive communication patterns. In this researcher's review of LGB psychotherapy research literature, 50%-85% of therapists self-identified or were perceived as heterosexual by their LGB clients (see Garnets et al., 1991; Israel, Gorcheva, Walther, Sulzner, & Cohen, 2009; Jones & Gabriel, 1999; Kilgore, Sideman, Amin, Baca, & Bohanske, 2005). This is not to say that microaggressions cannot or are not transmitted in same-sexual orientation therapeutic

relationships; however, as the vast majority of mental health professionals identify as heterosexual, there is a high likelihood that LGBQ individuals will have a cross-sexual orientation therapeutic relationship. Therefore, unless LGBQ individuals intentionally seek out LGBQ therapists, it is highly unlikely that they will be seen by one. As LGB individuals are frequent consumers of mental health services, it is imperative to understand the role microaggressions play in the therapeutic environment.

<div align="center">Purpose</div>

Research on microaggressions, specifically racial microaggressions received by African and Asian Americans, is a popular topic in the counseling literature as the concept of microaggressions encompasses covert, subtle and unintentional racism. This research continuously demonstrates the pervasive use of racial microaggressions directed to persons/clients of color and the detrimental effects racial microaggressions have on the therapeutic relationship. Not only do racial microaggressions challenge the therapeutic environment, they are potentially personally injurious to the psyche of clients who participate in therapy. As counseling research is silent on the microaggressions experienced by LGBQ clients based on their sexual orientation, this investigation hopes to offer a detailed account of such a phenomenon.

The rationale for this study emanates from the researcher's desire to further the current research on microaggressions. Leaders in the field of microaggressions call for the expansion of microaggression research with diverse populations, including LGB individuals because as witnessed with racial microaggressions, 'sexual orientation microaggressions' (Sue & Capodilupo, 2007) may have a powerful and devastating impact on the lives and therapeutic experiences of LGB persons (Sue & Capodilupo, 2007; Sue et al., 2007b). The purpose of this

psychological phenomenological study is to explore with 16 LGBQ psychotherapy clients their experience of microaggressions directed towards their sexual orientation in the individual therapeutic environment and to create a typology of microaggressions experienced by LGBQ individuals.

Uncovering microaggressions directed towards LGBQ clients can help clinicians recognize the microaggressive message they communicate to clients. Better understanding the effect such microaggressions have on LGBQ clients in individual therapy will have direct results on the quality of services provided to LGBQ clients. Expectantly, with this enhanced knowledge, clinicians can work constructively to limit or eradicate their microaggressive assaults. Additionally, service provision that includes clinicians' assessment and recognition of their biases, whether conscious or unconscious, is a prerequisite for ethical practice (ACA, 2005; APA, 2002) and for gay-affirming therapy (Matthews, 2007).

Statement of the Problem

Existing literature repeatedly illuminates the detrimental effects homophobia and heterosexism have on LGB clients and on the therapeutic relationship (e.g., special issues in *Journal of Counseling Psychology*, 2009). However, to date, research literature fails to discuss the effects subtle forms of discrimination (specifically sexual orientation microaggressions), have on LGBQ clients and the therapeutic relationship; nor is there an established typology of microaggressions directed towards LGBQ psychotherapy clients. As LGB individuals have high mental health seeking behaviors, it is anticipated that understanding the manifestation of microaggressions will improve the service provision of psychotherapy to LGBQ individuals and will enhance the training of those working with LGB individuals. To shed light on the problem, the following research questions are addressed:

1. What are the common themes in which sexual orientation microaggressions directed towards LGBQ psychotherapy clients manifest?

2. What is the impact of sexual orientation microaggressions directed toward LGBQ psychotherapy clients?

3. How are microaggressions directed towards one's sexual orientation experienced by LGBQ psychotherapy clients?

General Hypotheses

Based on a review of literature pertaining to homophobia, heterosexism, microaggressions, and therapy with LGB individuals, three primary hypotheses were made regarding this study:

1. This study hypothesizes that themes or a typology will emerge to represent the forms of microaggressions directed towards LGBQ psychotherapy clients. This hypothesis is guided by the body of microaggression literature, which articulates commonalities between the microaggressive experiences of minority groups.

2. The researcher hypothesizes that the presence of microaggressions within the individual therapeutic environment will have a negative impact on the therapeutic process and LGBQ clients as evidenced by their attitude towards therapy or changes in help seeking behaviors. This hypothesis is formed from existing literature's reportage of the harmful effects covert discrimination has on the therapeutic environment and from previous studies that document the damaging effects microaggressions have on minority populations.

3. The final hypothesis is that LGBQ individuals experience microaggression in a variety of formats within the individual therapy environment. This hypothesis is based on the

recognition that communication is multidimensional existing in verbal, behavioral, and environmental interactions or exchanges.

Delimitations

With the approval of the University of Georgia Institutional Review Board (IRB), the researcher studied the experiences and perceptions of 16 LGBQ psychotherapy clients. Participants of this study had at least one psychotherapy session with a mental health professional. As research participants may be unaware of the specific educational degree or license of their therapists, for the purpose of this investigation, a mental health professional was defined as a psychologist, psychiatrist, licensed professional counselor/mental health counselor, social worker, psychotherapist or marriage and family therapist.

This investigation made use of a phenomenological qualitative methodology. Two focus groups were used as the primary method of data collection. An exhaustive search of microaggression literature showed the frequent use of focus groups as the primary means for collecting data. Focus group questions were derived from a review of microaggression research and literature on homophobia and heterosexism. The focus group process began with a practice focus group consisting of three doctoral-level counseling and clinical psychology students whom had experience working with sexual minority clients. Two of the practice participants identified as sexual minorities and one identified as an ally.

The information obtained from the two primary focus groups subsequently formed the basis for the overall findings of this study. One nonparticipating observer was present in each focus group (N=2). The two observers identified as queer and were in clinical psychology or marriage and family therapy doctoral programs. Each focus group was digitally voice recorded and the resulting verbatim transcript identified focus group participants by pseudonyms. To

support the findings emanating from the focus group studies, participants were contacted post-preliminary data analysis for feedback on the emergent themes. Data triangulation was achieved by the inclusion of observations from the nonparticipating observer, and feedback given from participants.

The Researcher

The researcher is a counseling psychology doctoral candidate at the University of Georgia. I am a heterosexual ally who is professionally and personally interested in the lived experiences of LGBQ individuals and am seeking to better understand the existence of microaggressions. Professionally speaking, I have had practicum and predoctoral internship experience working with LGBTQ persons in individual and group counseling. I have received training from two universities, the University of Georgia and Georgia State University, on counseling the LGBTQ community, ally development, Safe Space and Safe Zone programs. I feel honored to have been an invited lecturer on both the topics of microaggressions and LGBTQ issues. Continuous learning, challenging hidden biases, and uncovering the heterosexist views I hold is especially important to me; therefore, I regularly attend conferences and workshops on LGBTQ issues, microaggressions, diversity, social justice and multiculturalism. Thus, to this project I bring practical experience as a practicing clinician and knowledge gained from formal education.

My personal experiences as an African American woman have in many ways shaped my desire and dedication to working with oppressed populations, including LGBTQ individuals. As well as leaders from within minority groups, majority group allies have been instrumental to the movement of equal rights and treatment for minority individuals. Noting that I also hold a privileged status due to my heterosexual orientation pulls me to use my privilege to help those

who are persecuted and victimized for their sexual orientation. Going into my first experience

working clinically with LGBTQ individuals, I held the belief that I was well-informed and

understanding of the plight many LGBT persons face. However, I soon discovered that I held

hidden biases and heteronormative beliefs, which negatively impacted my views of LGBT

persons. Fortunately, I quickly became aware of some of my biases and have since been

committed to greater self-awareness of my heteronormative beliefs, and I continuously attempt

to rid such biases from entering the therapy room. Undertaking this research project is yet

another way to explore my hidden biases and use of microaggressions; as well as to help other

clinicians who work with LGBQ individuals.

     As the researcher is an intricate part in the conduction of any research, it is important that

the assumptions of the researcher are made explicit at the outset of the study. From my

professional education and personal experiences, three primary assumptions were made

regarding this study.

1. It is well established that homophobia and heterosexism are pervasive in the U.S. culture.

   As cultural beings who are bombarded with homophobia and heterosexist messages on a

   daily basis, it is assumed that mental health professionals, even those who are well

   intentioned, deliver microaggressive assaults to their LGBQ clients.

2. As a typology of microaggressions exists for persons of color, including clients of color, I

   assume that a typology of microaggressions will arise that represents the experiences of

   LGBQ psychotherapy clients.

3. Microaggression literature and other literature on marginalized populations suggest that

   research participants feel more comfortable and disclose at a greater quantity with

   researchers who are of their community. With this knowledge, my final assumption is

that focus group participants may not be completely forthcoming because of my

heterosexual ally status. To minimize this, I chose to include a nonparticipating observer

who identified as L, G, B, or Q to encourage participants to be forthcoming.

To minimize subjectivity, I remained committed in engaging in ongoing critical self-

reflection by way of journaling and conversing with mentors. Moreover, to strengthen the

credibility of the research, various procedural safeguards were taken, such as triangulation of

data sources and debriefing with nonparticipating observers.

Definitions and Operational Terms

A frequently expressed strength and limitation of LGB literature is its lack of commonly

agreed upon definitions or terminology (Fassinger & Arseneau, 2007). Nonconsensual

terminology as a strength is aligned with many LGB individuals beliefs in individual definitions

of sexual orientation labels (or the lack of using labels) (Fassinger & Arseneau, 2007). Indeed, it

is political in nature to reject concepts or labels that have been prescribed to those who identify

as LGBQ. Limitations of consensually accepted definitions and terminology is that

misconceptions or errors in interpretation can alter research findings (making the role of the

researcher all the more daunting) and cohesion within the LGBQ community could be comprised

without a commonly accepted language. Although the meaning of words has been an area of

contention in LGBQ literature, for this current study operational definitions for terms and

concepts used in this current work are listed below:

Biphobia—Fear and rejection of individuals who do not identify with an exclusively heterosexual

orientation and are romantically, erotically, and/or relationally attracted to both males and

females (Hutchins & Ka'ahumanu, 1991). Biphobia can exist within both heterosexual and LGB

communities.

Bisexual—Constellation of sexual identities that are neither exclusively heterosexual nor exclusively lesbian or gay identities and speaks to sexual identity/orientation as a true continuum (Firestein, 2007). There is not an established definition of who is bisexual or what bisexuality consists of, as bisexuality may take many forms ranging from sexual attraction, sexual behavior, romantic attraction or identifies as bisexual (Weinberg, Williams, & Pryor, 1994).

Coming Out—The process in which LGBQ individuals acknowledge and accept their nonexclusively heterosexual orientation (Fassinger & Arseneau, 2007, Matthews, 2007, Shelton & Wells, 2007). There are various models that explicate the developmental stages or statuses of the coming out process (i.e. Cass, 1984; D'Augelli, 1994) and the complex cognitive, affective and behavioral changes involved in LGB individuals gaining awareness of their same-sex or both-sex feelings and attractions (Reynolds and Hanjorgiris, 2000). Coming out is a lifelong process for many LGB individuals in which they may choose (or others may choose) to share their lesbian, gay or bisexual identity in different environments such as with family members, friends, work environments, religious groups or with their therapist (Cramer & Roach, 1988; Matthews, 2007).

Gay—The term gay has often been used to describe men who prefer sexual relationships with men (Lips, 2005). Currently experts in the field of LGB issues note the limitations to this definition as it only incorporates sexual behavior and ignores other salient features that are important components to gay identity. Broido (2000) provides a more comprehensive definition of gay as referring to males who self-acknowledge same-sex sexual attraction, engage in same-sex sexual behavior and/or have same-sex emotional desire.

Not only is the term gay used in the above-mentioned manner, gay is also an umbrella phrase for all persons who identify with a sexual orientation other than heterosexual. This shared

umbrella comes from sexual minorities collective concerns of invisibility, isolation and discrimination based on their sexual orientation (Fassinger and Arseneua, 2007). However, grouping sexual minorities into the term gay or only acknowledging three nonheterosexual identities (lesbian, gay, and bisexual) is problematic (Bohan, 1996; Fassinger, 2000). Lumping all sexual minorities under the category of gay ignores the great diversity amongst different groups and ignores the great variance within each group. Gay as an umbrella term may also incline one to think of males; therefore, use of the term gay could exclude the experiences of women who do not identify as heterosexual.

Homophobia—Persons who are homophobic hold a negative attitude towards gay, lesbian and bisexual individuals and have a hatred and rejection of the behaviors gay, lesbian and bisexual individuals engage in (APA et al., 2000; Weinberg, 1972).

Heteronormative—Very much related to heterosexism, heteronormative is the idea that heterosexuality is the dominant and 'normal' way of being (Kates, 1999), thus anyone or any construct that deviates from heterosexuality is 'abnormal' or even sinful (Herek, 2003). Heteronormative culture promotes ideas such as two sexes (male/female) and binary gender norms (masculinity/femininity) and affords privileges to those who maintain heterosexual identities including legal sanctions that protect rights, and marriage, family, and adoption privileges (Firestein, 2007).

Heterosexism—The belief that heterosexuality is the more natural and superior way of being as compared to any other sexual orientation or lifestyle (Iasenz, 1989, Morin, 1977). Heterosexism "denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship or community" (Herek, 1995, p. 321).

Internalized Homophobia—Living in a society that denigrates and demeans non-heterosexual exclusive sexual orientations and same-sex/both sex sexual behavior can have an aversive effect on the way LGBQ individuals view themselves. Having ascribed to such negative views, LGBQ individuals can develop fear and hatred of identifying and being recognized by others as homosexual, thus they internalize negative beliefs, attitudes, and feelings regarding one's own sexual orientation (Szymanski & Gupta, 2008). Sexual minorities developing some degree of self-hatred (McHenry & Johnson, 1993; Hencken, 1982) or internalized homophobia is difficult if not impossible to avoid as homophobia and heterosexism are so pervasive within the U.S. culture (DuBay, 1987; Fein & Nuehring, 1981; McHenry & Johnson, 1993).

Lesbian—Similarly to the term gay, the definition of lesbian as merely women who have sexual relationships with other women (Lips, 2005) has been seen to be too limiting. A more comprehensive definition of lesbian refers to females who self-acknowledge same-sex (gender) sexual behavior and attraction and/or same-sex (gender) emotional desire (Broido, 2000).

Queer—Queer is a historical negative epithet that was "taken back" by the LGB community in a sociopolitical fashion. The term queer represents a movement or paradigm shift in identity labeling, as a queer identity can represent a number of nonexclusively heterosexual behaviors, attractions, romantic feelings and relationships (Driver, 2008). Therefore, queer challenges a dichotomous view of sex, gender and sexuality (Rust, 2007). Queer encompasses those who identify as gay, lesbian, bisexual, transsexual, transgender, intersex, queer and or questioning (Driver, 2008). The term queer also serves as a means to detach sexual behavior from sexual orientation (i.e., LGB individuals being classified by the sex of their sexual partner) to a view that is more broadly encompassing of the multidimensionality of one's "temporality, life scheduling, and eccentric economic practices" (Halberstam, 2008, p.27).

*Microaggressions—*Subtle, often innocuous messages that communicate a denigrating message to an attended target (Constantine, 2007; Sue et al., 2007a; Sue et al., 2007b). Microaggressions may be delivered in the form of snubs, dismissive looks, gestures and tones, and may be delivered from person-to-person interactions or person-to-environment interactions (Constantine, 2007; Sue et al., 2007a; Sue et al., 2007b).

*Sexual Orientation—*Contemporary scholars reject the notion that sexual orientation is a dichotomy of heterosexuality and homosexuality, purporting that a fluid and continuum-based view of human sexuality exists in which there are numerous gradations (Fassinger & Arseneau, 2007; Fausto-Sterling, 1998; Rust, 2007). Fassinger and Arseneau (2007) provide a definition of sexual orientation that comprises this contemporary view, "the constellation of affective, cognitive, and behavioral characteristics that constitute an individual's sense of self as a sexual and intimately relational being" (p. 30).

A lack of agreement regarding the distinction of sexual orientation and sexual identity exists within LGB literature. Some authors view the term sexual orientation as a negative connotation in that it de-emphasizes other aspects that are central to lesbian, gay, or bisexual identities and overemphasizes sexuality and sexual behavior (Perez, DeBord, & Bieschek, 2000). Therefore, they choose to delineate between the terms of sexual orientation and sexual identity. Worthington and colleagues (2002) distinguish sexual orientation as one's sexual predisposition and sexual identity as one's recognition, claiming, acceptance and self-identification with such predisposition. However, others note no difference in the use of these words. For such reasons, within this current study, the terms sexual orientation and sexual identity are used interchangeably.

Of note, as transgender individuals often have a transient placement with in the LGB(T) community, I feel compelled to explain the exclusion of transgender individuals within this study. Transgender describes persons who are gender-variant and 'trans'cend traditionally accepted societal gender norms (Fassinger & Arseneau, 2007). Included within the transgender label are transsexuals, cross-dressers, and drag queens and kings (Fassinger & Arseneau, 2007). Although commonly mistaken for such, transgender is not a sexual orientation; it is a gender-identity. As this study seeks to explore microaggressions based on one's nonexclusively heterosexual status, particularly for transgender individuals who identify as heterosexual, those who identify as transgender are not appropriate for this study. Furthermore, with the lack of research on microaggressions based on sexual orientation or gender identity, it is my belief that it may be difficult to decipher whether the microaggressions experienced by transgender individuals are based on their gender identity or sexual orientation or (more likely) a combination of both gender-identity and sexual orientation. Finally, microaggressions experienced by transgender individuals merits its own attention and could not be thoroughly explored within the confines of this investigation.

Chapter II

Review of Related Research

Microaggressions

This study assumes that sexual orientation microaggressions exist, and due to a shared minority experience, microaggressions against LGBQ individuals will have characterological similarities to microaggressions experienced by racial and cultural minorities. Sexual minorities and ethnic minorities share a history of discrimination and victimization in the U.S., experience discrimination from well-meaning individuals, may experience internalized discrimination, and have a history of abuse and neglect at the hands of mental health professionals.

The history of the ethnic minority experience in the U.S. is filled with overt racism and oppression (i.e. slavery of African Americans, placement of Japanese Americans into internment camps, and forced relocation of American Indian tribes), which was often supported by laws and sanctions. Although such acts of racism have suggestively dissipated, in many ways ethnic minorities maintain an inferior status within the U.S. (i.e. lower socioeconomic status as compared to Whites, lower educational attainment as compared to Whites, etc.). Laws, sanctions and attitudes towards ethnic minorities have changed for the better; however, the cultural conditioning of biases and prejudice continues (Abelson, Dasgupta, Park, & Banaji, 1998). Although clearly still in existence, overt racism has transformed into covert and hidden forms of discrimination; racial microaggressions (Helms & Cook, 1999; Sue et al., 2007b).

Racial Microaggressions

Racial microaggressions are defined as "brief and commonplace daily verbal, behavioral and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (Sue et al., 2007b,

p. 273). On the surface, microaggressions may appear harmless (Sue et al., 2007b) but the accumulation and regularity of racial microaggressions express denigrating messages to people of color because of their race or ethnicity (Solórzano, Ceja, & Yosso, 2000). Sue and colleagues (2007b) describe three forms of microaggressions: microassault, microinsults and microinvalidations. Microassaults are overt and explicit forms of racial derogation such as name-calling, avoidant behavior and intentional discriminatory actions (Sue et al., 2007b). Microassaults differentiate from similar traditional forms of racial discrimination in that microassaults are communicated in private situations that provide the perpetrator with a sense of anonymity; hence their "micro" nature. Sue and colleagues (2007b) explain that microassaults may occur in public, but only when the perpetrator feels relatively safe to engage in microassaults or when they lose control. Regardless of the specific setting, microassaults are always intentional and conscious behaviors.

Microinsults are "characterized by communications that convey rudeness and insensitivity and demean a person's racial heritage or identity" (Sue et al., 2007b, p. 274). Perpetrators of microinsults are often unaware that their subtle snubs or gestures convey a hidden insulting message to persons of color (Sue et al., 2007b). An example of a microinsult would be a White person saying, "I believe the most qualified person should get the job" (Sue et al., 2007b). This statement sends an underlying message that persons of color are not qualified for the position and that the person of color obtained the job through means such as affirmative action or quota systems (Sue et al., 2007b).

Microinvalidations are "characterized by communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of persons of color" (Sue et al 2007b, p.274). An example of a microinvalidations occurrence is when White individuals negate the

race of a person of color (Sue et al., 2007b). Microinvalidations lead to increased levels of racial anger, mistrust and lose of self-esteem by persons of color. White individuals are limited by microinvalidations because they do not allow themselves the opportunity to understand the racial realities of others (Sue et al., 2007b). This current study is concerned with discrimination and heterosexism that is unintentional and unconscious; therefore, the forms of microaggressions that will be explored are microinsults and microinvalidations.

All studies on racial microaggressions within the counseling literature have been focused on cross-racial interactions; primarily interactions between White individuals and ethnic minorities (see Constantine 2007; Sue et al., 2007a; Sue et al., 2007b; Constantine & Sue, 2007; Solórzano, et al., 2000; See Table 2:1). The literature, thus far, only examines the experience of persons of color who experience racial microaggressions, who are labeled by Sue as 'victims' and 'targets', and the literature is quiet about the experience of microaggression experiences by White individuals, who are often labeled as the 'perpetrator'.

Based on research with Black/African American and Asian American groups, typologies of racial microaggression themes have been generalized for the everyday living experiences of ethnic minority groups. Sue (2007b) identified the following nine racial microaggression themes for the everyday living experiences of people of color: a) alien in own land, b) ascription of intelligence, c) color blindness, d) criminality/assumption of criminal status, e) denial of individual racism, f) myth of meritocracy, g) pathologizing cultural values/communication styles, h) second-class citizen, and i) environmental microaggressions. Constantine (2007) gives the racial microaggression example of a person of color being ignored by a salesclerk who is more willing to accommodate a White customer. Additionally, numerous narrative stories exist

that provide evidence about the existence of racial microaggressions in everyday life (ACA, 1999).

Microaggressions delivered in verbal, nonverbal and environmental means (Sue, Capodilupo, & Holder, 2008; Sue et al., 2007b) challenge people of colors' perception of the experience (i.e. feeling confused as to if a microaggression just occurred). The invisibility of unintentional racial microaggressions challenges people of colors' and Whites' reaction to such events (Sue et al., 2007b). Hidden biases are cultural conditioned; therefore, people may be unaware that they have just engaged in a microaggressive event resulting in a clash of racial realities between Whites and people of color (Sue et al., 2007b). Microaggressions are further complicated because they are often perpetuated by well-meaning and good intentioned individuals who hold egalitarian beliefs (Fouad & Arredondo, 2007). Therefore, Whites are left feeling defensive and guarded if confronted with engaging in microaggressive behavior (Sue et al., 2007b) and people of color feel as if they are caught in a 'catch 22' (Sue et al., 2007b). Ethnic minorities' reactions to racial microaggressions run the gamete from reacting with: a) a healthy sense of paranoia, b) completing a sanity check by following up with other minority individuals, c) feeling empowered by the belief that microaggressions are the fault of the perpetrator and not of the victim, and d) by feeling pulled to rescue the offender, thus minimizing the impact of racial microaggressions (Sue, Capodilupo, & Holder, 2008).

The power in racial microaggressions comes from the message it sends to its target. Whether verbal, nonverbal, or environmental, racial microaggressions send the message that due to one's minority status they are a criminal, do not belong in the U.S., are less intelligent than Whites, need to assimilate to the White culture, and are given unfair benefits because of their race (Sue et al., 2007b). After a microaggression incident, the recipient of the microaggression is

left feeling powerless, invisible, feels pressured to represent one's group, and may experience a loss of integrity (Sue, Capodilupo, & Holder, 2008). One dilemma in microaggressions is the perception that microaggressions cause little or minimal harm, yet, the consequences of microaggressions survive past the actual act itself (Sue et al., 2007). Sue and Constantine noted emotive responses from the participants in their studies which suggested participants remained hurt, angered and frustrated by microaggressive incidents that happened in the past (Sue et al. 2007a; Sue et al., 2007b; Sue, Capodilupo, & Holder, 2008).

Microaggressions in Psychotherapy

Similar to the expression of racial microaggressions in everyday life, racial microaggressions also occur within the therapeutic environment. The occurrence of microaggressions is particularly dangerous to the therapeutic environment because of the power imbalance between clinician and client. Sue and colleagues (2008) acknowledge that any group or individual can deliver racial microaggressions; however, the greatest harm comes when messages are transmitted from those who hold power to those who are disempowered. Therefore, White therapists are particularly vulnerable to negatively impacting ethnic minority clients through their use of microaggressions. The majority of mental health professionals racially identify as White, therefore, expectantly many ethnic minority clients are seen by White clinicians. Despite the well-meaning intentions of many White clinicians, racial discrimination directed towards persons of color is present in the counseling room (Helms & Cook, 1999). Subtle forms of racism often go unnoticed by White therapists because their behaviors are not deliberate acts of racism (Gaertner & Dovido, 1986; Neville, Lilly, Duran, Lee, & Browne, 2000; Ridley, 2005; Sue, 2003). White individuals inherit racial bias from their membership in larger society (Burkard & Knox, 2004; Sue, 2005), which often renders the subtle forms of

discrimination against person of colors automatic and invisible to White individuals (Sue et al. 2007a).

    Constantine (2007) found that African American clients perceived racial microaggressions as being negatively associated with the therapeutic working alliance and their White therapist's counseling competence. Therefore, whether conscious, subconscious, or preconscious, racial microaggressions can have a profoundly negative impact the therapeutic working alliance and can contribute to African Americans' premature termination of mental health services (Constantine, 2007). The nebulous nature of microaggressions may make it difficult for African American clients to verbalize their experience, which may result in greater frustration or anger (Solozano et al., 2000). Additionally, as the client/counselor relationship is often perceived as a hierarchical relationship, African American clients may erroneous label their perceptions as internal issues, their own misperceptions and blame themselves (Constantine, 2007).

The existence of racial microaggressions extends past direct service provision and also has been shown to have detrimental effects within training and supervision of persons of color (Constantine & Sue, 2007), and on professional identity and development of Black/African American faculty members (Constantine, Smith, Redington & Owens, 2008). Within these settings racial microaggressions continually challenge ethnic minorities' worldview, invalidates their racial reality, causes discomfort, creates an environment of mistrust, and has negative psychological, cognitive, emotional and behavior effects.

Racial microaggressions also extend past counseling and have been reviewed within other disciplines such as the criminal justice system (DeJesus-Torres, 2008), nursing (Hochberg, 2008), public relations (McGee, 2008) and business (i.e. Microtriggers, Ivy, 2008). However, not

everyone agrees with the existence of microaggressions (i.e. Schact, 2008, Thomas, 2008; Harris 2008, 2009). The nature of microaggressions has been challenged in the counseling field as being "pure nonsense" (Thomas, 2008, p. 274) and "an array of clearly irrational reasons for experiencing emotional turmoil" (Thomas, 2008, p. 274). In addition, the protection of ethnic minorities having their perception validated has also been challenged. Ethnic minorities routinely comment on feeling psychological ease after they have discussed the microaggression and discrimination events or situations and received validation from another ethnic minority individual; however, Harris' (2008) commentary on racial microaggressions states that it is unnecessary to have one's perception validated and describes such an experience as "neither helpful nor explanatory" (p. 275). Sue attributes much of the negative reactions to microaggressions to the invisibility of aversive racism and the need to preserve one's self-image as being fair and moral (Sue et al., 2008). They note that such a strong need to trivialize and minimize racial microaggressions and the racial realties of people of color are microaggressions in themselves and perpetuates the beliefs that people of color are "overly sensitive, out of contact with reality and even paranoid" (p. 277).

Constantine and Sue (2007) suggest replication and extension of the study of microaggressions to determine the generalizablity of themes. Extension of microaggression research includes using diverse dyads other than cross-racial pairings (Constantine, 2007). Sue and colleagues (2007a) acknowledge that microaggressions may have equally detrimental effects on LGB individuals and that further investigation is needed to understand their complexities. Using racial microaggression research and literature on covert discrimination against LGB individuals, Sue labeled several dynamics of "sexual orientation" microaggressions, which he describes as microaggressions made towards sexual minorities. Sue suggests several sexual

orientation microaggressions themes (i.e. second class citizen, assumption of abnormality, denial of heterosexism); however, an empirical study with LGB clients is yet to occur. This study hopes to fill this gap in research literature. To explore the phenomenon of sexual orientation microaggressions within psychotherapy, clinicians must having a working knowledge on the history of covert and overt heterosexism and homophobia within society and the mental health field. The follow sections outline heterosexism and homophobia within the mental health field, discusses covert forms of sexual orientation discrimination, and provides an in-depth rationale for the needed study of sexual orientation microaggressions.

Heterosexism and Homophobia within Psychotherapy

Cultural Conditioning of Homophobia and Heterosexism

Lesbian women, gay men, and bisexual (LGB) persons are estimated to comprise approximately 5-15% of the U.S. population (Atkinson & Hackett, 1988; Avert, 2009; Gelber & Chojnacki, 1995). There are multiple challenges to collecting population statistics of LGB individuals. For one, estimates vary depending on the definition used to classify LGB identification or homosexuality. For example, definitions have been based on engaging in same-sex sexual behavior, having emotional feelings for the same-sex or for both sexes, and by self-identification as LGB. Rust (2000) reported that 20.3% of men have had a same-sex experience in their lifetime (9.1% had their experience after puberty), yet less than 1% of men identify as bisexual in the U.S.. Furthermore, the U.S. Census (2000) does not ask any questions regarding sexual orientation. The 2000 Census reported that 5.5 million households consist of unmarried partnerships, of these 595,000 consisted of same sex partners. Avert (2009) interpreted these findings to estimate that there are 1.2 million gay people living with a same-sex partner.

Additionally, due to stigmatization of LGB individuals and homosexuality in the U.S., some people may choose not to reveal their sexual orientation, especially to the government. Like other minority populations in the U.S., LGB individuals experience discrimination, social inequality and oppression based on their minority group status (Herek, et al., 2002). Many LGB individuals are confronted with discrimination on several fronts due their multiple identities in minority groups, for example as well as experiencing discrimination on sexual orientation, additional discrimination can occur based on one's gender, race, ethnicity, religion, and/or socioeconomic status (Bieschke, Perez, & DeBord, 2007; Perez, DeBord, & Bieschke, 2000).

The endurance of heterosexism, homophobia, and biphobia within the U.S. culture can be explained from gender, educational, health and religious perspectives. As a patriarchal society, the U.S. maintains a social structure that implicitly and explicitly favors men and masculinity. Gender and sex as binary constructs are expressed within this patriarchal view. Stereotypes such as gay men are effeminate and lesbian women are masculine (Herek, 1993: Jackson & Sullivan, 1990), challenge the antiquated view of patriarchy and potentially upsets the status quo, thus, heterosexism, homophobia, and biphobia continue to thrive as a means to rectify any deviation from gender norms and male dominance.

As with any form of discrimination and phobia, fear is associated with miseducation and/or limited exposure. Those who tend to hold strong negativity against LGB individuals also report having little exposure with LGB individuals (Ben-Ari, 1995; Kite, 1992). Thus, one does not have the opportunity to challenge or confirm their ideals; therefore, they maintain opinions and beliefs that may be founded in ignorance. Over time, fear and discrimination of LGB individuals (particularly homophobia against gay men) increased with the equation of LGB individuals and 'lifestyles' with sexually transmitted diseases. Although research over the last

three decades shows that all individuals, regardless of sexual orientation, are susceptible to HIV and AIDS, there continues to be a skewed view that HIV/AIDS is a gay issue.

Disparaging views of homosexuality and LGB persons are heavily connected to religiosity. There are few religions that are supportive to LGB individuals and families (with the exceptions of Quakers and United Church of Christ, Haldeman, 1996), instead most tend to condemn and reject sexual minorities (Garanzini, 1989; LeVay & Novas, 1995; Ritter and O'Neill, 1989). Most religions prescribe strong consequences for disobeying religious doctrine and law, such as damnation and hell (Morrow & Tyson, 2006) and being rejected by God (Wagner, Serafini, Rabkin, Remien, & Williams, 1994). Such messages and religious training are unavoidable for most LGB individuals because most LGB persons grow up in homes with religious backgrounds (Schuck & Liddle, 2005). Conflicting religious beliefs and same-sex attraction can leave LGB individuals feeling confused, ashamed, and forced to repress their sexual orientation; thus, holding condemning religious beliefs is damaging to the identity development and the mental well-being of LGB individuals (Haldeman, 1996; Wagner et al., 1994).

Such distress between religious beliefs and sexual orientation is commonly experienced by LGB individuals as two-thirds of participants in Shunck and Liddle's (2005) study reported experiencing a conflict between their religion and sexual orientation. Religious and sexual orientation conflict places LGB persons in the unfortunate position to feel compelled at times to choose between their religion and sexuality (Schuck & Liddle, 2005; Wagner et al., 1994). Religion can be a source of support and is of such great of value that LGB individuals may forsake their sexual orientation to remain in a religion. When this occurs, clients may voluntarily seek therapy to change their sexual orientation (Morrow & Tyson, 2006). Some mental health

professionals openly hold on to the amoral beliefs associated with identifying as LGB, hence the continued practice of conversion and reparative therapy. However, clinicians who disagree with such practices and have a nonpathological view of sexual minorities may unintentionally connect homosexuality with deviance and amorality, which can unknowingly be reflected in their clinical work.

The oppression of LGB individuals manifest in many different ways including physical, relational, political, and legal intimidation (Bieschke, Perez & DeBord, 2007). Investigating hate crimes on minority populations, Finn and McNeil (1987) found that gay men and lesbian women were targets of hate crimes at rates higher than any other minority group in the U.S.. Gay men and lesbians report the frequent occurrence of antigay violence ranging from antigay slurs to death threats and physical injury and assault (Dillon & Rose, 1996). Tragically, numerous individuals have been murdered due to their sexual orientation (see The LGBT Hate Crimes Project, 2008). Within political and legal spheres, LGB individuals continue to experience social inequality. Gay men and lesbian women are not able to legally marry, often have difficulty adopting children and face possible discrimination within housing and educational attainment.

LGB Individuals Mental Health Seeking Behavior

Although sexual minorities are estimated to compromise a small percentage of the overall U.S. population, LGB individuals' utilization of mental health services tends to be higher than that of their heterosexual counterparts (Barrett,1993; Bell & Weinberg, 1978; Liddle, 1996; Morgan, 1992). Estimates suggest that gay men and lesbian women enter counseling at a rate two to four times greater than do heterosexual men and women (Barrett, 1993; Elliot, 1993; Haldeman, 2001). Studies investigating the use of therapy by lesbian women show that 73-78% of lesbians surveyed had utilized counseling services (Bradford, Ryan, & Rothblum, 1994;

Morgan, 1992). In Cochran and colleagues' (2003) study, over the course of a year, over half of

the 37 gay and bisexual men and two thirds of lesbian and bisexual women surveyed reported

using at least one form of mental health services (i.e. saw a mental health provider, general

practitioner for mental/emotional consultation, attended self-help groups, and/or saw a

psychiatrist for mediations), which are rates higher than that of their heterosexual counterparts.

Several arguments are made to explain LGB individuals' high mental help-seeking

behavior. One notable argument is the fact that some sexual minorities, particularly lesbian

women, report more positive attitudes towards psychotherapy than heterosexual women

(Morgan, 1992; Morgan & Eliason, 1992) and may place increased value on therapy (Liddle,

1996) which increases their likelihood of seeking and receiving mental health services.

Another proposition for the high help-seeking practices of LGB individuals is the idea

that LGB individuals demonstrate greater psychopathology than do heterosexual individuals.

Research on greater pathology within the LGB population is mixed. On one hand, higher levels

of psychological distress have been noted in several studies (see Silverschanz, 2004). As

compared to heterosexual individuals, LGB individuals have been reported to show higher levels

of depression, anxiety, and substance use (Bradford et al., 1994; Cochran, Bybee, Gage, & Mays,

1996; Cochran, Keenan, Schober, & Mays, 2000; Dohrenwend, 2000). State and national

investigations report that the consideration and attempts of suicide rates are higher for gay,

lesbian, and bisexual adults and youth than are the rates for their heterosexual counterparts

(Cochran, 2001; Faulkner & Cranston, 1998; Russell & Joyner, 2001). Using data from the

MacArthur Foundation National Survey of Midlife Development in the United States (MIDUS),

Cochran and colleagues, (2003) found that over 12-months, gay and bisexual men were more

likely to be diagnosed with at least one of the five mental health disorders assessed by the

MIDUS (major depression, generalized anxiety disorder, panic disorder, alcohol dependency, and drug dependency) than heterosexual men. Lesbian and bisexual women were shown to have higher prevalence rates of generalized anxiety disorder than rates among heterosexual women. LGB individuals also demonstrated greater comorbidity than heterosexual individuals did.

On the other hand, studies show no significant difference in pathology or mental health issues as compared to heterosexual counterparts. In examining quality of life (Bronn, 2001), lifestyle and health indicators (Davis & Smith, 1996), and wellness (Ketz & Israel, 2002), no statistically significant differences were found to exist between LGB and heterosexual individuals. The discrepancy in research findings is likely due to methodological issues and the dearth of research on the mental health of LGB individuals (Rothblum & Factor, 2001). Additionally, research suggests that elevated risk for affective, anxiety and substance disorders is likely influenced by the effects of social stress and social stigma (Dohrenwend, 2000; Fife & Wright, 2000; Kessler, Mickelson, & Williams, 1999; Mazure, 1995).

Given the social stigma and social inequality associated with any nonexclusively heterosexual identity and deviation from gender-norms (Bradford, Ryan & Rothblum, 1994; Cochran & Mays, 1994; Herek, Gilis, & Cogan, 2009), it is no surprise that LGB individuals seek psychotherapy services by many mental health professionals (APA, 2000). Social stigma of homosexuality is a risk factor for depression (Kessler, Mickelson, & Williams 1999; Mays & Cochran, 2001; Ottis & Skinnner, 1996). Haldeman (2001) asserts that based on sexual orientation, most gay and bisexual men experience some emotional and/or physical scarring during their developmental years ranging from verbal harassment to violent crimes. Lesbian and bisexual women present to therapy with fears associated with social stigmatization, fear of

rejection, employment concerns, and difficulty integrating religious teachings with their sexuality (Liddle, 2007).

Although bisexual individuals' sexual minority status places them under a shared umbrella with lesbian and gay individuals, beyond sharing commonalities, they also experience differences. Bisexual individuals face the interesting dilemma of being an 'outsider' and 'insider' in both LGB and heterosexual communities and consequently may experience "double discrimination" (Bradford, 2004; Ochs, 1996, as cited in Firestein, 2007, p. 91). Biphobia and negative attitudes toward bisexual men and women are present in both the LG and heterosexual communities (Eliason, 1997; Mayfield, Carrubba, & Louie, 1996; Rust, 1995; Shuster, 1987; Udis-Kessler, 1996; Weise, 1992) and are not identical to the attitudes held for gay and lesbian individuals (Eliason, 1997; Mayfield & Carrubba, 1996; Ochs, 1996; Queen, 1996). Within the LG community, bisexual individuals may be criticized as being indecisive, "haven't come 'all the way' out" (Potoczniak, 2007, p. 127) and closeted lesbian and gay men who have not accepted their sexual orientation status (Eliason, 1997; Fox, 1996). Often times, bisexual individuals feel pressure to adopt a non-bisexual identity based on the gender of one's partner (Bower, Gurevich & Mathieson, 2002). Haldeman (2001) describes this vacillating experience as "cultural homelessness" (p. 807).

LGB youth are particularly vulnerable to harassment, rejection, and violence based on their sexual orientation (American Academy of Pediatrics, et al., 1999). Societal homophobia and heterosexism can make the acknowledgement and exploration of same-sex feelings and attractions, and the expression of gender variant behaviors a difficult and often dangerous process. Sexual minority youth are often targets of harassment, violence, and bullying by peers and adults. As school encompasses a considerable amount of adolescents' time, much of this

victimization and stigmatization occurs at school (Fleischer & Fillman, 1995). Sexual minority youth frequently report being socially ostracized by peers, and experience shame, confusion, anxiety and depression (Fleischer & Fillman, 1995).

LGB individuals report experiencing familial abuse and harassment after disclosing their sexual orientation (D'Augelli, 1998; Savin-Williams, 1994), parental maltreatment (Corliss, Cochran, & Mays, 2002), and peer and stranger victimization (Garofalo, Wolf, Kessel, Palfrey, & DuRant,1998). Therefore, therapy is often sought to gain social support (Morgan, 1992). Unfortunately, with the limited research on LGB individuals' mental well-being and focused research on pathology, little empirical evidence is kwon about the resiliency and strengths of LGB individuals (Reynolds, 2003).

Given the psychological distress caused by societal oppression, mental health professionals providing therapy to LGB individuals should be prepared to address issues specific to sexual orientation (Appleby & Anastas, 1998). The act of self-identification with a sexual orientation other than heterosexual can provoke feelings of confusion, upset or isolation (Page, 2004). Page (2004) suggest six core issues to investigate when working with lesbian and bisexual women: a) identity development and management; b) relationship concerns, d) career and vocational concerns, e) spirituality issues, f) family of origin concerns, and g) children and parenting issues. Research also describes unique challenges gay and bisexual men face with intimacy, coming out, culture and family (Haldeman, 2001).

Another unique issue that has dangerous consequences for the mental well-being of LGB individuals is internalized homophobia. As with heterosexual individuals, LGB individuals live in a heterosexist culture and are not immune to internalizing heterosexist and homophobic beliefs and values (Brown, 1988; Haldeman, 2002, Matthews, 2007). Due to this LGBQ individuals

may internalize these negative messages about themselves. Shidlo & Schroeder (2001) contend that society's strong ascription to right and wrong and inflexible view of a sexual orientation binary suggests a high likelihood that at some point in their lives LGB individuals have thought of themselves or their behaviors as wrong. These teachings and emotive experiences have most likely prompted LGB individuals to develop a sense of shame regarding themselves and their sexual orientation (Shidlo & Schroeder, 2002). Furthermore, internalized homophobia does not only affect the LGB individual's perception of their identity, but they may often internalize and pass judgment onto other LGB individuals (Rothblum, 2000). For example, lesbians who appear too "butch" or "femme" may be criticized by other lesbians for perpetuating stereotypes regarding lesbian women (Rothblum, 2000).

It is also important for therapists to recognize the fluidity of sexual orientation and expression. Literature that is more recent suggests that cognitive process and sexual identity development continues over the lifespan (Rotheran-Borus & Langabeer, 2001) and that the fluidity of sexuality proves that questioning and changing of sexual identity can occur throughout the course of a lifetime (Brodio, 2000). Therefore, identity issues can be present in both adolescents and adults and is not confined to an age cap. Some individuals may find themselves questioning their sexual orientation during adolescents and fine-tuning their sexual orientation during adulthood (Schnieder & Tremble, 1985), whereas others experience questioning and resolution of sexual orientation later in life. Chan (2005) described recognition of his gay orientation during adolescence, "The first 'person' to whom I came out was God. I was then 14 years old and was secretly in love with a male classmate" (p.47). Carrubba (2005) provides an account of her recognition of her bisexuality during her 20's:

I realized that I was attracted to women during my master's program…I was in

my mid-20's, had a long history of dating men, and had never questioned my

sexual orientation…Once I realized that I was definitely attracted to this women

[a bartender], and I was also still attracted to men, it changed my whole world

dramatically. Ten years later, I am a 35-year-old, Italian American, bisexual

counseling psychologist working full-time in an university counseling center (p.

41).

There is little argument that LGBQ persons may present to therapy with certain needs and

unique stressors consequential to societal devaluing of their sexual orientation, however

therapists working with LGBQ individuals must also be aware that LGBQ individuals do not

always present with issues specific to their sexual orientation. It must be noted that LGBQ

individuals share many of the same motivations for seeking therapy as do their heterosexual

counterparts. In many therapeutic instances, LGB individuals seek services for issues and

problems unrelated to their sexual orientation (Jones & Gabriel, 1999; Page, 2004). Jones and

Gabriel (1999) found that two-thirds of treatment episodes made by lesbian women and gay men

in their study had nothing to do with their sexual orientation. Respondents reported presenting

for dissatisfaction with their relationships, their work life, general sense of happiness, and well-

being, yet respondents did not view them as inextricably linked to their sexual orientation.

Heterosexism and Homophobia within the Mental Health Professions

Regardless of the conditions LGB individuals enter therapy, with their high rates of

mental health obtainment, the chances are extremely great that at some point in their careers

mental health practitioners will work with at least one LGBQ client. In fact, most clinicians have

or will see a LGB client (Corey, Corey, Callanan, 1998; Liszcz & Yarhouse, 2005) and one does

not have to specialize in LGB issues to see LGB clients or individuals who are questioning their sexual orientation. Garnets and colleagues (1991) surveyed 2,544 mental health practitioners' experiences with lesbian and gay clients. Ninety-nine percent of the sample participants reported seeing at least one gay, lesbian or bisexual psychotherapy client. Furthermore, practitioners reported that their current caseloads were comprised of 6% gay men and 7% lesbian women. In a study involving fewer practitioners, Graham and colleagues (1984) also found a high number of practitioners reporting seeing gay and lesbian clients. They found that 86% of the therapists in their study had professionally counseled at least one gay male or lesbian during their career. A recent survey of APA licensed psychologists showed that within the last week 3% of the psychologists caseload constituted of lesbian women and gay men, and less than 1% constituted bisexual men and women, and 56% of the psychologists had seen at least one gay or lesbian client in the past week (Murphy, et al., 2002).

The nature of therapy is to create an inviting environment from which clients can explore difficulties and attend to their presenting problems. Most theoretical orientations would agree that the responsibilities of therapists include demonstrating warmth, openness, empathy and expertise to help establish a strong working alliance. With such an assertion it could be assumed that counseling is a safe haven for LGBQ individuals; however, LGB clients frequently report experiencing events in therapy initiated by their therapists that mirror the discrimination and bias reflected in the outside world (Atkinson & Hacket, 1998; Fassinger, 1991; Garnets et al., 1991). The disapproval, stigmization and barriers to social equality that LGB clients experience outside the therapy room can occur within the therapy room (Garnets, et al., 1991). The discussion of heterosexism and homophobia is not a topic of new conversation within psychology and

counseling. In fact, psychology and therapy have done much to advance discrimination against LGB individuals within and outside of the therapy room.

It is no wonder that bias and inadequate treatment is mentioned when working with LGB clients, as overt forms of discrimination against LGB individuals is deeply embedded within the mental health field (Brown, 1989a) including psychiatry, social work, professional counseling, marriage and family counseling, and psychology (Berkman & Zinberg, 1997; Clarke & Serovich, 1997; Kidd, 2005; Rudolph, 1990; Wisniewski, & Toomey, 2001).

Psychiatry is undeniable linked to the pathologizing of homosexuality. Using common cultural stereotypes of human behavior, psychiatry viewed homosexuality as a deviance and labeled homosexuality and same-sex sexual behaviors as a diagnosable psychiatric condition (Lewes, 1988). In the DSM, homosexuality was classified as a sociopathic personality disorder, which was a sexual deviance illness worthy of treatment (Bayer, 1981; McHenry & Johnson, 1993). Prior to the removal of homosexuality from the DSM, homosexuality was described by psychological literature as a mental illness, personality disorder, and neuroticism (McHenry & Johnson, 1993). Homosexual persons were described as lonely, unhappy, tormented, masochistic, empty, bored, alienated, sadist and repressed (Marmor, 1980), and the primary mode of treatment for this diagnosable mental illness was conversion to a heterosexual identity after underlying causes of sexual deviancy were addressed (Bullough, 1977; Haldeman, 1994). Many mental health practitioners advocated that treatments for LGB individuals be based on homosexuality being a mental disorder (see Socarides et al., 1997) (APA, 1997; Martinez, 2006; VanDyke, 2006). LGB individuals could be sent to mental institutions for such psychopathology (Cochran & Mays, 1994), and children were pressured to conform to sexual norms. It was not only LGB clients and patients who were affected by heterosexism and homophobia within

psychiatry, the same treatment was also provided to mental health practitioners. Before the 1980's, lesbian women and gay men could not be accepted into psychoanalytic institutes (Drescher, 2002).

It is only within the last 35 years that homosexuality has stopped being treated as a diagnosable psychiatric illness. At the political pressure of gay, lesbian and bisexual mental health practitioners, in 1973, the American Psychiatric Association removed the diagnosis of homosexuality from the DSM (McHenry & Johnson, 1993). In 1974, APA publically supported the decision made by the American Psychiatric Association in depathologizing homosexuality, "The American Psychological Association supports the action taken on December, 15, 1973, by the American Psychiatric Association, removing homosexuality from the Association's official list of mental disorders" (Congers, 1975, p. 633). APA adopted several resolutions, which urged mental health professionals to remove the stigma associated with homosexuality and to end discriminatory practices against LGB individuals (Congers, 1975). In 1997, APA adopted the Appropriate Therapeutic Responses to Sexual Orientation, which included resolutions for mental health professionals to disengage from discriminatory practices, respect the rights of others, and eliminate bias within their work. Reparative therapies were no longer viewed as a treatment of choice for LGB individuals and were condemned by all major psychological organizations as such methods were seen as unhelpful (Jones, Botsko, & Gorman, 2003) and outright dangerous to the mental well-being of LGB individuals.

The 70's brought forth many positive changes for LGB clients; however, stigmization and bias towards LGBQ individuals persisted post formal removal of homosexuality's psychiatric label and was in a way, rejuvenated by the 1980's onset of the HIV/AIDS epidemic. After the removal of homosexuality from the DSM, Scwanberg (1990) reviewed American

healthcare literature to survey the attitudes of mental health practitioners in the 1980's. Scwanberg found that mental health practitioners commonly held prejudicial beliefs regarding LGB clients and there were increased negative attitudes and prejudice against the LGB clients they served. Stereotypical beliefs between the association of homosexuality and HIV/AIDS have served to maintain homophobia within society and the counseling profession (Luchetta, 1999; Pugh, 1998). The continued pairing of same-sex sexual behavior and LGB individuals with HIV/AIDS is seen as a "great social concern" (Bowers, Plummer, & Minichiell, 2005) to the treatment of LGB individuals.

With political, religious, medical and educational subjugation of LGB individuals and homosexual behavior, it is no surprise that mental health professionals' despairing views and inadequate treatment of LGB clients has survived past the HIV/AIDS crisis of the 80's. Cochran (2001) noted that the same year the Guidelines for working with LGB clients was released, at least three articles came out which stated that homosexuality is pathological and were in support of conversion therapies. In 1997, it was estimated that 700 members of the National Association for Research and Therapy for Homosexuals, identified homosexuality as a modifiable and curable condition (Berlau, 1997). Persistent derogation of same-sex behavior and LGB individuals is evidenced in helping professionals' attitudes towards the LGB population, training on LGB issues, and LGB individuals' invisibility in research literature.

Mental Health Professionals' Attitudes toward LGB Individuals

Psychologists' attitudes toward homosexuality and LGB individuals have been noted as "divided and contradictory" (Rudolph 1988, p. 167). On one hand counselors, psychologists and psychiatrists express the belief that LGB individuals are able to fully function and maintain a level of mental-wellness similar to heterosexual individuals. As mentioned above, guidelines and

standards of practice represent a view of homosexuality as a legitimate sexual orientation of equal value to heterosexuality. Efforts have been made to abandon a dichotomous/trichotomous view of sexual orientation, to a fluid continuum of sexuality. Yet, on the other hand, "counselors are torn" (Rudolph 1988, p. 167), as society maintains an anti-gay stance, many mental health professionals continue to hold on to the belief that homosexuality is deviant (Ben-Ari, 1998), and thus, maintain anti-gay and discriminatory practices. In Rudolph's (1988) study of master's and doctoral level clinician and clinician-in-training, he found that sample participants viewed eroticized interactions between persons of the same-sex as negative. A study of social workers attitudes toward LG clients showed that one-third of the social workers surveyed fell within the homophobic classification on the Index of Attitudes toward Homosexuals scale (Wilniewski & Toomey, 2005).

The gender of the therapist and the gender of the client is another factor that influences the negative attitudes, prejudicial views and treatment of LGB individuals (Kemph & Kasser, 1996; LaMar & Kite, 1998). Overall findings both within the mental health field and in general society express that heterosexual males hold more negative attitudes and prejudice against sexual minorities than heterosexual women (Ben-Ari, 1998; Brown & Amoroso, 1975; D'Augelli, 1989) and gay men experience more negative attitudes than do lesbian women base on sociocultural gender norms (Morrow, 2000). In Bowers and Bieschke's (2005) study of members of APA, they found that male participants indicated a greater likelihood that LGB clients would threaten to harm someone than would heterosexual clients, and their ratings for harm by LGB clients were significantly higher than female participants' ratings of all clients. One reason that heterosexual men may hold greater biases for LGB individuals is a matter of training. Male psychologists receive less formal education on LGB issues than do female psychologists do

(Kilgore et al., 2005). Of note heterosexual psychologists in general report receiving less formal education on LGB issues than either lesbian, gay, or bisexual psychologists.

Another interesting finding in literature is that heterosexual men tend to hold more negative attitudes toward gay men, and heterosexual women tend to hold more negative views for lesbian women than they do for the opposite sex (D'Augelli, 1998; Gelso, Fassinger, Gomez, & Latts, 1995; Gentry, 1986; Hayes & Gelso, 1993). Psychologists' homophobic views are detrimental to the nature of work done with LGB clients because the greater the reported homophobia and discomfort in working with clients, the more clinicians feel it is necessary to breach confidentiality without LGB clients' permission.

Rainey and Trusty (2007) noted that values and attitudes of counselors are affected by their level of political conservatism, religiosity, and previous experience with gay men and lesbian women. They found a correlation between participants' negative attitudes toward lesbian and gay individuals with higher degrees of political conservatism, religiosity, and limited or negative previous experience with gay men and lesbian women. Geographic location has also been related to attitudes and value. Those residing in urban, densely populated locations tend to hold more tolerant views and attitudes than persons living in rural, smaller cities (Stephan & McMullin, 1982).

Less is known about mental health professionals' and societal attitudes regarding bisexual men and women as only a few studies discuss therapists' attitudes toward bisexual clients (i.e. Biescheke & Matthews, 1996; Mohr, Israel, & Sedlacek, 2001; Phillips & Fischer, 1998). Bisexual individuals are often clustered into the discriminatory practices against gay and lesbian persons; however, distinctive differences exist within these groups (Mohr & Rochlen, 1999; Ochs, 1996). A distinct issue that influences attitudes toward bisexual individuals is the

degree to which bisexuality is recognized as a legitimate sexual orientation. Clinicians who view sexual orientation as a dichotomy have a negative impact on bisexual clients by viewing them as having poorer psychological functioning, invisible, or abnormal (Firestein, 1996). In one of the few studies on counselors' attitudes toward bisexual individuals, Mohr and colleagues (1999) found that most of the counselors survied held moderately positive to very positive attitudes for bisexual individuals and 33% of the participants held tolerance and negative views of bisexual individuals. Eight percent of the individuals felt that they would impose their views on clients.

Training on LGB issues and Affirmative Therapy

Heterosexism and homophobia by mental health professionals is not necessarily mitigated by professional training (Greene, 2007). Mental health professionals' lack of adequate training in providing affirmative and efficient psychological services impairs their ability to work with LGBQ individuals. Deficiency in training exists even within counseling psychology, which as a profession provides the most training on sexual orientation issues as compared to other disciplines (Bidell, Ragen, Broach, & Carrillo, 2007; Sherry, Whidle & Patton, 2005). Doctoral psychology students frequently report that that their graduate training programs failed to sufficiently address LGB concerns and issues (von Kleist, 1992). In 1989, Buhrke found that 29% of female doctoral counseling psychology students in her study reported not having gay and lesbian issues covered in any of their courses. The remaining 81% of female doctoral students reported that lesbian and gay issues consumed only about 8% of course time and on average, gay and lesbian issues were discussed in a moderately positive manner. Of two doctoral training programs studied by von Kleist (1992), 30% of the female and male doctoral students surveyed reported that the when lesbian and gay concerns were addressed, they were addressed from a

psychopathological nature. Furthermore, several students reported that they were taught, "It is best for homosexual clients to change and adopt a heterosexual orientation" (p. 6617).

Research continually states the need for greater and improved clinical training experiences for clinicians working with LGB individuals (e.g., Phillips & Fischer, 1998). Ponterotto (1996) found that 86% of graduate training programs have at least one multicultural course; however, far fewer LGB specific courses exist. LGB issues were rarely incorporated in curriculum (Buhrke, 1989; Phillips & Fisher, 1998; Pilkington & Cantor, 1996) and when it was, it was due to student initiation (Philips & Fisher, 1998).

Another area of concern within education is that training often reflects the heterosexist status quo (Phillips, 2000) and graduate students report hearing heterosexist remarks and stereotypes by professors and supervisors (Pilkington & Cantor, 1996). When sexual orientation issues are ignored, they can exacerbate and reinforce old distortions of homosexuality as a pathology and deviance (Phillips, 2000). Additionally, heterosexist bias reinforced in didactic training as professors presumed their students to be heterosexual unless otherwise stated (Greene, 2007).

Research has attempted to answer the posed question of what constitutes good LGB training that shifts the negative attitudes clinicians hold. The research on this is mixed. In a 2002 study, licensed psychologists reported that the most common types of training on LGB issues included reading articles (64%), supervision (46%), continuing education (46%), attending presentations (36%), and reading books (32%) (Murphy et al., 2002). Of those who reported receiving training through supervision, only half felt that their supervisors were knowledgeable about LGB issues (Burhke, 1989; Murphy et al., 2002). When asked about the training they received from their graduate institution or internship site, only 10% responded that their training

program offered a course on LGB issues, and of the sample, only half of the student took the course (Murphy et al., 2002). Other methods of training offered during graduate studies included graduate training opportunities (22%), and internship or postdoctoral training (14%). Graduate trainees also sought peer supervision and consultation with experts on LGB issues, attended workshops that were not for continuing education credit and attended weekly case sharing, learned from clients and friends, found post-doctoral training in a specialty area, and learned from their own life experience as a gay, lesbian, or bisexual person. Twenty-eight percent of the study participants reported having no formal training (Murphy et al., 2002).

In a similar study, VanDyke (2006) found that class discussion, conference presentations, class lectures and on the job training and knowing LGB individuals was not related to more positive attitudes in clinicians. However, class reading assignments on LGB issues and individuals, as well practicum or internship supervision did relate to a more positive view of LGB individuals.

Although there is a positive trend of inclusion of LG issues into curriculum, bisexual issues continue to receive less attention. Mohr and colleagues (1999) found that of the 76 participants who completed demographic data that reported their formal training, 41% reported not having class discussions, readings, or lectures on bisexual issues, and only seven percent had received formal counseling supervision on bisexual issues. On a more positive note, 42% of participants reported discussing bisexual issues in a class, 51% reported having been assigned readings on bisexual issues, and 32% reported having had lecture material on bisexual issues.

LGB Issues in Research Literature

Discriminatory practices and bias are also present in LGB literature. Most apparent is the fact that early published reports on the pathological nature and moral deficiency of LGB persons

derived from prison and clinical samples (Morin, 1977). Such overt practices have declined, yet covert acts of discrimination within literature have become more apparent. Clinicians may be led to assume that LGB individuals are more disturbed than heterosexual identifying individuals (Cabaj, 1996) as words such as 'disease' were transformed to "condition" (Dubay, 1987) and "alternate lifestyle choice" (McHenry & Johnson, 1993).

The omission of LGB issues in mainstream psychological literature (Goldfreid, 2001) also provides a subtle message regarding a devaluation of LGB issues or as described by Greene (2007) the dearth of LGB research is a covert message that LGB individuals are not as worthy of study consideration as are heterosexual clients. Schwanberg (1990) investigated articles between the five-year period of 1983 and 1987 and found only one article in psychiatric literature that reflected a positive portrayal of gay men and lesbian women. Not only was it difficult to locate literature with positive language regarding LGB individuals, finding counseling literature on gay and lesbian individuals during the 1970s and 1980s was difficult. Buhrke (1992) examined 6,661 articles published in six major counseling journals between 1978 and 1989 and found only 42 articles that addressed lesbian and gay issues. None of the literature investigations uncovered information regarding the therapy usage, mental health concerns, and training preparation for practitioners working with bisexual individuals.

Impact of Heterosexism and Homophobia within the Therapeutic Environment

To be most effective in working with LGB clients, therapists need to develop awareness of the unique issues LGB clients face (Appleby & Anastas, 1998), understand LGB identity development (Reynolds & Hanjorigirlis, 2000) and understand the affects homophobia has on the therapeutic relationship (Markowitz, 1992). With all the misinformation and bias about homosexuality that continues to circulate (APA, 1998; Haldeman, 1994), coupled with mental

health professionals' lack of formal educational training in LGB issues, mental health professionals continue to be disadvantaged when working with LGB clients.

Across disciplines and regardless of the reasoning for holding negative views, the majority of research supports that clinicians' negative attitudes are, at minimally, a hindrance to the therapeutic process, ranging to potentially harming LGB clients' psychological well-being. Negative attitudes diminish clinicians' capability to provide affirmative and appropriate services to LGB clients (Garnets et al., 1991; Gelso et al., 1995; Hayes & Gelso, 1993; Rudolph, 1988). Mainstream culture tends to define sexual minority individuals in terms of their sexual orientation and fail to account for other important distinguishable features LGB individual have (DeCecco, 1990; Coleman, 1990). When this same attitude occurs in the therapy room, if a LGB client discloses his or her sexual orientation, clinicians may mistakenly focus on the sexual orientation of the client and forgo providing a holistic or balanced therapeutic approach. Prescribing the LGB clients' sexual orientation as the clients main concern can interfere with the therapeutic process (Bowers et al., 2005). When mental health practitioners ignore individuality and draw on activated stereotypes to guide their work with LGB clients they are perpetuating the social shame and homophobia LGB clients may have experienced and may in fact retraumatize clients (Kaufmann & Raphael, 1996).

Progressive Changes in Training, Ethics, and Clinical Work with LGB Clients

As well as participating in continued discriminatory practices against LGBQ individuals, psychology and counseling have been contributors to the movement to eradicate homophobia and heterosexism within the mental health professions and within greater society. Consistent with society's general trend of more tolerant and accepting views of LGB individual and issues, over the last two decades, the attitudes of mental health professionals have also shifted to a more

positive nature (Herek, et al., 2009). Psychology, psychiatry, counseling, social work, and marriage and family counseling literature displays mental health professionals' attitudes toward lesbian, gay, and bisexual individuals as growing increasingly positive.

Although issues persist, training and education seem to play a large role in mental health professionals shifting attitudes. A recent study showed that the integration of lesbian and gay issues is on the rise in curriculum and training programs (Bidell, Ragen, Broach, & Carrillo 2007). Mohr and colleagues (1999) found that 78% of participants in their study reported having discussed LG issues in a class, 75% reported having been assigned readings on LG issues, 67% reported having had lecture material on LG issues, and 24% had received formal counseling supervision on LG issues.

Post-tests reveal that clinicians and clinicians-in-training who have had training on LGB issues show less homophobia and hold more positive and affirming views of LGB individuals than those who have not had training (Kilgore et al., 2005). As compared to a control group of trainees, Kilgore and colleagues (2005) found that students who had a course on LGB issues significantly decreased their scores on the Index of Homophobia scale. Furthermore, free associations written by the students also changed between pre and post test. Prior to a course on LGB issues, students were asked to write free associations about the concept of homosexuality, which revealed that they related homosexuality to: a) AIDS (35%), b) deviance, being different (30%), c) sex, secret life (26%), d) social rejecting, and e) sexual preference (24%). After the course, post test free associations showed the following relations: a) out of the closet (24%), b) homophobia (13%), and c) love, difficulties, friendship, being different (10%). Dillon and colleagues (2004) found that after a yearlong course/research team, trainees were more sensitive

to heterosexism and homophobia in society, challenged their own and others heterosexist reasoning, and advocated for LGB individuals.

Major counseling and psychological organizations are aware of the continued mistreatment of LGB clients and heterosexism within the counseling profession. The APA Committee on Lesbian and Gay Concerns (Garnets et al., 1991) surveyed 2,544 psychologists to examine their views and treatment of LGB clients. The survey indicated numerous negative biases and mistreatment of gay and lesbian clients. The numerous guidelines and revisions to ethical codes and standards reflect psychological organizations efforts to improve the quality of services provided to gay, lesbian and bisexual clients. For example, with the adoption of the Appropriate Therapeutic Responses to Sexual Orientation policy statement, APA (1997) again protested discrimination and bias against LGB clients by psychologists. The APA, Division 44/Committee on Lesbian, Gay and Bisexual Concerns Joint Tasks Force on Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients created the Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (2000). The guidelines reiterate that homosexuality and bisexuality are not indicative of mental illness and call for psychologists to recognize how their views of homosexuality and bisexuality affect their work with LGB clients.

Additionally, the APA Ethical Principles of Psychologists and Code of Conduct (2002), ACA's Code of Ethics (2005) and AAMFT Code of Ethics (2001) insist that ethical practices be used with LGB clients. Providing nondiscriminatory and ethical standards to the services provided to lesbian, gay and bisexual individuals is also evidence in the Guidelines for Multicultural Education, Training, Research, Practice, and Organizational Change Policy, (2003) and Guidelines for Women and Girls (2007). In all ethical codes and LGB guideline nomenclature ethical practice includes therapists' acknowledging their own sexuality and views

of sexuality, and ensuring that they are taking proper steps in educating themselves in issues concerning diverse populations, which includes sexual minorities.

Since the 1980s, although still dearth, counseling literature has become more inclusive of gay and lesbian therapy client focused articles (Bowers, Plummer, & Minichiello, 2005). Major counseling journals have commented on the difficulty in recruiting LGB clients and have noted methodological issues present in LGB research (Meyer, & Wilson, 2009; Moradi, Mohr, Worthington, & Fassinger, 2009). The January 2009 *Journal of Counseling Psychology* explores these issues and provides suggestions for improved research on LGB issues. Furthermore, there is a range of specialty journals and specialty publications dedicated to LGB individuals and issues (i.e. *Journal of Homosexuality, Journal of Gay and Lesbian Mental Health,* and *Journal of Bisexuality*).

The treatment standards for working with LGB clients have also undergone a dramatic makeover. The first treatment shift moved from pathologizing and attempting to convert LGB clients to heterosexuals, to a neutral therapeutic approach in which clinicians did not advise or avoid heterosexual or homosexual outcomes (cited in Van Naerssen, 1987). A neutral therapeutic stance has shifted to a strong movement towards affirmative practice with LGB clients. Dillon and colleagues (2004) noted the counseling field's dedication to affirmative practice in training and service delivery. With or without the mandates by the mental health organizational bodies, clinicians-in-training and licensed therapists show a greater interest in furthering their knowledge and insight about affirming work with LGB individuals and show a concern for their own ignorance and insensitivity (Dillon et al., 2004).

Concerted efforts have been made to bridge the multicultural counseling research/literature with LGB issues (Israel & Selvidge, 2003), particularly in the areas of

counselor competence, training and environment. Competent practice with LGB individuals requires clinicians to examine the interface of their (and their clients) attitudes, have knowledge and understanding of values and worldviews held by LGB clients, and have the skill to provide proper assessment and diagnosis. Training should have content that is inclusive, and training formats should integrate LGB material into curriculum (Israel & Selvedge, 2002). Additionally, training and therapeutic environments can promote messages of affirmation and acceptance through written organizational policies (i.e. informed consent forms and disclosure statements), safe zone stickers, rainbow buttons, and by having literature that does not use discriminatory language (Eldrigde & Barnett, 1991).

Affirmative practice also encourages therapists to help LGB clients develop and adopt an openly gay identity (Browning, Reynolds, & Dworkin, 1991) and to integrate their LGB identity with their other multiple identities (Mivilee & Ferguson, 2004). Affirmative practice promotes the therapist and the client to collaborate on goals for therapy. Particular to affirmative practice is understanding the impact of externalized homophobia (Leslie, 1995) and helping clients to overcome their own internalized homophobia.

More and more psychologists are taking a gay-affirmative view and approach to therapy with LGB clients. In Kilgore and colleagues' (2005) study, fifty-eight percent held a gay-affirmative theoretical approach when working with LGB clients, whereas 32% held a "neutral" approach, and 10% held an "other" approach. This shows dramatic improvement as compared to Garnets and colleagues' (1991) report in which only 5% of psychologists surveyed held a gay-affirmative stance in therapy. Finding suggests that even if clients' primary concern is not sexual orientation, gay affirming attitudes create positive results for LGB clients.

Covert Heterosexism and Homophobia in Psychotherapy

U.S. society has become increasingly accepting of sexual minority individuals and psychotherapy has undergone dramatic changes in improved clinician attitudes, training programs and counseling literature. Yet, LGB individuals continue to experience considerable discrimination and hostility during the therapeutic process (e.g., Herek, 2009; Rostosky, Riggle, Horne, & Miller, 2009), although it may not be in an overt form such as outright refusal to see any gay, lesbian or bisexual clients (Friedman & Lilling, 1996); nevertheless, LGB discrimination still holds a place in psychotherapy.

Extreme forms of homophobia occur less frequently in the counseling setting and have been replaced with a more subtle form of homophobia and heterosexism that are often outside of the therapist's awareness (Bowers et al., 2005). Even though overt forms of discrimination have been on the decrease and even with organizational bodies continued push for better psychotherapy treatment for LGB clients, ineffective, bias and inadequate treatment are still present in work with LGB clients.

Plummer (1999) and others argue that negative attitudes and treatment of homosexual persons are conscious efforts that have been well indoctrinated and sanctioned by everyday discourses. Insight into their own homophobia is often impaired to a counselor's judgment when working with LGB clients because homophobia is so commonplace and normalized. Others challenge this argument and propose that individuals use cognitive maps that are stereotypical of gay and lesbian women and bisexual persons. Homophobic cognitive maps may be out of the counselors' awareness but validate and reinforce a negative yet familiar framework that is inherently prejudicial (Smith & Gordon, 1998).

Regardless of its origin, if homophobia persists in invisible manners because it is out of the counselor's awareness or is so widespread in our society that counselors do not recognize it to address it, the invisibility of homophobia transmits negative messages to LGB clients. Bowers and colleagues (2005) provide an example of a counselor's unawareness of his participation in behaviors that may communicate a homophobic message to LGB clients with the excerpt of a psychologist's statement regarding a client's failure to disclose his sexual orientation until six months into their work together:

> "It might have been because they weren't… it might have been because they
>
> didn't think it was relevant. It might have been because they wanted to get to
>
> know me better… I think the most common answer to that would be, it was just
>
> not relevant to the matter that brought them to counseling in the first place. And a
>
> lot of people do separate their study or their work" (p.476).

This particular counselor failed to account for how he may have attributed to his client's procrastination in disclosing his sexual orientation. Combating obvious and overt prejudice is made challenging because like non-counseling persons, counselors may be unlikely to admit to their prejudicial views or may attempt to justify their homophobic practices (Noel, 1994; Plummer, 1999). To provide LGB affirmative therapy, therapists must presume that they hold discriminatory views and heterosexist bias and work to disengage from them (Greene, 2007).

As well as exemplary service provision, Garnets and colleagues' (1991) landmark study identified biased and inadequate services to LGB clients. The biased treatment occurred in reference to assessment, intervention, identity, relationship, family and therapist's expertise and education. More recently, Israel and colleagues (2008) investigated psychotherapists' perceptions of helpful and unhelpful therapy experiences of lesbian, gay, bisexual, and

transgender individuals. Helpful experiences were times when therapists were knowledgeable and affirming in dealing with the client's sexual orientation or gender identity. Therapists reported it was helpful to assist clients in coming out, identity, understanding sexual orientation as a continuum, and exploring client's internalized phobia. Unhelpful experiences most commonly occurred when therapists exhibited unsupportive and dissatisfying reactions to the client's sexual orientation, when therapists evaluated the outcome of therapy as unhelpful, had a hard time engaging or connecting with the client, and assumed the LGBT client is LGBT without such disclosure. Other aspects identified as unhelpful were clients not trusting the therapist, therapists not being prepared to deal with LGBT complexities or presenting issues, and therapists imposing their own values or judgments on clients. Helpful and unhelpful treatment occurred based off of clients' entry into treatment, the agency and environmental factors, and the context of therapy.

Factors that have also been associated with unhelpful therapy experiences for gay and lesbian clients include: a) viewing homosexuality as a disorder, b) attributing all presenting concerns to sexual orientation, c) lacking knowledge and awareness about the possible consequences of coming out, d) using a heterosexual frame of reference for a same-sex relationship, and e) expressing demeaning beliefs about homosexuality (Bartlett, King, & Phillips, 2001; Garnets et al., 1991; Hayes & Gelso, 1993).

Current Study

Literature on psychotherapy with gay, lesbian and bisexual clients emphasizes mental health practitioners increased understanding of subtle and covert forms of heterosexism that may occur in the counseling room. An invisible and subtle form of discrimination that is yet to be explored is heterosexism and homophobia in the form of sexual orientation microaggressions.

Gaining greater understanding of the types of microaggressions that are directed toward LGBQ clients can improve mental health professionals' work with such identifying clients.

Although not specifically suggested by research, queer individuals who do not identify as transgender are purposely included in this study. Queer identifying individuals' inclusion in this study was to gain a wider range of sexual minority experiences with microaggressions, and because there is a movement, specifically within youth and young adult cultures, for traditionally LGB-identifying individuals to identify as queer to represent a view that is defiant of narrow sexual orientation classifications. Additionally, this researcher assumes that a queer identity presents certain challenges (and possible microaggressions) when therapists are unfamiliar or have underdeveloped discourses for those who identify as queer.

Constantine (2002) notes that a meaningful therapeutic alliance is still possible even with the presence of perceived subtle racism from White clinicians, yet, White clinicians should monitor and acknowledge racial microaggressions within the therapeutic environment (Constantine, 2007). It is hoped that once sexual orientation microaggressions are identified, heterosexual therapists can work towards monitoring and acknowledging sexual orientation microaggressions to decrease the negative and harmful impact they may have on the therapeutic relationships and on LGBQ clients.

Although LGBQ individuals have a shared minority status with people of color, it is not assumed that the experience of microaggressions is the same for LGBQ individuals as are the microaggressions experienced by people of color. Furthermore, racial/ethnic minorities may also identify as LGBQ and therefore may experience both racial and sexual orientation microaggressions. It is also important to note that the researcher does not believe that one group's experience of microaggressions is superior or inferior to that of the other minority

population. Yet, the work done on racial/ethnic minority populations sets a strong foundation for the investigation of sexual orientation microaggressions.

The current study replicates much of the work done by Constantine and Sue's studies on racial microaggressions only extending the work to LGB clients. Both Constantine (2007) and Sue and colleagues (2007b) used focus groups to examine the microaggressions persons of color (African Americans and Asian American, respectively) experience, which is the primary mode of data collection for this current study. This study does not necessary solicit the experience of LGBQ clients who have worked specifically with heterosexual clinicians; however, as the majority of mental health professionals identify as heterosexual, it is highly likely that sexual orientation microaggression experiences will arise from predominately cross-sexual orientation relationships.

Table 2:1 Summary of Empirical Microaggression Studies

Study	Population	Themes
Constantine, M. (2007). Microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*, 1-16.	24 Black Or African American Students	Theme 1: Colorblindness Theme 2: Overidentification Theme 3: Denial Of Personal Or Individual Racism Theme 4: Minimization Of Racial–Cultural Issues Theme 5: Assigning Unique/Special Status On The Basis Of Race Or Ethnicity Theme 6: Stereotypic Assumptions About Members Of Theme 7: A Racial Or Ethnic Group Theme 8: Accused Hypersensitivity Regarding Racial Or Cultural Issues Theme 9: Meritocracy Myth Theme 10: Culturally Insensitive Treatment Theme 11: Considerations Or Recommendations Theme 12: Acceptance Of Less Than Optimal Behaviors Theme 13: On The Basis Of Racial–Cultural Group Membership Theme 14: Idealization Theme 15:Dysfunctional Helping/Patronization
Constantine, M. G., Smith, L., Redington, R. M., & Owens, D. (2008). Racial microaggressions against Black counseling and counseling psychology faculty: A central challenge in the multicultural counseling movement. *Journal of counseling & Development, 86,* 348-355.	12 Black Faculty Members	Theme 1: Alternating Feelings Of Invisibility/Marginalization And Hypervisibility Theme 2: Qualifications Or Credentials Questioned Or Challenged By Other Faculty Colleagues, Staff Members, Or Students Theme 3: Receiving Inadequate Mentoring In The Workplace Theme 4: Organizational Expectations To Serve In Service-Oriented Roles With Low-Perceived Value By Administrators Or Other Faculty Colleagues Theme 5: Difficulties Determining Whether Subtle Discrimination Was Race Or Gender Based Theme 6: Self Consciousness Regarding Choice Of Clothing, Hairstyle, Or Manner Of Speech Theme 7: Coping Strategies To Address Racial

		Microaggressions
Constantine, M, & Sue, D. W. (2007). Perception of racial microaggressions among black supervisees in cross-racial dyads. *Journal of Counseling Psychology, 54*, 142-153.	10 Black Advanced Practicum Or Externship Supervisees	Theme 1: Invalidating Racial–Cultural Issues Theme 2: Making Stereotypic Assumptions About Black Clients Theme 3: Making Stereotypic Assumptions About Black Supervisees Theme 4: Reluctance To Give Performance Feedback For Fear Of Being Viewed As Racist Theme 5: Focusing Primarily On Clinical Weaknesses Theme 6: Blaming Clients Of Color For Problems Stemming From Oppression Theme 7: Offering Culturally Insensitive Treatment Recommendations
Sue, D. W., Bucceri, J. , Lin. A. L., Nadal, K. L., & Torino, G. C. (2007a). Racial microaggressions and the Asian American experience. *Cultural Diversity and Ethnic Minority Psychology, 13,* 72-81.	10 Self-Identified Asian Americans Participated	Theme 1: Alien In Own Land Theme 2: Ascription Of Intelligence Theme 4: Eroticization Of Asian American Women Theme 5: Invalidation Of Interethnic Differences Theme 3: Denial Of Racial Reality Theme 6: Pathologizing Cultural Values/Communication Styles Theme 7: Second Class Citizenship Theme 8: Invisibility Theme 9: Undeveloped Incidents/Responses
Sue, D. W., Capodilupo, C. M., & Holder, A. M. B. (2008). Racial microaggression in the life experiences of Black Americans. *Professional Psychology: Research and Practice 39*, 329-336.	13 Self-Identifying Black Or African Americans	Theme 1: You Do Not Belong Theme 2: You Are Abnormal Theme 3: You Are Intellectually Inferior Theme 4:You Are Not Trustworthy Theme 5: You Are All The Same
Sue, D. W., Lin, A. I., Torino, G. C., Capodilupo, C. M., & Rivera, D. P. (2009). Racial microaggressions and difficult dialogues on race in the classroom. *Cultural Diversity and Ethnic Minority Psychology, 15*, 183-190	14 People Of Color	Theme 1: Ascription Of Intelligence Theme 2: Alien In Own Land Theme 3: Denial Of Racial Reality Theme 4: Assumption Of Criminality
Sue, D. W., Nadal, K. L., Capodilupo, C.	13 Self identified	Theme 1: Assumption Of Intellectual Inferiority

| M., Lin, A. I., Torino, G. C., & Rivera, D. (2008). Racial microaggressions against black Americans: Implications for counseling. *Journal of Counseling & Development, 86,* 330-338. | Black Americans | Theme 2: Second-Class Citizenship
Theme 3: Assumption Of Criminality
Theme 4: Assumption Of Inferior Status
Theme 5: Assumed Universality Of The Black American Experience
Theme 6: Assumed Superiority Of White Cultural Values/Communication Styles
Theme 7: Underdeveloped Incidents/Responses |

Chapter III

Methods and Procedures

Research Design

Psychological Phenomenology

Qualitative research is well suited for research within counseling psychology as it can be closely related to practice and is relevant to multicultural counseling and psychology (Morrow, 2007). Due to the lack of psychological research investigating the microaggressive experiences of LGB therapy clients, and because qualitative inquiry can produce "new forms of knowing" (Morgan, 1997), the use of qualitative inquiry was essential for this study. The lack of psychological research into microaggressions experienced by LGBQ clients limits our understanding of this phenomenon; therefore, the descriptions provided in this investigation serve to produce new knowledge. The richness of lived experiences can be described using qualitative inquiry because qualitative inquiry focuses on the language, conversations, behaviors and actions individuals use to express their world (Morgan, 1997). The way in which LGBQ clients articulate their accounts of their therapeutic experiences will provide insight into this invisible or hidden phenomenon.

As this investigation aims to describe the phenomenon of microaggressions experienced by LGBQ therapy clients, and is not intended to provide an explanation or theory of microaggressive assaults, phenomenology is appropriate for this study. Phenomenology's roots are philosophical in nature and began with the work of Edmund Husserl, a German mathematician (Stewart & Mickunas, 1990). Husserl's focus on the exploration of meaning and essence is a core tent of phenomenology, yet many view Husserl's work as abstract (Creswell, 1998) in which many variants of phenomenology have developed. Aligned with Husserl's

concern with discovering the essence of a phenomenon, Creswell and colleagues (2007) suggest that the phenomenological approach is best suited for a research design that seeks to understand the lived experiences of a person's relationship with a particular phenomenon. As phenomenological approaches aim to grasp "the very nature of the thing" (van Manen, 1990, p. 177), the essence of microaggressive experiences of LGBQ clients can be revealed using this approach.

Phenomenology is based on the ontological assumption that multiple realities exist, including both the participant's realities and the reality of the researcher (Creswell, 1998). The manner in which realties are constructed is of lesser importance, the focus of phenomenology and this study is to report the multiple realities of individuals. To uncover the essence of a phenomenon, the description of microaggressions is not taken at face value but is considered from different angles and perspectives to create an exhaustive description of "a truth" of the phenomena (McLeod, 2001). Phenomenological reductionism, reducing the phenomena to it essence (McLeod, 2001), is done by considering each experience expressed by individuals. Although an individual's experiences are meaningful in phenomenology, phenomenological reductionism can convey the "universal essence" (Creswell et al., 2007, p. 252) of microaggressive assaults experienced by LGBQ clients. Phenomenology assumes that an individual's experience and description of a phenomenon can be extrapolated to other individuals who have had contact with the same phenomenon. Therefore, the analysis of consistencies across descriptions of microaggressions made by study participants will convey the essence of the experiences other LGBQ therapy clients may have had.

The particular variation of phenomenology used in the current study is psychological phenomenology (also referred to as empirical or transcendental phenomenology) (Creswell et al.,

2007; Moustakas, 1994). Researchers in the Department of Psychology at Duquesne University, particularly Amedeo Giorgi, are credited with much of the development and current use of psychological phenomenology (Brennan, 2002). The central tenet of psychological phenomenology is to, "determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it. From the descriptions, general or universal meanings are derived, in other words, the essences of structures of the experience" (Moustakas, 1994, p. 13). This study hopes that the use of psychological phenomenology will provide descriptive accounts of the microaggressions LGBQ clients experience in therapy.

To discover the essence of a phenomenon, investigators must approach research with an open mind and with suspended judgment. Therefore, prior to data collection and analysis, investigators using phenomenology engage in a process known as epoche. With the use of epoche "everything is perceived freshly, as if for the first time" (Moustakas, 1994, p. 34). The process of epoche requires the investigator to suspend judgment and maintain a neutral attitude throughout all phases of the research process (Wertz, 2005). A neutral attitude is accomplished by doubting one's natural attitude, which is the way in which we operate in processing everyday occurrences that is often taken for granted. This approach is similar to entering therapy with a nonjudgmental and neutral stance. To apply my natural attitude to this investigation, I may miss the essence of microaggressions as experienced by participants. Engaging in epoche, through setting aside my natural attitude and actively attempting to empathize with participants, will increase the likelihood of this investigation accurately describing the lived experiences of participants. Moustakas acknowledges that this fresh and unbiased state is rarely completely

achieved; however, it should be the aspiration for psychological phenomenologists (Creswell, 2007).

<div align="center">*Description of the Sample*</div>

Participants were drawn from the predominately White institution (PWI) of which the study was conducted. The focus group participants were recruited through their involvement in the campus's Lesbian, Gay, Bisexual, and Transgender (LGBT) Resource Center. Information regarding the nature of the study and time of the focus groups was posted on the campus Lambda Alliance listserv, posted in the form of flyers in the LGBT Resource Center and posted on the LGBT Resource Center website. Additionally, participants were recruited from local LGBTQ oriented listservs. The posted flyers and web information asked for gay, lesbian and bisexual individuals to volunteer to participate in small focus groups designed to obtain their input about their counseling experiences. Potential participants directly contacted the investigator by phone or email to sign up for the focus groups. Prior to being asked to join the focus group, each participated completed a brief phone screening to assess appropriateness for study participation (see Appendix A). Each participant received a monetary inducement of $20 and light refreshments.

In phenomenology, it is important that the research participants have experienced the phenomena of investigation (Creswell, 1998). To explore all possibilities of a phenomenon, Polkinghorn (1989) suggested using a phenomenology methodology that includes five to twenty-five participants. Racial microaggression studies were able to create a typology of microaggressions using focus groups that contained approximately five to ten individuals. For topics that are emotional or controversial, smaller focus groups allow for more detailed accounts of the phenomena (Litosseliti, 2003); therefore, a more thorough depiction of microaggressions

experienced by gay, lesbian and bisexual therapy clients may materialize within a small group format.

Prior to beginning the study, each participant signed a consent form (Appendix B) and completed a demographic form (Appendix C). The participants in this study were 16 LGBQ self-identifying individuals. Six participants self-identified as gay, four as queer, three as bisexual, one as lesbian, one as bisexual/queer and one as lesbian/queer. There were seven men and nine women. Thirteen of the participants racially identified as White (European, Eastern European descent, Caucasian, Scottish, WASP, and German), two identified as Hispanic/Latino (Mexican and South American) and one participant identified as Black (African American). Participants ranged in age from 20-47 and the average age was 26.25. A summary of participant demographics is provided in Table 3:1. Participants were highly educated in that all were working towards college and professional degrees or held a college degree. As a perquisite for this study, all participants had had at least one individual counseling session with a mental health professional. A mental health professional was defined as a psychologist, psychiatrist, social worker, psychotherapist, licensed professional counselor/mental health counselor or marriage and family therapist. An individual therapy session was defined as a 50-60 minute episode with a mental health professional. The number of therapists participants had seen in their lifetime ranged from 1-13. In terms of number of individual sessions, participants reported having had one session to over 1000 sessions. The criteria for selection of participation were:

· All participants were over the age 18.

· All participants self-identified as lesbian, gay, bisexual or queer.

· Participants did not identify as transgender.

· All participants had had at least one individual psychotherapy session with a mental health professional.

· On a subjective scale of 1-5 (1-Low, 5-High), participants remembered their experience in therapy at a level of three or higher.

· All participants felt comfortable sharing their own and hearing others sexual orientation and therapy experiences.

Data Collection

Focus Groups

Focus groups are "a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment" (Krueger, 1994, p. 6). Self-contained focus groups were used as the primary method of inquire and data collection for this investigation because focus groups have an established legitimacy with social science research, are advantageous over other forms of data collection when a specific phenomenon is being explored, and are operationalized in both LGBT and racial microaggression literature.

Self-contained focus groups, as the sole or primary source of data collection, are accepted in the social science community (Morgan, 1997). Morgan (1997) states that, "the key distinguishing feature of a self-contained focus group is that the results of the research can stand on their own" (p. 18). Therefore, the descriptive qualities sexual minority clients provide in focus groups were sufficient to complete this study without other forms of data collection such as assessments, interventions or individual interviews.

Focus groups were particularly valuable for this investigation because the structure of focus groups allows the researcher to concentrate on a specific topic of interest (Morgan, 1997). The goal of this study was to discover a consensus of microaggressive themes and experiences.

To elicit a universal essence (universal themes) of microaggressions from the accounts of only a few participants, data collection must focus on exploring this specific topic.

The inherent qualities of group interactions deemed the use of a focus group for this investigation advantageous over other forms of data collection. Litosseliti (2003) offers several advantages that focus groups have over individual interviews. Individual interviews provide only a single person's beliefs and experiences whereas focus groups provide a more naturalistic environment in which participants are influenced by one another, possibly resulting in the creation of a synergic atmosphere in which multiple and shared beliefs and experiences may emerge. The interactions between focus group participants aided in constructing a more complete picture of the range and types of microaggressions experienced by LGBQ psychotherapy clients.

Based on the extensive use of focus group in research pertaining to sexual minorities, the use of a focus group was appropriate for this current investigation. One might assume that the public nature of focus groups would hinder open and frank discussions on controversial topics, such as sexual orientation and psychotherapy. Conversely, the opportunity to engage in a conversation of a shared experience and shared lifestyle can actually foster greater discussion and disclosure about a sensitive issue (Frith, 2000).

Allen's (2006) use of focus groups to explore gay and lesbian youths' feelings toward their formal sexual education provides a strong example of the open discourse elicited from participant interaction in focus groups. Allen noted that participants shared personal experiences with ease and that other members could relate to the experience of the sharer. Furthermore, Allen found that focus group members felt relatively 'safe' to disclosure personal information in the presence of other gay and lesbian youth. Additional studies that employed focus group use can be seen in Orel's (2004) study which included elderly gay, lesbian and bisexual individuals and

Grove's (2003) examination of gay and lesbian couples' perceptions of their heterosexual clinicians. The implementation of focus groups in these studies demonstrates that focus groups have the ability to provide an opportunity to examine questions of cultural differences and to "give voice" to a population that has been silenced (Morgan, 1997).

This study intends to extend the previous work completed on microaggressions. All of the investigations that provided a typology and description of racial microaggressions used focus groups as their primary means of data collection. Each of the studies reported using focus groups to enhance the sharing of similar experiences and to facilitate the development of common meanings and themes. In an attempt to successfully map out microaggressive themes experienced by sexual minority therapy clients, the replication of focus group methodology was fitting for this examination.

Focus group questions were formulated from a review of empirical and theoretical literature pertaining to microaggressions, sexual minority therapy clients and heterosexism within the therapy environment. Structured focus group questions encourage the group to stay concentrated on the topic (Morgan, 1997) and a semi-structured interview is the most common interview structure used in phenomenological inquiries (Langdridge, 2007). The script used in this study was adapted from the script and questions used by Sue's (2007b) study of racial microaggressions and Litosseliti's (2003) examples of stages for focus groups. The specific script and focus group questions are located in Appendix D.

To increase the likelihood of capturing the essence of microaggressions experienced by sexual minority therapy clients, a practice focus group containing three participants, a self-identified gay male, a self-identified lesbian female and a self-identified straight female who is knowledgeable about gay, lesbian, bisexual and transgender issues was conducted prior to the

main focus group for this study. The practice focus group followed the protocol that was adapted

for the current study. Practice participants completed a demographic form, the moderator

informed the group of confidentiality and limits to confidentiality and the moderator used a script

to facilitate the discussion. The practice focus group lasted for approximately one hour and was

audio recorded. Following the practice group, feedback from the participants were given to the

moderator and appropriate changes were made to help assist in leading a successful focus group

for the current study. The moderator also listened to the audio recording and made additional

changes to the format of the focus group facilitation. The investigator also completed a one-on-

one interview with a gay identifying counseling psychology doctoral trainee, in which focus

groups questions were asked and feedback from the trainee was provided. Changes that occurred

from the practice focus group and one-on-one interview included adding or omitting particular

words or questions that were confusing or irrelevant, such as "In what ways have therapists made

you feel 'put down' because of your sexual orientation [or communication style]?" Of note,

practice participants provided considerable feedback that validated the questions and prompted

prolonged dialogue.

Two focus groups were utilized to collect data for primary investigation. One group was

comprised of five participants while the other held 11 participants. The focus groups lasted from

90-120 minutes and were digitally audiorecorded and transcribed verbatim.

Methods for Data Analysis and Synthesis

Experts of phenomenology suggest using phenomenological guides or outlines when

conducting phenomenological inquiry (Creswell, 1998; Moustakas, 1994). The data collection

and analysis of this investigation is derived from the guidelines of Moustaksa (1994) and the

'Duquesne method', which involves:

1. Collecting verbal protocols that describe the experience

2. Reading them through carefully to get a sense of the whole

3. Extracting significant statements

4. Eliminating irrelevant repetition

5. Identifying central themes

6. Integrating these meanings into a single description (Creswell, 1998)

The collection of verbal data begins the process of exploring LGBQ psychotherapy clients lived experiences of microaggression. It was hoped that the specific language sexual minorities use to describe the presence of microaggressions within the therapeutic environment would originate from the narratives provided by LGBQ participants. This study was less concerned with the explanation of the development of microaggression; however, the verbally collected data can provide insight as to how LGBQ clients understand the phenomenon.

Before the essence of microaggressions can be explored, the entire experience as a whole must be understood; "One cannot begin with an analysis of a description without first having understood the whole situation" (Giorgi, 2006, p.71). To gain a sense of microaggressions directed towards sexual minorities in their entirety, the transcripts are read from beginning to end. At this point in data analysis, scrutiny and interpretation of the transcript are avoided. Interjecting my personal subjective analysis at this initial stage is erroneous as the finding may more reflect my description of how sexual minority clients experience microaggressions and fail to describe the phenomena as experienced by participants (Giorgi, 2006). The continued use of epoche and the process of horizonalization (giving each statement equal value and operating under the guise of the phenomenon having limitless perceptions) increases the likelihood that each participant's point of view or reality is recognized (Moustakas, 1994).

The complete description of a phenomenon is too challenging to understand through analysis of an entire transcript (Giorgi, 2006). Careful analysis of microaggressions came from reducing the entirety of participant experiences and descriptions into significant statements and descriptions that formed meaningful units. Creating units of meaning was done by reading and re-reading the transcripts more slowly, and acknowledging a series of meaningful statements or shared ideas. Using the guidelines of the van Kaam method of phenomenological analysis (cited in Moustakas,1994), statements that did not meet the following criteria were eliminated from the study: (a) statements that contained a moment of the experience that was sufficient for understanding it and (b) statements that could be abstracted and labeled. Additionally, statements that overlapped, were repetitive or vague were also eliminated as redundant statements or irrelevant statements pull away from the actual description of the phenomenon being studied (Morse, 2000).

Meaningful units that are related were then clustered together into central themes and the essence of the phenomena was described using the participant's language. Beyond simply clustering themes, during this stage of data analysis, the essence of the phenomenon expressed by the participants was transformed into psychologically sensitive expressions (Giorgi, 2006). The goal of this was to articulate the occurrence of microaggressions as expressed by the participants into the language of psychological science. For example, the description of an experience that conveyed subtle discrimination was transformed into the psychological label of a "microaggression".

The final stage of data analysis involves providing both a textual description (description of the participant's experience) and structural description (context in which microaggressions

take place) from the synthesized and transformed data (Creswell, 1998; Creswell, et al., 2007). Verbatim text from the transcripts provides examples of the communication of microaggressions.

Polkinghorne (1989) emphasizes that along with the use of guides and outlines, psychological phenomenologists are to develop plans that are suitable for their particular experiential phenomenon; therefore, interpretations from the researcher and observers were included in the present study. Throughout the interview process and initial stages of data analysis I actively avoided interpreting the data. However, during the later stages of data analysis, particularly during the transformation of participant language into psychologically scientific language, it is acceptable for the researcher to integrate previous theoretical data and personal insights with the participant data (Wertz, 2005). Although they should not be confused with the realities as expressed by research participants, the interpretations of the observers and I can provide additional light on the understanding of sexual minority clients experience of microaggressions that occur in therapy.

Validity

As with other forms of research, validity and trustworthiness are important in qualitative research. The validity of any form of qualitative inquiry can be compromised by the subjectivity of the researcher (Maxwell, 1996; Huberman & Miles, 1994; Morrow, 2005). Along with the previously mentioned use of epoche and the later mention of reflexivity, the utilization of additional strategies assist in reducing the threat of researcher subjectivity.

For this investigation, it was important to decipher if the psychological meaning assigned to describe microaggressions accurately captured the experience as reported by sexual minority therapy clients and was not the researcher's interpretation of the essence of microaggressions. To examine if the psychologically transformed description were representative of the experiences

reported by study participants, imaginative variation was applied during the final stage of data analysis. Imaginative variation involves changing aspects of the description to determine if the interpreted or transformed description of the phenomenon correctly reflects the description given by participants (Giorgi, 2006; Moustaksas, 1994). For example, I would need to check the accuracy of applying the label "fear of discrimination" to a participant's statement of, "I was scared to tell my therapist I am bisexual because I know she would look at me differently and that she wouldn't be as understanding of me." Using imaginative variation, I change an aspect of the statement to determine if my label is correct; "I was (*excited, happy, unafraid*) to tell my therapist…" The inconsistency with excitement and the client's later statement helps verify the accuracy of my psychological label.

Data triangulation was another means to perform a subjectivity check and add to the description of the experience being explored (Janesick, 1998). Data triangulation involves using other artifacts to achieve multidimensional data sets (Denzin, 1998). In this investigation, triangulation occurred from data provided from the investigator, observers and research participants.

An observer was present in the focus group for two reasons. Observation is a method of data collection that can provide additional insights into the investigation. Debriefing with the observer and myself occurred immediately after data collecting concluded. In the debriefing the investigator and observer considered the following questions: a) what are the most important themes or ideas that were discussed; b) how were these consistent or different from what we expected; c) were microaggressions (using the definition from racial microaggression literature) present in the focus group; and d) initial feelings and comments about the discussion. The observational notes of the observer were compared to my notes and incorporated into the

research in the following ways: a) the observer notes aided in identifying themes and confirming themes; b) reviewing the observer's notes also validated the focus group format, as observers noted that participants grew increasing comfortable in the focus group (as evidenced in their body language and increased disclosure); and c) the observer's notes were used to highlight the emotional reactions of participants.

It was also important to include an observer who identified as gay, lesbian, bisexual or queer to attempt to recreate the atmosphere constructed in racial microaggression research. Constantine (2007), Constantine and Sue (2007) and Sue (2007b) operated from the assumption that maximized group comfort and sharing could be obtained from matching the race of the moderator and focus group participants. As the moderator is not a sexual minority, it was hoped that the presence of a queer identified observer would facilitate the open discourse that was reportedly present in racial microaggression studies.

Verification of the microaggression labels was solicited directly from the research participants. For participants who agreed to have further communication with the investigator post data analysis, the descriptive results of the investigation were provided to participants for their feedback. The participant's perceptions of the findings communicated if the true essence of their experiences was captured. In addition to verifying descriptive findings, following up with participants allows them to add supplementary stories that confirm the model (Glaser, 1978). Of the 11 participants who endorsed follow-up from the investigator, only one participant responded and provided feedback. Feedback from this participant validated the sexual orientation microaggression themes created by the researcher.

The Primary Researcher's Background, Experiences and Biases

Examination and disclosure of the cultural identity of the researcher is encouraged in most forms of qualitative inquiry. Throughout the research, there should be continual cultural self-exploration on the part of the researcher to ascertain how the researcher's own cultural perspective affects the construction and deconstruction of data and theory (Creswell, 1998). A reflexive approach as outlined by Landgridge (2007) was used by the primary investigator to explore bias and the potentiality of subjectivity. A reflexive approach means that an investigator acknowledges that by the selection of research questions, the investigator is a co-constructor of the knowledge gained in studies. The particular reflexive questions used by the investigator are: (a)Why am I carrying out this research?; (b) What do I hope to achieved with this research?; (c) Who am I and how might I influence the research I am conducting?; (e) How might the findings impact the participant?; and (f) Do I empathize with the participants?

Reflexivity is particularly important when working with vulnerable populations, especially if the investigator is not a member of the group being investigated (Landgridge, 2007). Without reflexivity, the investigator may misrepresent or misinterpret the participants' experiences or discussions. A complete reflexive approach involves questioning one's subjectivity and attitudes from personal, functional and epistemic (academic discourse) stances. To make this current investigation as unbiased as possible reflexive questions were be asked and answered before the research begins, during the research process and after the data has been analyzed.

The primary investigator for this study is a self-identified heterosexual African American female counseling psychology doctoral candidate. For two years, I have co-facilitated a weekly gender discussion group in a LGBT Resource Center and currently co-facilitate a Sexual and

Gender Diversity group for LGBTQ college students. Of note, the moderator emphasized that sample participants would be discussing their experiences receiving individual counseling and not their participation in the LGBT Resource Center discussion groups.

Limitations

The study accomplished its mission of exploring microaggressions lesbian, gay, bisexual and queer and identified eight sexual orientation microaggression themes; however, several limitations exist in this study. Caution should be used in generalizing results from this study to all LGBQ clients and their experience in psychotherapy. First, although the sample size of 16 participants proved appropriate in developing microaggression themes, participants in this study were highly educated and 81% of the participants identified as White, as is much of the research on LGB individuals. The experience of LGBQ individuals without collegiate educational attainment and ethnic minorities may resemble that of what was revealed in this study or may shed a different experience of microaggressions.

Second, this study was conducted in the Southeast U.S., which has a history of conservative views regarding same-sex relationships often based on religious doctrine. The microaggression experiences of participants in this study could be swayed by their geographical location. Many of the participants described growing up in areas in the southeast that held strong religious views that condemned any nonexclusively heterosexual relationships or sexual behaviors. The experiences of LGBQ clients in other locations, particularly more liberal settings could portray differing results.

Not identifying as a sexual minority may serve to both hinder and enhance this investigation. My heterosexual identity may compromise participant's willingness to openly share their experiences (the involvement of a queer identified observer was meant expectantly

curtail this reaction); however, non-identification as a sexual minority is beneficial to the validity of this investigation. Membership is a particular culture may inadvertently cause the researcher to focus on his or her reality of the experience and may underrepresent the experience as expressed by the research participants (Yeh & Inman, 2007). My identity as an "outsider" to the GLBT community allows me to approach this investigation with a sense of naivety that will support my reliance on using the participant's accounts of their therapeutic experiences as sexual minorities.

Although the researcher made several attempts to elicit feedback from research participants of the 12 participants who agreed to be contacted post data analysis, only one participant provided feedback on the study results. This study is limited in not having a fuller account of the participants' perception of the data analysis. Additional feedback from a greater number of participants could have affected the final analysis and development of microaggression themes.

Finally, this research is based off the interpretation of a researcher who indentifies as a heterosexual ally from the Northeast U.S. Efforts were made to bracket the experiences of the principal researcher through journaling and horizontalization, however as the researcher is the instrument in this study, the views of the researcher (conscious and otherwise) guide the study. Feedback from one of the focus group observers indicated one incident of the researcher engaging in a sexual orientation microaggression incident. Participants in the second focus group engaged in a prolonged discussion about their disdain for therapists to use words such as "partner" when addressing relationships and stated their preference for the terms "girlfriend/boyfriend." Following this discussion, the researcher used the label "significant other" to describe romantic relationships. This event and other sexual orientation

microaggression incidents, which the researcher is not aware of, may have impacted the integrity

of the data collection.

Table 3:1: Participant Demographics

Pseudonym	Gender	Sexual Orientation	Age	Race/ethnicity	Number of therapists in lifetime	Number of therapy sessions in lifetime
Adam	Male	Gay	47	White- Eastern European descent	8	Incomplete response
Bethany	Female	Queer	27	White	4	30
Courtney	Male	Gay	47	White-European	13	>1000
Debbie	Female	Queer	29	White	3	>30
Evon	Female	Bisexual	25	White-Caucasian	1	Incomplete response
Felicia	Female	Queer	22	Hispanic/Latino-South American	1	>20
Gabriella	Female	Bisexual	28	White-Caucasian	3	3
Hines	Male	Queer	20	Black-African American	1	3
Iris	Female	Bisexual/Queer	20	White-Western European/Native American	8	>90
Johnson	Male	Gay	22	White-Western European	3	12
Kristopher	Male	Gay	21	White	2	~42
Lamar	Male	Gay	23	White	4	20-30
Marissa	Female	Lesbian/queer	20	White-European	3	20-25
Nolen	Male	Gay	28	Hispanic/Latino-North American	2	~30
Olivia	Female	Bisexual	21	White-WASP	5	Incomplete response
Phoenix	Female	Lesbian	20	White-American/European	5	>20

Chapter IV

Results

Sexual Orientation Microaggression Themes

The purpose of this phenomenological study was to explore with a sample of lesbian, gay, bisexual and queer clients their experience and perception of microaggressions within the psychotherapeutic process. The researcher believed that better understanding this phenomenon would generate knowledge and lead to a typology of microaggressions experienced by LGBQ individuals. This study hypothesized that themes or a typology would emerge to represent the forms of microaggressions directed towards LGBQ psychotherapy clients, the presence of microaggressions within the individual therapeutic environment would have a negative impact on the therapeutic process and that LGBQ individuals experience microaggression in a variety of formats within the individual therapy environment. This chapter presents the key findings obtained primarily from two focus groups with a sample of 16 LGBQ identifying individuals who had had at least one individual psychotherapy session. Additionally, feedback from participants and focus group observers assisted in the production of these findings.

Eight themes emerged from focus group data that represent microaggressions experienced by LGBQ individuals in psychotherapy. Freestanding microaggression themes were created from statements that: (a) were shared by multiple participants; (b) contained a moment of the experience that was sufficient for understanding it; and (c) could be abstracted and labeled. Of note, some of the participant's statements expressed microaggressions that could fit into more than one theme; therefore, some themes are interrelated to one another to some degree. Each microaggressive theme is illustrated by multiple examples using direct quotes from the transcripts. By way of "thick description" (Denzin, 1998, 2001), this study sought to represent

the true experience of LGBQ individuals, therefore, this chapter emphasizes on using the language from LGBQ participants to understand the microaggression themes. The impact microaggressions had on the cognitive, behavioral and emotional state of LGBQ clients and the therapeutic relationship is shared when possible. A summary of sexual orientation microaggression themes, examples of microaggressions and their underlying messages is presented in Table 4:1. The eight sexual orientation microaggression themes are presented below:

1. Assumption that sexual orientation is the cause of all presenting issues
2. Avoidance and minimizing of sexual orientation
3. Attempts to overidentify with LGBQ clients
4. Making stereotypical assumptions about LGBQ clients
5. Assumed superiority of heterosexuality
6. Assumption that LGBQ individuals need psychotherapeutic treatment
7. Therapists have a "Duty to Warn" LGBQ clients about the perils of identifying with a nonexclusively heterosexual orientation
8. Underdeveloped themes

Theme 1: Assumption that sexual orientation is the cause of all presenting issues

One of the overriding findings of this study was participants' expression of feeling as if their therapists assumed that their sexual orientation was the cause of all of their presenting issues. Participants discussed presenting in therapy for treatment of issues such as depression, anxiety, homesickness, and trauma, yet regardless of client's presenting issues or symptomology, therapists frequently focused on issues of sexual orientation. This was a common theme

expressed by LGBQ clients who felt their therapists brought up their sexual orientation at unnecessary times or in abrupt rudimentary ways as described by two participants:

> Just not too long ago, I was talking about spending the holidays with my family and how awkward it is sometimes with my family. And my therapist asked how my boyfriend felt about that, and I was like, "well it's not really his bus[iness].., this is", I was on a completely separate page. I was off in my family world and he was just, I don't know, he brought him in in such a blunt way, I guess, it didn't seem to fit very well me with. It kinda threw me off. (Lamar)
>
> I kind of had the same issue with the one I had with [a university counseling center]. I would be talking about my stress and anxiety and how I am freaking about schoolwork and everything has to be prefect and perfectionism and so on and so forth because I am already prefectionistic and get all into a whirlwind of stress. And then, I would be in the middle of conversing about this and I would get a question like, "So how does your family feel about you being gay?" And I was like, "they aren't really pleased, but anyway, back to what I was talking about 5 seconds earlier." (Kristopher)

Marcus, a 21-year-old gay male reported his negative reaction with his first encounter with his therapist, "…the very first thing he said to me was, 'I know exactly what the problem is [referring to his gay sexual orientation]'. I was like you don't know a fucking thing about me!"

Regardless of age, sex or LGBQ-identity status, participants reported feeling frustrated, invalidated, angered and confused when their presenting problems were ignored and their sexual orientation status was overempathized.

But I just thought it was, that something wasn't right that somebody could take a

little tiny piece of the big intake picture that had nothing whatsoever to do with

why I wanted to see a counselor. And say, "Well no no no, the problem isn't the

abusive drunk that your old man was and all this history that you are carrying

with you, the problem is that you are gay." (Courtney)

I felt like I kinda had the opposite frustration because I was seeing someone to

have actual issues dealt with and she wanted to turn my sexuality into a problem

and into an issue. And so, the same thing, you are paying to go see a therapist to

go get something fixed but she was not actually addressing the things that I

wanted to deal with and make better because she was so hung up on trying to

convince me that I wasn't gay or figure out why I was gay and I didn't really care.

(Marissa)

Failure to sufficiently address presenting issues and overemphasis on sexual orientation was also

responsible for some participants' premature termination of therapy as described by Kristopher,

"That whole part of my life is really good, let's focus on this other part. But she wouldn't stop

talking about that so I just had to leave."

Theme 2: Avoidance and Minimizing of Sexual orientation

LGBQ participants described the process of both feeling as if issues pertaining to their

sexual orientation were overemphasized, but also described the process of issues pertaining to

sexual orientation being avoided and minimized. When LGBQ individuals brought up issues

around their sexuality, they frequently reported that therapists shied away from addressing these

issues. Iris shared her experience of sexuality being ignored, "Probably the most subtle

discrimination would be silence that I can think of." Participants did not report that therapists

mistakenly overlooked or unconsciously ignored sexuality and their sexual orientation.
Therapists were not blind to clients' sexual orientation, most participants described silencing of
sexuality and avoidance of sexual orientation as an active and conscious effort made by
therapists:

> I remember the first session my parents came in, you know and I am gay. But like
> going to every session, the psychiatrist wouldn't focus on that issue, it was just
> about the drug usage and he misdiagnosed me as bipolar before. Every session, he
> would never focus on me coming out, it was just, "How is your day? How are you
> doing in school?" (Nolan)
>
> He [the therapist] wouldn't talk about it, "I'm not ready to deal with this abuse
> stuff but I will talk to you about this relationship I am having some trouble with,"
> and he wouldn't talk about it. This is a complete waste of my time. I just sat there
> and answered some questions. (Debbie)

Active avoidance of addressing LGBQ issues was also reflected in therapists' absence in using of
LGBQ terminology. The following sub-conversation represents the evasive efforts therapists
used to circumvent addressing LGBQ issues:

> *Kristopher*: Then they would avoid the word gay. So that you would not use it
> back. So you would learn the repressive techniques of not telling people. So it
> was even like trying to cram you into the closet to a certain extent.
> *Lamar*: You can be gay, but you can't talk about it.
> *Kristopher*: Or you just make everything gender neutral really fast and use
> demonstratives when you can. I mean you learn really fast how to talk about a
> significant other without using gendered words.

Lamar: They.

Kristopher: They, and not using real gender neutral pronouns, but you know. Cuz

that would let on that you know something. They, them.

Lamar: Never say gay; always say "this choice or this decision or lifestyle".

Kristopher: Always choices.

Lamar: Yeah choice, or decision.

Beyond complete silence or unacknowledgment of sexual orientation, many participants discussed their perception of issues related to sexual orientation being minimized and inadequately addressed. This theme was routinely expressed in participants' recollection of their therapists saying, "You don't need to worry about that [LGBQ identity] right now", "It's just a phase", and "Experimentation is normal". Marissa described her experience of minimization when her therapist stated, "That I didn't need to worry that I was gay because I probably wasn't because it is perfectly normal to like to cuddle and kiss girls and that doesn't make you gay." This sentiment is also captured in the following quote:

I think some of the times I have said things that I felt were aimed mainly at gay

people and my therapists hadn't completely invalidated it but they played it down.

I know that kind of thing happens to everybody in a certain way. Especially about

relationships and stuff, you know. That happens in heterosexual relationships too,

which may be true, but it still feels invalidating. (Adam)

Therapists' lack of empathy in understanding the effect sexual orientation had on presenting issues was especially salient in issues surrounding coming out. Therapists tended to focus on the freeing and accepting components associated with coming out, yet failed to the

recognize pain, internalized heterosexism and rejection that can also be associated with coming

out. A 47-year-old gay male participant described his therapist's reaction to him being outed:

> When I came out, I got outed accidentally to my mom, it's a long story but I told
>
> my therapist about it and he said, "Well good". You know obviously I had been
>
> crying before I even went in his office. I don't think heterosexual people know
>
> what an impact coming out can have. It can be freeing in one way and at the same
>
> time be very frightening and everything and another. So I stopped going to him
>
> after that and I just, that attitude, I had had it so. (Courtney)

Therapists' lack of empathy was also conveyed in participants' experience of feeling

manipulated to come out. Participants in both groups endorsed having felt manipulated by their

therapists and had similar experiences as the event described below:

> But 6 months into it [therapy] when I got my first boyfriend, I of course disclosed
>
> it because I wanted to rub it in his face you know. And then after I said that, he
>
> said, "Do your parents know?" I said, "Hell no my parents don't know are you
>
> crazy! I would be in here for 2 hours a week instead of just one." He was like,
>
> "Oh, well don't you think you need to honest with them? Don't you think you
>
> need to tell them?" And like he kinda manipulated me into getting my parents
>
> both into the room and me telling them. Because I was like, yeah, I guess I should
>
> rub it in their faces too. And then, it became a whole issue of my family life
>
> getting even worse because my parents would make sure I was exactly where I
>
> was and where I said that I was. And they were making sure that I wasn't near
>
> him or whatever. So I mean, he actually kinda shut that down by like thinking he

was my friend and blah blah blah. And I just took the bait of trying to shove it in

their face and it went the other way around. (Kristopher)

Participants' felt invalidated, unaffirmed, frustrated and angry when their sexual orientation and

issues pertaining to sexuality were ignored, avoided or minimized. Clients' were left feeling

doubtful about the amount and quality of help they could receive from therapists who minimized

their sexual reality. Johnson, a 22-year-old gay male shared the manner in which minimizing

sexual orientation affected his therapeutic experience:

Like that was one of the things I wanted to talk about because for me my issues

interfacing with my family and my friends on a completely truthful level was

sexuality based. So I needed to tell her that. But to have it brushed aside seemed

stup.., seemed kind of, to be dismissive about it when I would bring it up as an

issue seems pointless because, you know at the same time we talk about you don't

want people to talk about my gay friend and that be the first thing, your sexuality

really is an overriding thing that really influences how you understand the world

and interfaces with every aspect of the world.

Theme 3: Attempts to overidentify with LGBQ clients

In efforts to show LGBQ clients that they are comfortable, affirming, or to deny their

homophobia and heterosexism, many LGBQ clients reported that therapists attempted to

overidentify with their experiences. This was commonly expressed in therapists discussing their

encounters with LGBQ individuals, "I once had a gay client", and "I met a lesbian woman

before". Participants cited numerous occasions of therapists relating their personal heterosexual

experiences to the experiences of their LGBQ clients:

But I had a couple of counselors who almost seemed like they had to make a point

from time to time to mention something about a family situation or a comparison

about something that I was going through. And I don't think and I am not saying

this to defend them, never came across like it was intentional or trying to make a

point but it was more like my life should be the same as theirs kind of thing.

(Adam)

The two biggest things that I have seen, and I have not seen to a great extent, are

the people who try to be overly sensitive you know. Instead of saying it's a client

like any other client, but feeling they have to draw a connection when there is no

need for a connection. It kinda smacks at being condescending. And it is clear that

it is a well intentioned kind of thing and you kinda of wonder if they would,

would a White, would a White counselor try to pretend that they were Asian to

make an Asian client happy? It seems like it gets treated differently, like sexuality

gets treated differently than some of the other more physically obvious

differences that people have. (Courtney)

Several LGBQ clients indicated that their therapists changed their demeanor and

behaviors to exhibit understanding and acceptance. This ranged from participant's explaining

that they felt like their therapists, "Wanted to be my best friend", and that their therapist "Felt

good about themselves for being so supportive of me". The following quotes shed additional

light on the efforts made by therapists to attempt to identify with clients or to overly show

support:

And one time I just casually mentioned that I had a crush on a TA and she

[therapist] was like, "Oh, what's his name?" And I was like, "Victoria (group

laughter)". She got really excited. Like it was this big deal you know. That I'm

bisexual. Like, I don't know. It was like she like welcomed me to like the open-

minded tribe. You know. (Olivia)

The person who took me in to [the counseling center], when I told her I was gay,

she got a huge smile and I was like, it's just a statement of fact. You don't need to

get all excited that you have another one to add to your collection. Ok, I'm not a

token, thanks. Just take it as it is. I was not like, "Surprise, Gay, Celebrate".

(Kristopher)

And then once, it came out, "[therapist asking] do you have a boyfriend?",

"[Phoenix responding] No, I don't, I'm gay". And then he started to tell me about

the one lesbian he knew. His total demeanor changed. Like he just moved in his

little rolly chair and he just like sat back and relaxed. Were you trying to, "Oh,

you're a girl, let me talk all sweet to you? Oh, you're gay, ok, awesome, I can

chill out now?" It was really weird that he was like, "Oh cool, so I can act cool

around you, I can act like a dude and you won't mind." (Phoenix)

Participants reported struggling with reacting and understanding therapists' attempts to

identify with them, which was clearly addressed by Adam, "It's tough, how do you say to

someone who is trying to go out of their way to make the appropriate accommodations,

'Don't'?" In some ways participants reported feeling accepted by their therapists' reactions;

however, they felt that the expression of their therapists' validation and affirmation was

frequently done in a patronizing and condescending manner.

Theme 4: Making stereotypical assumptions about LGBQ clients

Participants identified stereotypical beliefs that were placed on them by their therapists. A range of stereotypes made by clinicians were disclosed with many focusing on appearance, particularly with female participants. Participants commented that therapists have suggested, "You are to pretty to be gay", and "You look too heteronormative." A 20-year-old lesbian/queer female participant explained the manner in which her therapist attempted to learn more about the physical appearance of her girlfriend:

My therapist tried to get around that by asking me way too many unnecessary questions about what my girlfriend looks like. She would be like, "What is your girlfriend like?" And I was like, "Oh, she is this great musician and she is really smart". And she would be like "How does she dress, how long is her hair?" Like seriously, asking me, "How long has she been a lesbian?" (Marissa)

Stereotypical suppositions also occurred in therapists' assumptions of: (a) romantic relationships, "I think a lot of therapists bring up codependence right away when you're a lesbian"; and (b) quality of family relationships, "I remember part of the conversation being, I couldn't tell you specifically, but it was, 'Of course I have a bad relationship with my family, all gay people have a bad relationship with their family'", and "There is also the assumption that you don't have children. Like you are sitting there in their office and you see their pictures of their kids or their screen savers will be their children, there is just this assumption that you don't."

Another common assumption was that LGBQ clients have undergone religious conflict or that they were currently engaged in a tumultuous religious experience. Participants reported numerous incidents of being told, "Oh, if you value your traditional Christian roots, then you

can't be this [LGBQ] either." Participants expressed that their some of their therapists disagreed with religious doctrine that judged and condemn LGBQ individuals and would make statements such as, "Well, maybe you should think about just not being a Christian anymore." Although participants interpreted such remarks as coming from a place of support for the LGBQ client, such statements left LGBQ clients questioning their religious beliefs and feeling unheard by their therapists. Debbie, a 29-year-old queer female expressed how religiosity assumptions affected her, "Condensing or even assuming that I am religious because my family is or because how I grew up or whatever."

Additional stereotypes included making faulty assumptions regarding the seriousness or monogamy of gay male relationships and where gay men choose to live:

> The guy that I didn't like when I was younger, asked me completely out of
> context, he asked me if I had ever thought about living in New York, or San
> Francisco or Atlanta or a couple of other places. And I was like, "Yeah, I kinda
> like Atlanta." And he was like, "Yeah, I thought so." (Lamar)

Theme 5: Assumed superiority of heterosexuality

LGBQ clients were sensitive to the fact that as a component of being genuine, heterosexual identifying therapists may disclose their heterosexuality. Displays of heterosexuality often came across through pictures of families and children and language therapists used when talking about their personal relationships and involvement. Participants expressed feeling stifled when heterosexuality was communicated as being the norm and superior way of being and when nonexclusively heterosexual orientations were viewed as abnormal or inferior. Courtney, a 47-year-old gay male explained this in his comment, "When

you see family pictures in the office. You can go right down the line of all the things that are supposedly normal."

Unanimously, clients reported the propagation of heterosexuality as the norm in the pronouns and descriptive labels used by therapists: "Do you have a boyfriend?", "Do you have a girlfriend?", "Are you married?" Adam described the following experience, "For the most part in my case, first contact when you get in their office the assumptions are made. 'Do you have a wife?', 'No.', 'Why not?', 'Cuz I am gay?', 'Oh.'"

Heterosexuality as the norm was also promoted in recommendations and suggestions given to LGBQ individuals from their therapists, including bibilotherapy, pamphlets and brochures. These resources were typically exclusive to heterosexual individuals and couples and ignored LGBQ issues and individuals as illustrated by Adam's experience, "I have been given some books on, I think one was finding your true love or something like that. The guy actually apologized in the forward because this is his second edition that it did all refer to heterosexual relationships." Participants identified that heterosexuality as the norm was also promoted by the lack of LGBQ friendly books and materials located on therapists' bookshelves and in waiting rooms. The following quotes represent a multitude of experiences in which therapists suggested that an LGBQ identity was inferior or abnormal to heterosexuality:

> Maybe it's just me, but, I always find it a little bit, I always notice when a therapist has pictures of their family, wife and kids, or husband and kids on the desk. It is always the one first thing I notice. It makes it stand out that "Oh, you're different than I am". (Lamar)

I don't know exactly how to say it, but I think that the assumption that things must be different for you because you are gay. The difference for me is like I live on the south side of town, you live on the west side of town. (Adam)

A question I get asked by therapists, "Do you want to have a family?" Well yes, why shouldn't I be able to? Just because I am gay or I'm gonna be, even if I don't want to be in a long-term relationship, how is that going to affect my changes of having offspring. It just always bothered me; it's like an immediate barrier to any type of offspring or any type of normal life. (Nolan)

Fear of being seen as abnormal or different had a suppressive and muting affect on some participants' disclosure of their sexual orientation to their therapists. In line with this theme a 28-year-old bisexual female participant stated:

I didn't really have an open dialogue about my sexuality when I had some therapy sessions. I mean it was kind of clear that she thought it was the norm from her saying like, okay, and well like, it was towards the one of the last times I saw her and she was like, "Yeah, you never really told me like do you have a boyfriend", or like she would make jokes like, "Oh, did your boyfriend drop you off?", cuz I don't really drive. And things like that. I wasn't really out at the time to anybody, it was just like… I didn't really feel like talking about it anyways, and definitely didn't want to talk about it because I would know how she would feel. And then also, she already made it seem like kind of the normal thing to have a boyfriend drop me off. Well maybe I don't. But I don't want to, we just got along really well, so didn't want be like, oh you think it's wrong. Alright, well I am just not going to talk about it. (Gabriella)

Theme 6: Assumption that LGBQ individuals need psychotherapeutic treatment

Several LGBQ clients indicated that their therapists' actions were directed under the assumption that LGBQ individuals are naturally flawed and need to be in psychotherapeutic treatment. This assumption was expressed to clients when they felt pressured by their therapists to remain in psychotherapy when clients were ready to terminate. Therapists' continued treatment of high functioning individuals who expressed little interest in continuing psychotherapy conveyed therapists' assumption of LGBQ individuals need for counseling services based primarily on their sexual orientation. This assumption was especially true for clients who felt forced to be in therapy because of family members concern for their sexual orientation. Participants expressed feeling that they and their families were taken advantage of by mental health professionals, "And I mean, a chore that's cost my parents tons of money too." Clients' perception of the quality of care they received was compromised by their furloughed stay in therapy:

> I just felt he was running it as, on autopilot. That he was getting X amount of
> money for seeing me for 45 minutes on Thursdays at five and it didn't really
> matter what he did. It's just kind of like his last thing of the day. He just kind of
> relaxes and does nothing and gets paid. (Lamar)

Similar sentiments were repeated when clients reported feeling pressured to follow recommendations and treatment plans they disagreed with. After coming out to her therapists, Marissa expressed feeling as if she was "battling" with her therapist regarding her need for therapy and medication:

> Because of that [a previous experience with a different therapist], that actually
> kept me from coming out to the very last possible second to my therapist, and

when I did, the reaction that she had was the exact reason that I had tried to hold

that back. Because I really feel like I lost a lot of creditability because I felt like

every time I went to see her, it was a fight. Like, I mean basically we had a fight,

and, "No, you just need to take drugs", and I am like, "No, I really don't I just

need to talk and get things straightened out." And as soon as I told her, like she

asked me how my boyfriend was, and I told her that I had left him for my

bestfriend, all of a sudden, it's like I lost so much creditability. Like all the ground

that I gained in that battle had been lost. And so it began all over again…

This theme was also reflected in the lack of consideration applied to referral options or the

expertise of mental health professionals servicing LGBQ individuals:

I think part of it, at least in my experience, there are a lot of assumptions that as

long as you are seeing someone you are doing the right thing and you are okay

and it doesn't matter who that person is or how egregious their stereotypes are or

anything. Just see somebody, anybody, and I don't think there is enough emphasis

given to finding the right person. (Bethany)

Theme 7: Therapists have a "Duty to Warn" LGBQ clients about the perils of a identifying with

a nonexclusively heterosexual orientation

Many participants expressed feeling as if their therapists felt it was his or her

responsibility to warn them of the inherent dangers associated with a LGBQ identity. Therapists

often took an expert stance on LGBQ issues and felt it necessary to provide LGBQ individuals

with knowledge regarding entering and maintaining a LGBQ lifestyle. This came across in the

form of questioning, "Are you sure you know what you are getting into?" and "Have you thought

this through?" Warnings were more directive in statements such as, "Well, you should expect

those sorts of things to happen with this lifestyle", and " Well, if you are going to be gay, you have to expect to come up against these certain conflicts against your religious family and other people in your religion". Although not a sexual orientation, Bethany, a 27-year-old queer female, described a warning made to her regarding her gender identity:

> And I mentioned being trans-questioning and she was like, "that by itself can cause a hospitalization." And it was just sort of like that was the only thing that was the whole explanatory factor and there was nothing else going on. I could definitely see where that kind of thinking can come in. I mean for some people maybe that is the case but not for everybody.

One client recounted his experience of how his therapist's warnings and attempts to change his sexual orientation felt to him:

> It seems like you go to see a therapist for support and they just try to turn it around or fix you or make you what's normal in society. I just think it's awkward for how you go to therapy for support and they try to brainwash you differently.
>
> (Nolan)

Theme 8: Underdeveloped themes

From the analysis of transcripts, several incidents emerged that did not fully meet the criteria to be a freestanding theme. They failed to be endorsed by multiple participants, described a moment of the event that could not be sufficiently understood, or could not be distinctively abstracted and labeled. As there were time constrictions on each focus group, further exploration of the below mentioned themes was not permitted. Therefore, with extended probing, the themes could have fit with one of the aforementioned seven themes or could have developed into freestanding themes.

Several participants made remarks suggesting their therapists assumed there was a universality of gay experiences and lacked to see within group differences inside the LGBQ community. Participants commented on feeling as if they had to answer for all LGBQ individuals. Another undeveloped theme was receiving increased credibility due to lesbian identity. Several lesbian and queer women commented that in terms of relationship and monogamy, they felt as if their therapists respected their long-term commitment and relationships with women more than they had prior to their same-sex attraction disclosure. The sentiment described below was shared by several lesbian and queer women:

> But at the same time I think, and I know that this wasn't earned by any means or merited by me being a lesbian. But I earned a lot more respect. I was talking about being in a long distance relationship because at the time I was. My girlfriend went to school here and I was there. And we didn't get to see each other very often. And I was talking about that, you know, I was dealing with stress issues in school and talking about how being in a long distance relationship effected all of that. And her initial reaction was, "Well you know, you never can be sure that you meet the person you marry right way and sometimes relationship can be difficult, and each one will be different." Then when she was asking more specific questions and I said, "Actually, I am lesbian, I am with a girl." All of a sudden she was like, "Oh, that's really good, how long you have been together? What are your future plans?" It was kinda of nice, but it was unearned. (Marissa)

Table 4:1 Sexual Orientation Microaggressions in Psychotherapy

Theme	Microaggression	Message
Assumption that sexual orientation is the cause of all presenting issues	A therapist says to a client, "I know what the problem is, you are gay." When a client discusses academic issues, a therapist interjects, "What do you think this issue has to do with your sexuality?"	Your sexual orientation is the problem. Your sexual orientation needs to be treated.
Avoidance and minimizing of sexual orientation	A therapist avoids using LGBQ terminology. A therapist tells a client, "You don't have to worry about that [sexual orientation] right now, let's talk about this other issue." When a client is accidently outed, a therapist responses, "Good, it's about time."	Issues related to your sexual orientation are not important to talk about. You should feel uncomfortable talking about your sexual orientation. You make me uncomfortable. Coming out is not a big deal.
Attempts to overidentify with LGBQ clients	A therapist makes frequent references to distant family members who are LGBQ. A therapist tries to befriend LGBQ clients or frequently engages in small talk. A therapist changes the way he or she speaks or changes physical posture to appear more comfortable with LGBQ individuals.	I understand your issues because I know someone who is LGBQ. I am not homophobic because I know someone who is LGBQ. You are an oddity, and I am "cool" because I work with you.
Making stereotypical assumptions about LGBQ clients	A gay client describes his weekend and the therapist says, "You were in a hardware store?!" A therapist tells an attractive lesbian woman, "You don't look like a lesbian."	All LGBQ people are alike. I don't need to make an effort to get to know you as an individual.
Assumed superiority of heterosexuality	A LGBQ client notices that a therapist's office only displays heterosexual books and pamphlets. After a client discloses their sexual orientation, a therapist proclaims, "I am not gay!"	You are abnormal. You need to change or conform.
Assumption that LGBQ individuals need psychotherapeutic treatment	A therapist encourages a client to stay in treatment against the client's wishes. When a client is being referred, the referring therapist states, "It doesn't matter who you see as long as you seeing someone."	Any nonexclusively heterosexual identity is pathological and needs treatment. You are inherently flawed.

Therapists have a "Duty to Warn" LGBQ clients about the perils of identifying with a nonexclusively heterosexual orientation	A therapist asks a client, "Are you sure you want to enter this lifestyle?" or "Have you really thought this through?" When a client discusses experiencing discrimination, the therapist says, "This lifestyle brings certain problems with it."	You are incapable of making rational decisions. Any problems you face are your own fault for choosing a LGBQ identity.
Underdeveloped themes	When a female client discloses she is in a same-sex relationship, a therapist that once encouraged her to end a relationship with a male partner now encourages the client to make long-term plans with her female partner.	Lesbians are more monogamous than heterosexual individuals or gay males.

Chapter V

Summary, Conclusions and Implications

Summary

The purpose of this psychological phenomenological study was to explore with a sample of lesbian, gay, bisexual and queer clients their experience and perception of microaggressions within the psychotherapeutic process. It was hoped that a better understanding of the perceptions of LGBQ clients' experience in psychotherapy would uncover the potential effect that sexual orientation microaggressions have on the client's understanding of the therapeutic environment. Understanding sexual orientation microaggressions can advance clinical training and therapists' self-awareness of potentially microaggressive acts, thus improving the quality of services provided to the LGBQ community.

This researcher used two semi-structured focused groups to collect qualitative data. Supplemental data for this study was obtained from the use of participant feedback, observer feedback and the researcher's journaling. Participants in this study included 16 LGBQ identifying individuals who had at least one individual therapy session with a mental health professional prior to the study. After the data was collected and transcribed it was carefully read through to get a sense of the whole, followed by the extraction of significant statements, identification of central themes and ended with the integration of contextual and descriptive meanings. This analysis methodology was guided by the 'Duquesne method' as described in chapter III. The study was based on the following three research questions:

1. What are the common themes in which microaggressions directed towards LGBQ psychotherapy clients manifest?

2. What is the impact of microaggressions directed toward LGBQ psychotherapy clients?

3. How are microaggressions directed towards one's sexual orientation experienced by LGBQ psychotherapy clients?

Based on a review of literature pertaining to covert homophobia and heterosexism, microaggressions, and therapy with LGB individuals, three primary hypotheses were made regarding this study:

1. Themes or a typology will emerge to represent the forms of microaggressions directed towards LGBQ psychotherapy clients.

2. The presence of microaggressions within the individual therapeutic environment will have a negative impact on the therapeutic process and LGBQ clients as evidenced by their attitude towards therapy or changes in help seeking behaviors.

3. LGBQ individuals experience microaggression in a variety formats within individual therapy environment.

The following is a discussion of the major findings and conclusions drawn from this research. The conclusions are followed by implications and recommendations for future research.

Conclusions

Hypothesis 1

Leading microaggression researchers call for the expansion on the study of microaggressions with diverse populations. This study set to an extent previous microaggression research that has focused primarily on persons/clients of color. Results from this study revealed that 'sexual orientation microaggressions' (Sue et al., 2008a) exist within the therapeutic environment and as hypothesized, a typology of eight sexual orientation microaggression themes emerged from the data:

1. Assumption that sexual orientation is the cause of all presenting issues

2. Avoidance and minimizing of sexual orientation

3. Attempts to overidentify with LGBQ clients

4. Making stereotypical assumptions about LGBQ clients

5. Assumed superiority of heterosexuality

6. Assumption that LGBQ individuals need psychotherapeutic treatment

7. Therapists have a "Duty to Warn" LGBQ clients about the perils of identifying with a nonexclusively heterosexual orientation

8. Underdeveloped themes

The emergence of sexual orientation microaggression themes satisfies this study's purpose of advancing the examination of microaggressions, specifically within the therapy relationship; however, the phenomenon of sexual orientation microaggressions can also be conceptualized within the different dynamics of the therapeutic environment. The following discussion utilizes a framework based on Garnets and colleagues' (1991) abridged report of both exemplary and biased practices in psychotherapy/counseling work with gay and lesbian clients. Although the report was created 18 years ago, this report is considered foundational reading within the LGB, multiculturalism, and diversity literature.

Garnets and colleagues' (1991) report is also relevant to the current work with LGBQ individuals because professional guidelines for working with LGB clients, including the current *Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients* (2000), followed from this report's conclusions. Data for Garnets and colleagues study was derived from the 1984 joint task force efforts of the APA Committee on Lesbian and Gay Concerns (CLGC), Board of Social and Ethical Responsibilities in Psychology (BSERP) and the Board of Professional Affairs' (BPA)

investigation of biases in psychotherapy with lesbian women and gay men. A survey of 1,481 psychologists provided critical incident material of gay and lesbian psychotherapy experiences within the context of therapy including: (a) assessment, (b) intervention, (c) identity, (d) relationships, (e) family, and (f) therapist's expertise and education. The aforementioned categories are used to further expound the relationship between sexual orientation microaggressions and psychotherapy.

As this study set out to describe the phenomenon of microaggressions from the vantage point of those who have experienced the phenomenon, quotes and statements from participants in this study are used to illustrate the presence and effects of sexual orientation microaggressions. To offer additional insight into the relationship and the pervasiveness of sexual orientation microaggressions within psychotherapy, excerpts of sexual orientation microaggression themes presented within LGB psychotherapy literature are also provided.

Assessment

A central component to the helping process is conducting an assessment to clarify clients' presenting issues and to identify relevant factors for further exploration (e.g., Corey & Corey, 2006). Conclusions drawn from initial and ongoing assessment procedures influence rapport building, case conceptualization, and diagnosis. Garnet and colleagues (1991) identified several biased, inadequate and inappropriate practices existing in assessment procedures including therapists' attributing clients' problems to their sexual orientation without evidence that this is so, and therapists automatically assuming a client is heterosexual or discounts a client's self-identification as gay or lesbian.

The first major finding of this current study was therapists' use of sexual orientation microaggressions to advance their assumption that LGBQ clients' sexual orientation is the

primary cause of all presenting concerns (*Theme 1*). This theme showed in the rigidity and lack of continued inquiry displayed in therapists' assessment procedures. Regardless of the information gained from intake assessments and in spite of the clients' self-reported issues and symptomology, LGBQ clients repeatedly reported the subtle methods used by therapists to imply clients' sexual orientation was the clients' primary area of concern.

Acting as the expert, the therapist's role is to assist clients with their presenting goals and is also to highlight blindspots that clients may hold. Therefore, client-directed treatment goals alone are not sufficient in therapists deciding one treatment over another (Schneider, Brown, & Glassgold, 2002). For example, a gay male client may present to therapy seeking assistance with self-esteem and employment searches. In this situation, a therapist should be attuned to employment discrimination that the client may be unaware of. The client-directed goals should be incorporated in the therapeutic framework, yet are not to be overshadowed by the therapist's agenda.

Therapists' difficulty in seeing past clients' sexual orientation can be explained by 'spread', a concept that has been most well attended to in disability literature. The concept of spread is based on the premise of individuals possessing central characteristics (Olkin, 1999). These central characteristics, such as ability, sexual orientation, race and gender, are essential to impression formation. One holds preconceived ideas and judgments regarding central characteristics that can be positive or negative. When someone knows little about another individual and is only aware of a central characteristic, the idea/judgment one holds for the central characteristics 'spreads' to how they define other aspects or characteristics of the person (Olkin, 1999). Therefore, if one evaluates the central characteristic as positive, then positive ideas will spread regarding other characteristics and behaviors of the other person. The opposite

also exists; if one evaluates central characteristics as negative, then a negative view of the person will spread to other attributes. If a therapist holds overt or covert negative bias for sexual minorities, this negative impression of this central characteristic will spread to the therapist having a negative evaluation of their client's behaviors and attributes. For example, a bisexual client enters therapy for career advisement. If a therapist holds the stereotypical belief that bisexual individuals are indecisive, the therapist may assume that the bisexual client has trouble making decisions in all aspects of their life. In comparison to disability, Sue and Sue (2003) provide the example of the belief that a person who is blind is also intellectually deficit.

Therefore, spread is dangerous when other characteristics about someone are unknown or invisible. Spread is also dangerous as it serves as a means for erroneously explaining behaviors or personality traits (Olkin, 1999). If a therapist sees a client's sexual orientation as a defining characteristic, they may mistakenly attribute deficits or negative behaviors to the client's sexual orientation. For example, if a lesbian woman excels in athletics, under the concept of spread, a therapist may assume that they participate in sports to cope with not fitting into a traditional view of femininity.

Participants in this study did not deny that sexual orientation could have an influence on presenting problems; however, the manner in which therapists chose to attend to sexual orientation was often perceived as unnecessary and unhelpful. Additionally, the overemphasis of clients' sexual orientation in assessment and intervention is further evidenced by the lack of participants identifying sexual orientation as a primary area of concern for them. Information gathered from the demographic forms reveals that five participants entered therapy to specifically explore issues related to their sexual orientation while 11 participants reported not entering therapy for specific focus of issues related to sexual orientation. Participants expressed a

desire to address additional issues such as depression, anxiety, academic stress, substance abuse and addiction, and trauma that may or may not be primarily related to their sexual orientation status. Jones and Gabriel's (1999) study of 600 LGBT clients experience in psychotherapy lends support to the findings that LGBQ clients are not primarily seeking services for sexual orientation issues. Only 39% of the respondents reported that conflict about their sexual orientation was at least one of the reasons they entered therapy. As their therapy experience increased, i.e. continued therapy experiences over the lifetime, the desire to work on conflict with sexual orientation steadily declined. Similar findings have been illuminated in other studies.

Additionally, participants in this study noted microaggression themes during assessment procedures when therapists gathered information with the assumption that clients identified as exclusively heterosexual (*Theme 5*). This bias is frequently recorded in LGB research and is evidenced by therapists using gendered-normed pronouns and failing to ask clients about sexual identity.

Intervention

Therapeutic interventions are typically tailored to address the issues obtained from initial and continued assessment. Interventions should be timely, appropriate, flexible, reflective of clients' goals and culturally sensitive (Corey, 2001; Corey & Corey, 2006; Jongsma & Peterson, 1995). Homophobia and heterosexism distorts therapists' view of clients and influences the choice of interventions (Greene, 2007). Garnets and colleagues (2001) noted biased treatment in therapists' focus on sexual orientation as a therapeutic issue when it was not relevant, and when therapists' discouraged clients' from having or adopting a lesbian or gay sexual orientation.

Participants in this current study reported sexual orientation microaggression incidents within the abovementioned aspects of interventions. Therapists' focus on sexual orientation as a

therapeutic issue when it was not relevant to the nature of the client's concern was displayed in

covert and understated microaggressive assaults as therapists geared off subject to draw attention

to sexual orientation issues (*Theme 1*). The continued asking of questions aimed at exploring

clients' sexual orientation at the expense of investigating other issues also revealed bias within

therapeutic interventions (*Theme 1*). For example, a participant in the current study presented for

test anxiety, and the therapist persisted in asking questions such as "Tell me more about your

girlfriend", "What does she look like?", "What type of employment does she have?"

  Schwartz (2003) suggests that interventions that focus primarily on LGB issues at the

expense of clients' presenting concerns create a lack of growth for clients. Her response to a

narrative of a gay male therapist's psychotherapy provision to a gay patient (Levounis, 2003)

records the effects of overemphasizing sexual orientation:

> The patient first came to the student health center complaining of "overall
>
> malaise, low energy, an impulse to withdraw for school, loneliness,
>
> disappointment with friends, and a sense of alienation." He was recovering from a
>
> life-threatening illness, and was "overwhelmed with existential level questions
>
> about goals and sexual identity…"
>
> [At the end of long-term therapy]…But the patient's concerns upon entering
>
> treatment remained: his loneliness, and alienation, his tendency to withdraw into a
>
> world of books and split in is self-representation between his "social" and
>
> "intellectual" selves.
>
> …It is unclear from the case material whether the patient had particular issues
>
> concerning what the referring psychologist termed "sexual identity" when he
>
> [client] sought long-term psychotherapy (pp. 32-32).

As presented by Schwartz's, although not overtly expressed by the therapist, contributing his patient's mental health concerns to his sexual identity may have been detrimental in relieving the client's tendency to socially withdraw, feelings of loneliness and diminished the processing of his experience with a serious medical illness.

Sexual orientation microaggressive incidents during intervention were also experienced in therapists' subtle attempts to discourage clients from adopting an LGBQ orientation (*Theme 7*). Participants in the current study expressed a belief that their therapists felt that it was their responsibility to warn LGBQ clients about the impending repercussions of maintaining an LGBQ identity. At times, this concern came across as blaming the client for not expecting or responding appropriately to the oppression and discrimination they faced.

Interventions that blame the victim is an issue that has been addressed in racial microaggression studies. Blaming the victim for the oppression and discrimination they experience is well documented in Constantine and Sue's (2008) supervision racial microaggression study where a Black female supervisee reported:

> I was [counseling] a black woman who was going through a lot of problems and stress at her job because of feeling [racially] harassed by her all-White coworkers and boss. My [white male] supervisor said, "Well, [your client] has to know to expect some of that treatment in the workplace because she is a minority in a majority situation. If she doesn't learn how to deal with the fact that racism exists, she won't be successful in most [jobs] in this country.

In this example, the supervisor used his power and authority to suggest an intervention that neglected the discrimination faced by the client and delivered a message that warned

ethnic minority persons about the dangers of entering majority-dominated work environments.

Identity

There are several stage/status models that speak to the sexual identity development of gay, lesbian, and bisexual individuals (i.e. Cass, 1979; Coleman, 1982; D'Augelli, 1994; McDonald, 1982). More recent identity models suggest a process that is multidimensional (Rosario, Hunter, Maguen, Gwadz, & Smith, 2001) and incorporates developing both an individual and community identity (McCarn & Fassinger, 1996). Bisexual-specific identity development models are beginning to gain greater exploration (i.e. Weinberg et al., 1994; Brown, 2002; Bradford, 2004; Collins, 2000) yet given the diversity and multidimensionality of bisexuality, a universal framework is yet to develop (Potoczniak, 2007). Differences exist within identity models; however, most speak to transitional stages or statuses that move from an adoption of heterosexuality and heteronormative behaviors to the emergence of an integrated gay, lesbian or bisexual identity. Reaching an integrated identity is not presented as an easy feat for LGB individuals; it is typically portrayed as a process that involves a level of self-doubt, confusion, and turmoil prior to establishing an accepting, complete and healthy self-identity.

In regards to identity, Garnets and colleagues (1991) revealed bias, inadequate and neglectful treatment in therapists' lack of understanding of the nature of lesbian and gay identity development by interpreting a client's lesbian or gay identity as a "phase" that will be outgrown. Biased treatment was also noted when therapists did not sufficiently take into account the extent to which lesbian or gay identity development is complicated by the client's own negative attitudes toward homosexuality (Garnet et al., 1991).

Participants in the current study routinely expressed that their therapists failed to attend to their sexual identity developmental needs and minimized their emerging LGBQ identity as a "phase" or "experimentation" (*Theme 2*). Clients offered several suggestions as to why therapists failed to validate or explore the development of LGBQ identities, which included the therapists' own discomfort and lack of training. The explanation that gained the greatest consensus within both focus groups was that heterosexual therapists operated using what participants labeled as a 'straight filter', which makes it difficult, if not impossible, for heterosexual therapists to understand the complexity of establishing and maintaining a healthy LGBQ identity. Courtney shared his reasoning as to why therapists lack empathy in understanding identity issues, "… I think it is the same way with being gay, unless you are gay or are very close friends with someone that is, then you don't really understand. You don't see the subtleties." This message was well expressed by another focus group participant:

Because I do feel that there is that straight filter that you don't see. It's kind of like that White privilege thing, it is easy to dismiss it, but. When you're coming from a gay perspective, it is very easy to nail it, to see it. Wow. I guess it just makes the whole discrimination so much obvious. (Lamar)

Participants readily identified heterosexual therapists' empathic failures as resultant of a "straight filter"; however, if and how the sexual orientation of the majority of therapists was obtained is unknown in this study. Very few participants reported that their therapists explicitly disclosed their sexual orientation, yet most of the participants assumed that their therapists held an exclusively heterosexual identity, when in fact their sexual orientation may have not been such.

Most identity theories express the importance of overcoming internalized homophobia to develop a healthy LGB identity. One way in which internalized homophobia can be expressed and reinforced is through the use of silence (*Theme 2*). Silence and invisibility in the lives of LGB individuals have longstanding roots within the societal oppression sexual minorities' experience (Croteau, Lark, & Lance, 2005). Clients may remain silent or fail to discuss issues pertaining to their sexual orientation because they are not conflicted by their sexual orientation status and feel it is not relevant to the topic at hand (Jones & Gabriel, 1999). However, there are others times when LGB client's remain silent in discussing their sexual orientation or share only minimally about issues regarding their sexual orientation status when it is in fact an therapeutic issue. In Jones and Gabriel's (1999) study of LGB clients experiences in psychotherapy, 42% of respondents failed to discuss or minimally discussed issues pertinent to their sexual orientation due shame, fear and denial, and 25% of the nondisclosures were due to the respondents perception that their therapist was "unreceptive…judgmental, discouraging, or dismissive (p. 214)" about sexual orientation issues. Nondisclosure of sexual orientation becomes a means to avoid bias in therapy (MacEwan, 1994). In the present study, some LGBQ individuals avoided talking about sexuality due to their own fears of exploring the topics and fears that their therapist would change how they felt or responded to them. In discussing her relationship with her therapist, one participant in the current study reported such a fear:

> And like everybody was talking about all this stuff that was happening [presenting problem], so I just kinda wanted somebody who didn't know all my friends, who wasn't a family member telling me to just wave it off. I didn't want to lose that. I didn't want her [therapist] to be like, "Oh wow you're bi. You're queer. Well let's talk about that." I thought that maybe if we didn't get along because of it, if

nothing else it would take away the focus and what I just really wanted to get it

[presenting problem] off my chest. (Gabriella)

Therapists perpetuated the need for this fear by implementing evasive strategies such as failing to comment on clients' remarks regarding their sexual orientation or same-sex relationships, refusing to use terminology associated with LGBQ-identities, and disallowing clients to engage in discussions that centered around LGBQ issue.

Relationships

Biased, inadequate and poor treatment towards lesbian and gay individuals appeared in therapy within the topic of relationships (Garnet et al., 1991). For example, therapists were insensitive to the nature and diversity of lesbian and gay relationships and inappropriately used a heterosexual frame of reference.

Participants in this study reported that therapists operated from a stereotypical gendered-normed paradigm of masculinity and femininity (*Theme 4*) and utilized a heterosexual frame of reference in their work with LGB clients (*Theme 5*). The gender role stereotypes cited by participants are consistent with existing literature on lesbian, gay, and bisexual stereotypes. As in this study, other studies report that gay men are often stereotyped as being effeminate and lesbian women are stereotyped as masculine (e.g., Herek, 1993). One participant commented on her feelings after being stereotyped by her therapists for appearing too heteronormative, "Lesbians are butch. And if you are not butch then you are not a lesbian."

Mohr and colleagues (2001) found that therapists also hold negative stereotypes for bisexual clients. In an analogue study of therapists' reactions to bisexual women, they found that therapists responded with negative stereotypes to a fictitious bisexual female client. In the

current study, a bisexual participant explains how her therapist attempted to place the client's

bisexual-identity within a gender binary:

> My favorite is the question, I don't know if it is standard operating procedure to
>
> ask what your sexuality is in counseling. But you get the questions and if you say
>
> that you are bisexual, the question comes, "Are you more attracted to women or
>
> more attracted to men?" (Bethany)

One relationship issue not presented by Garnets and colleagues (1991) that was present in

this study was therapists' assignment of unique status or higher value to lesbian relationships

than they placed on heterosexual, gay or bisexual relationships (*Theme 8*). Clients expressed the

belief that they received messages from their therapists that being in a lesbian relationship was

more solid and maintained more longevity than being in heterosexual, gay or different-gender

relationships. Some lesbian participants reported feeling more respected and validated by

therapists after the disclosure of being involved in a same-sex relationship. The fact that this was

only experienced by lesbian women reinforces the stereotype that lesbian women are committed

and monogamous while gay men (and heterosexual individuals) are associated with greater

promiscuity.

Family

In regards to family, concerns were noted in previous research regarding therapists'

reactions to LGB individuals with children (Garnets et al., 1991). However, in the present study,

none of the participants reported having children, therefore, issues of attribution of poor

parenting or insensitivity to the effects prejudice has on same-sex parents that were found in

previous research were not apparent in this study. Nevertheless, microaggressive themes

emerged in the relation of whom therapists considered to be family members (*Theme 4*).

Participants in this study reported that family constellations comprised of individuals who were not biologically-related and expressed feeling invalidated or that the importance of those relationships were dismissed by therapists who had a hard time understanding diverse concepts of family, "After I explain who my family is, they [therapists] say, "Yes, but who is your *real* family?" Participants also noted microaggressions when therapists minimized or questioned LGBQ clients' desires or plans for a future family with children. The development of a non-biological family or community for LGBQ individuals can serve as a buffer against minority stress, stigma and discrimination by providing support, social interaction, role modeling and safety (Liddle, 2007). Sexual orientation microaggressions that belittle such community and familial involvement may inadvertently pushes clients further away from creating a sense of belonging and may move them towards isolation and solidarity.

Therapist's Expertise and Education

Therapists' expertise and education were called into questions from the sexual orientation microaggressions directed at clients. Participants reported that they felt their therapists unduly relied on the LGBQ clients to educate them about LGBQ issues (*Theme 8*). This microaggression was evidenced by therapists asking LGBQ clients generalized questions about LGBQ individuals and issues, and by therapists asking questions at length about particular issues regarding sexual orientation and relationships that were not pertinent to the client's current presenting issues. One participant shared her perception of feeling that her therapists were undereducated in LGBQ issues:

> I think for both of them [two different therapists], the fact that they didn't
>
> understand made me more of like a study subject than a patient… She would try
>
> so hard to figure out where in my past I turned gay, or where in my past were the

signs… Like she was completely ignorant about it, but because she was ignorant

about it, she wanted to use me as her study subject to figure out how does it

happen. (Marissa)

Therapists showed evidence of miseducation when they attempted to warn or educate

clients about the impending repercussions of maintaining an LGBQ identity (*Theme 7*).

Additionally, therapists' expertise was called into judgment by their attempts to overidentify

with clients (*Theme 3*). Participants in this study revealed that some therapists went to great

extent to demonstrate a connection with LGBQ clients and LGBQ issues. As mentioned in

chapter IV, therapists changed the manner in which they spoke and made physical changes in an

attempt to better identify with clients. Most commonly, therapists related their own personal

experiences with LGB issues to show understanding.

Clients did not trust the motives of the therapists who overidentified with them and

believed that overidentification was done as an attempt of show clients that they were not

homophobic or heterosexist, which Sue and colleagues (2008a) described as a denial of

individual heterosexism. Sue and colleagues hypothesized that heterosexual therapists make

statements to erroneously renounce their biases and show comfort in discussing LGBT issues

when making statement such as, "I don't have any negative feelings towards gay people." This

behavior sends a message that the therapist is unable to admit to their heterosexist biases and are

unwilling to explore them.

Hypothesis 2

The second hypothesis of this study was that the presence of sexual orientation

microaggressions within the individual therapeutic environment would have a negative impact

on the therapeutic process. This hypothesis proved to true in the experiences of participants in

this study as evidenced by LGBQ clients changed attitudes towards therapy, the development of negative impressions about their therapists, the therapy relationship ending prematurely, and clients' diminished help-seeking behaviors.

Affective consequences of sexual orientation microaggressions included leaving clients feeling misunderstood, uncomfortable, angry, confused, frustrated, powerless, invisible, forced to comply with treatment and rejected. Clients felt as if their therapists could not understand their situation or the sexual-reality LGBQ individuals maintain. An example is noted in one participants comment, "And the person [therapist] just didn't really listen to me. Like they didn't believe that what I was saying was my actually experience and so..." As previously mentioned in chapter IV, clients reported feeling as if they were "battling" to have their thoughts and opinions heard by their therapists. One participant contributed his therapist's training to the discomfort that was present for both he and his therapist:

> Many therapists are not prepared for that, I think, and are like, "oh what is gay sex
> like uh ha ah". Awkward conversation you try to have and makes you more
> uncomfortable trying to talk about it because they are uncomfortable so it kind of
> perpetuates the cycle.

Client's active participation in the therapeutic process was compromised when clients experienced sexual orientation microaggressions that left them feeling misunderstood and invalidated. Participants withheld information, failed to discuss their sexual orientation or issues relevant to sexual orientation and felt the need to be deceptive to get their needs met. In response to receiving three prescriptions after his first 50-minute session with a psychiatrist, on client expressed feeling as if his psychiatrist did not put forth enough effort to get to know him and therefore withheld sharing his gay sexual orientation:

So, it didn't really feel like it would have gotten anything accomplished for me to

tell him anymore after that…I didn't really feel like he knew what he was doing

so I didn't feel much of a need to contribute more of myself to the sessions after

that. (Hines)

Another participant discussed his tentativeness in discussing issues regarding same-sex romantic relationships, "I think there are things that I do hesitate to talk about more. Like relationships. I feel like we talk about them but in different context." A client discussed the negative reaction and sexual orientation microaggressions he encountered when he was testing the water with his therapist in discussing relationship and sexual issues:

Like when he's confronted with actually sexuality, because I never talked to him

about any nitty gritty details about my love life, or like, any type of sexual

encounter because I knew I didn't want to go there. So I just wanted to see how he

might react to something like that and like if he didn't react to it that much,

maybe I would go on to talk to him about a sexual encounter and how he would

react to that. But with this, I'm just like okay that wall is shut up, I'm not going to

do anything. (Johnson)

Feeling misunderstood reverted several clients to be deceptive to their therapists about their experiences and symptoms as expressed by one participant, "And it just, I had to lie to them. I felt like I was trapped."

Therapists' use of sexual orientation microaggressions led to LGBQ clients negatively evaluating the effectiveness of therapy, the therapists' abilities, and the therapists' investment into the therapeutic process as seen in the comments of several participants, "I think I gained a distrust of therapist after my 1 ½ years", "…it was like pointless"; and "Just seemed like he

really didn't care. To me it seemed like a business. You know, if he had me there more sessions, more money. That's how it felt." Another client reported feeling that after he disclosed his sexual orientation to his therapist, his therapist operated as, "I don't have to go any further [in understanding client or client's presenting issues]." The connection between sexual orientation microaggressions and resulting negative impression of counseling and counselors is well captured by Johnson's comments:

> So dealing with that sort of society pressure and wanting to be a more true
>
> representation of self within that community and the conflict between those two
>
> things. And so, when you talk about those sorts of things with therapists and the
>
> therapist is like, you know, "I don't really see how those are related. How does
>
> your sexuality as a gay man have anything to do with you feeling cut off from the
>
> larger masses of the groups?" I mean but it is a big deal. If a therapist doesn't see
>
> that link, then it's not really going anywhere.

The help-seeking behaviors and length of therapy was affected by sexual orientation microaggressions. Participants developed a distrust and a distain for therapists and psychotherapy post experiencing sexual orientation microaggressions, "I avoided therapists for multiple multiple years until just recently because I was just distrustful of them after that." One client noted the detrimental impact his first therapy experience had on his desire to utilize counseling services, "My first one killed it for me. I didn't go back for six, seven years. I went seven years without seeing a therapist before I just realized that guy was a douche."

Several clients reported that they prematurely ended their therapy due to sexual orientation microaggressions and the resultant negative attribution to therapists and therapy. One client reported ending his therapeutic relationship during his intake, "She was trying to explain to

me how I couldn't have had the experiences that I had in my life and then she didn't understand why I got up and left in the middle of her ranting and raving at me." After a therapist's empathic failure in responding to a client being outed one participant reminisced, "So I stopped going to him after that, and I just, that attitude, I had had it."

Hypothesis 3

The final hypothesis of this study was that sexual orientation microaggression incidents would manifest in a variety of formats within the individual therapy environment. Sue and colleagues (2008a) noted that racial microaggression incidents manifested in verbal, behavioral and environmental situations. This study delivered a strikingly consistent manifestation as derogatory sexual orientation undertones were present in the verbal, behavioral and environmental contact LGBQ clients had while in psychotherapy.

Sue (2008a) describes verbal incidents as "direct and indirect comments made to individuals (p. 332)". Examples of direct and indirect comments regarding one's sexual orientation were delivered in the form of sexual orientation microaggression to participants in this study. For example, participants reported being told by therapists, "Well, you are not actually queer", and "Have you thought this [being gay] through?"

Nonverbal and behavioral sexual orientation microaggression incidents are derogatory messages that are communicated to LGBQ psychotherapy clients through a therapist's body language or physical action. For example, participants reported nonverbal messages of silence, "He wouldn't talk about it [my same-sex relationship]." Behavioral incidents also included therapists changing their physical demeanor or posture in response to clients disclosing their LGBQ sexual orientation status. This ranged from therapists attempts to appear more open and

accepting of LGBQ client's, to clients' perceiving their therapists as feeling very uncomfortable and awkward.

Finally, environmental microaggressions are "delivered through physical surroundings that represents a microaggression/microaggressive event (Sue et al., 2008a, p. 332)". For example, one participant reported, "All of the information you get, pamphlets and things, seem to be geared towards that [heterosexuality] as well." Environmental microaggressions also derived from seeing therapists' family pictures in their offices and the types of books maintained on therapists' bookshelves. Most participants stated a belief that therapists should not have to conceal their personal lives; however, they noted that seeing such items made them aware that they were different from their (assumed) heterosexual therapist and often LGBQ clients felt more guarded during initial visits. Only two participants commented on seeing LGBQ-affirming or ally material in the their therapists room and they reported feeling surprised when they saw more than one book on LGBQ-issues on their therapists' bookshelves; however, they did not express a resolve of their feelings of trepidation.

Implications

This study extends the previous literature on microaggressions by revealing the perception of sexual orientation microaggressions in psychotherapy by LGBQ clients; uncovering the verbal, behavioral and environment modes of sexual orientation microaggression transmission; and communicating the detrimental effects sexual orientation microaggressions have on the therapeutic environment, client/therapist relationship, and LGBQ clients' expectations of therapy. The presence of sexual orientation microaggressions within the therapeutic environment has several implications for mental health professionals working with LGBQ clients including recognizing the indivisible nature of sexual orientation

microaggressions, understanding how sexual orientation microaggressions can promote internalized homophobia, and implications for training.

Unconscious Transmission of Microaggressions by Well-Intentioned Therapists

Racial microaggression research initially proposed that the delivery of microaggressions is often done unintentionally and unconsciously. However, more recent literature expresses that microaggressions can be both unintentional and intentional. Within the confines of this study, it became apparent that most participants considered the microaggressions they experienced to be unintentional, and were often made by well-meaning therapists. Most participants described situations of genuinely feeling as if their therapists cared for their well-being and were looking out for the client's best interest. In the current study one participant stated, "It [sexual orientation microaggression incidents] is pretty pervasive I think, but I don't think it is malicious, it's just they don't know." Nolan commented on the reason he assumed his therapist chose to ignore discussing his gay sexual orientation:

> I think my problem is my [therapist] was a friend from high school, same grade,
> father [therapist was the father of one of participant's friends]… And I think that
> he was just trying to protect me, swing me the right way, brainwash me, I think
> that's why he avoided the thing [discussing my gay sexual orientation].

Courtney discussed a similar situation in which he did not perceive malice aforethought from his therapist:

> Actually my therapist, I don't remember what it was, she said something to me
> today and I said, "You are stereotyping me". I didn't feel bad about it though
> because it was not malicious on her part. We both laughed about it.

When racial microaggressions were enacted, it often triggered participants to respond in empathic ways to the racial microaggression perpetrator, which Sue and colleagues (2008a) described as "rescuing offenders" (p.332). They described taking care of perpetrators as "considering the White person's feeling in the situation before one's own" (p 332). Similarly, some LGBQ participants placed their (heterosexual) therapists' feelings ahead of their own when it came to addressing microaggressive incidents and felt pulled to take care of their kind and good-intentioned therapists, in spite of their therapist's microaggressive attacks. Another way clients took care of therapists was to ignore that such sexual orientation microaggressions occurred. However, the more common reaction to sexual orientation microaggressions was inaction due to LGBQ participants feeling blindsided and unprepared to make any response. This was described by one participant, "I am usually pretty angry but feel pretty helpless in terms of being able to do anything about it."

The existing literature on racial microaggressions demonstrates the harmful effects microaggressions have on the therapeutic environment and on the client. Individuals who experience racial microaggressions are left feeling invalidated, question their interpretation of their racial reality and develop hostility for those whom deliver microaggressive messages. Within psychotherapy, clients of color feel unheard, are angry, unable to work on goals, and subsequently exit therapy early. There are similar dynamics for LGBQ clients. This study provides a better understanding of the detrimental effects subtle forms of discrimination, sexual orientation microaggressions, have on the therapeutic environment. From this study, it is clear that sexual orientation microaggressions leave psychotherapy clients feeling confused, misunderstood, invisible and frustrated. The innocuousness and invisibility of sexual orientation

microaggressions makes it difficult to decipher microaggressive events from acceptable practice and calls LGBQ clients to question their own interpretation.

Promotion of Internalized Homophobia

Sexual orientation microaggressions are particularly dangerous for LGBQ clients because they promote internalized homophobia. Speight (2007) argued that internalized oppression (internalized homophobia) is a damaging psychological injury that is more destructive than external oppressive events. Sexual orientation microaggression messages suggest LGBQ individuals or same-sex attractions are wrong, abnormal, or inferior as compared to heterosexuals and heterosexuality, or that therapists are uncomfortable and uneducated in LGBQ issues. Such messages may lead LGBQ clients to refrain from discussing issues related to their sexual orientation, thus, within therapy they never challenge their internalized homophobia. When both a client and therapist are uncomfortable with addressing issues of sexual orientation and therapists do not take into account the extent LGBQ identity development is complicated by client's negative views of LGBQ identities, collusion can occur. As cited in Schwartz (2003), according to Frankl (1993):

> Collusion involves an unconscious deal—a mutual denial by patient and analyst,
> of some aspect of their relationship that frightens them both. Each party acts to
> insure that both remain unaware of the collusion (p. 228).

Unconsciously or consciously colluding to silence sexual orientation and identity development has a repressive stance on the work LGBQ clients are able to do in therapy. When therapists do not understand the magnitude internalized homophobia can have on sexual identity development and reasons why LGBQ clients would refrain from voluntarily deepening sexual orientation exploration, the ability to establish an integrated and advanced LGBQ identity is compromised.

Unconscious and conscious collusion impacts the relationship process, leading to a misalliance in which the client and therapist align with one another to avoid anxiety, pain, guilt and self-hatred, which is damaging to the client (Langs, 1978; McHenry & Johnson, 1993). Collusion prevents the growth and development of a healthy sense of self and fosters aspects of self hate/internalized homophobia. Acts of collusion within sexual orientation microaggressions can occur when therapists align to use terms such as calling lovers "friends" or "roommates", and avoid talking about sex and relationships. Sexual orientation microaggression acts that perpetuate collusion can occur at all major stages of therapy including the referral process, diagnosis and history taking, intervention choices, process, and outcome (McHenry & Johnson, 1993).

Implications for Training

Sexual orientation microaggressions have an enduring psychological impact on LGBQ clients by altering their view of therapy in such a way that they prolong returning to therapy, in some cases for months or years. The anger, frustration and helplessness participants expressed while telling their stories during the research interview substantiates the prolonged effect sexual orientation microaggressions have on the psychic of LGBQ individuals.

As sexual orientation microaggressions have psychological longevity and as most mental health professionals work with at least one LGBQ client, mental health professionals can benefit from continued training to become more aware of sexual orientation microaggression. Consistent with the Multicultural Counseling Competencies (2002) and Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (Sue, Arredondo, & McDavis, 2000), sexual orientation microaggression training should address therapist knowledge, beliefs, and skills. Prior to understanding the concept of sexual orientation microaggressions and to work efficiently with

LGBQ clients, it is imperative for clinicians and clinicians-in-training to develop a proficient level of knowledge regarding the experience of LGBQ individuals in the U.S.. Specifically, it is important to address the gross acceptability of heterosexism and the promotion of homophobia within different societal spheres. As heterosexism and homophobia often go unnoticed and unquestioned, it is the responsibility of trainers to provide trainees with examples of how such pervasive heterosexism and homophobia can manifest in hidden ways and the effects sexual orientation microaggression have on the entire therapeutic process.

Along with addressing overt attitudes and biases, clinicians-in-training should be encouraged to assess their hidden biases and beliefs they hold for sexual minorities. As heterosexism and homophobia plagues even those with good intentions, emphasis should be placed on assisting clinicians to accept the high likelihood that they do in fact hold heterosexism or homophobic views even if it is not in their immediate awareness. The innocuous nature of microaggressions lends nicely to explanations such as, "That's not what I meant," and "You are taking what I said/did the wrong way." Statements such as these provide an opportunity to challenge the hidden biases clinicians-in-training hold and allow for a dialogue regarding the impact sexual orientation microaggressions have on clients, but also on the classroom environment. Microaggression are often precipitators to difficult classroom dialogues, and evoke cognitive, behavioral and emotional reactions within students (Sue et al., 2009), and sexual orientation is generally considered a topic that sparks energized and reactive classroom discussions.

Although developing and utilizing skills for eradicating and confronting sexual orientation microaggressions is an area of need in microaggression research, there are efforts clinicians can take to move away from microaggressions. When confronted for communicating a

sexual orientation microaggression, mental health professionals should work hard to not become defensive, and should instead invest in exploring the possibility that their communication style or therapeutic environment may in fact have microaggressive undertones. This is not the time to attempt to explain away the microaggression or challenge the client's perception, as these acts may serve to invalidate or minimize the client's experience. Exploring sexual orientation microaggressions requires the clinician to engage in a conversation with their LGBQ clients to understand how such a remark, behavioral act, or environmental stimuli affected them.

Clinicians and clinicians-in-training should strive to create a more complete understanding of the microaggression incident from consolidating the clinician's self-reflection, the client's perspective and formally held knowledge regarding LGBQ issues and microaggressions. Microaggression skills require clinicians and clinicians-in-training utilize a conceptualization of microaggressions to ascertain the needs of LGBQ clients and work to promote growth and greater rapport with LGBQ clients. Thus, clinicians create a corrective experience from dialoguing with LGBQ clients, remaining open, and taking responsibility for their actions.

A great quantity is still unknown about sexual orientation microaggressions, the consequences they have for clients and the consequences they have clinicians. It may be within many academic departments' resources to create research and training labs/programs that investigate this topic. Specific research labs have been developed to answer difficult cultural questions and to service minority individuals such as Robert Seller's African American Racial Identity Research Lab at University of Michigan, and The University of Texas at Austin's Gender and Racial Attitudes Lab. Each of these labs has produced research literature and training for doctoral scholars, as well as provided valuable services to research participants. A sexual

orientation microaggression/LGBQ research and training program fits well within the tenets of counseling psychology's scientist-practitioner model, which emphasizes research, clinical training and service.

Persistence of Overt Homophobia and Heterosexism

Although the purpose of this study was to explore the phenomenon of sexual orientation microaggressions within psychotherapy, it must be noted that overt acts of heterosexism, homophobia and biases were also present in the psychotherapy experiences of LGBQ participants. This revelation is not surprising due to the continued presence of sexual orientation discrimination within society. Even with the U.S.'s growing tolerance and acceptance of LGBQ individuals, overt forms of heterosexism and homophobia continue within our society and are accepted practices (i.e. marital legislation, 'Don't Ask Don't Tell' military policies, religiously based discrimination and derogatory depictions of LGBQ individuals in the media). Therefore, it can be expected that overt forms of heterosexism and homophobia would remain in psychotherapy. One participant expressed the overt harassment he experienced at the hands of a therapist:

> I had one counselor who seemed to want to take the counseling out of the office. He would show up at my place of work and start asking people that I knew about me. It got to be very very weird… that counseling session ended it quickly. I don't know what he was doing and I never took the time to ask because it was too strange. (Evon)

Overt forms of sexual orientation discrimination were often connected to religiosity, specifically Christianity. One participant commented on his psychotherapy experience with a religious-based organization that espouses to the conversion of homosexual individuals:

And I would never say it was subtle heterosexism, it was overt. I mean that kind

of happens when your [therapists] opens the bible, gives it to you, and says,

"Read this Leviticus passage aloud to me and explain how you are still a

Christian." (Kristopher)

Conclusion

Several decades ago, APA urged "all mental health professionals to take the lead in

removing the stigma of mental illness that has long been associated with homosexual orientation

(Conger, 1975, p. 633)." The mental health field has transformed in many ways (Kilgore et al.,

2005) and is now more accepting, provides greater educational opportunities for mental health

practitioner working with LGBQ clients, and has more openly LGBQ identifying therapists than

in the past. Psychological and counseling ethics codes demand that ethical practice includes

providing unbiased and appropriate psychological services to minority populations, including

LGB individuals. LGB therapeutic response guidelines, call mental health professionals to be

knowledgeable, skilled and use appropriate interventions that promote a healthy sexual identity.

Therapists' attitudinal shift and adoption of ethical practices is acknowledged in most

LGB clients' reporting an overall satisfaction in psychotherapy. This finding was supported by

participants in the current study as they repeatedly noted the benefits of therapy. Participants'

stated, "…my experience in therapy has been so wonderful because I feel so open to talk about

my feelings and issues" and "And, I just like let it all out. And it only really took a couple times.

And I have felt much better since then. It was kinda brief but really really helpful. One

participant summed up his therapy experiences as, "It's kept me alive."

However, inadequate services to LGBQ clients continue with the transformation of overt

sexual orientation discrimination into sexual orientation microaggressions. Within greater

society, the LGBQ community continues to gain more political, legal, and religious power and their presence is more extensively noted within government, communities and organizations. As LGBQ individuals have maintained a strong presence within the mental health field for many years, the existence of sexual orientation microaggressions demonstrates a cultural lag between psychology/counseling rhetoric and actual practice. If unaddressed, the use and perpetuation of sexual orientation microaggressions compromises the mental health field's ability to fully take the lead in ending discrimination against LGBQ clients and the mental health stigma associated with homosexuality. One participant in this study remarked, "I will agree that the good [counseling] relationships are good, but the bad relationships are of the variety that are only good for the things that you learn about yourself to survive them."

Counseling psychology can further its engagement in addressing homophobia and heterosexism by attending to sexual orientation microaggressions and their impact on the therapeutic environment. One would be amiss to rely solely on counseling psychology literature to educate them on LGBQ clients' experience of subtle forms of sexual orientation discrimination and bias, as counseling psychology literature has only contributed four qualitative LGBQ-focused articles within the within the last 11 years (Singh & Shelton, submitted). As multiculturalism and qualitative research methodologies are designated as the fourth and fifth forces of psychology, counseling psychology is primed to develop and utilize clinical interventions and research methodologies that disrupt the current delivery of sexual orientation microaggressions.

Recommendations for Future Research

This study set out to extend the previous work on microaggressions, which focused primarily on racial and ethnic minorities. As well as addressing sexual orientation, greater

understanding of the impact microaggressions have on other minority communities is needed (e.g. ability, gender, and socioeconomic status). As this study set to explore sexual orientation, this study did not include transgender individuals (gender-identity) for fear that it would be too difficult to decipher if microaggressions were derivative of participants' sexual orientation or gender identity. Greater understanding of the impact microaggressions have on the LGBT community can be gained from exploring gender-identity microaggressions. Furthermore, the totality of a person or their experiences cannot be understood by one characteristics, trait, or quality. Multiple identities, and multiple internalized oppressions can impact the self-esteem and psychological distress of ethnic and sexual minorities (Szymanski & Gupta, 2009) and more than likely, multiple identities can also led to multidynamic microaggressions within therapy. Extending microaggression research to communities and individuals with multiple minority identities can supplement the current microaggression literature (i.e. sexual minorities of color).

Either from confrontation by a client or your own personal insight, you realize that you have just engaged in a sexual orientation microaggressive act towards a LGBQ client! Now what? Is a therapist's awareness enough to mend microaggression transgressions? Some therapists see this as a starting point, "Accepting that I am unintentionally homophobic has allowed me to be more compassionate with myself when I make mistakes or express prejudices and to also be more open to feedback that will help me correct them" (Berkowitz, 2005, p. 29-30). Brown (1996) suggest that ethical practice is done with the presumption that one holds heterosexist bias and actively works to understand and curtail engaging in biased practice. As suggested by racial microaggression literature, this researcher asks, "Is acknowledging that the microaggressive act happened enough to rebuild the therapeutic relationship and limit the client's enduring psychological injury?" or "Should you as the therapist apologize or ignore the

occurrence of microaggressions?" Future research is needed to develop a proper course of action for responding after microaggression events have occurred in therapy. Becoming more familiar with clients' needs after they have received a microaggression can help therapists correct or lessen the damage microaggressions have on the therapeutic relationship. This information can be gleamed from LGBQ clients, as well as clinicians who have experienced such a corrective experience with clients.

This study grazed the surface of coping strategies LGBQ clients use when faced with microaggressive attacks. Coping and resiliency are strengths for sexual minority individuals (Brown, 1989; Friend, 1990; Morrow, 2001). A greater understanding of how LGBQ clients manage and persevere from microaggression attacks can give additional insight into LGBQ individuals coping and resiliency. Use of diverse methodologies can help promote such an understanding (see Moradi, et al., 2009).

Understanding of the cultural impact discrimination has on clients and therapist as well as therapists' insight and openness to the experience of others appears to be key in recognizing and accepting the existence of microaggressions. As demonstrated by Thomas's (2008) reaction against the substantiation of microaggression, there are those within the mental health profession who deny the existence of microaggressions and disagree with the cited psychological determinant microaggressions have on both the receiver and perpetrator. Developmental models (i.e. Cass, 1974, & Helms, 1995) inform us that immature developmental stages contain disbelief, adoption of normed values without question, blindspots and defensiveness and rejection to ideas or beliefs that contradict internalized values. Therefore, mental health professionals operating from a sophomoric developmental stage may not be able to grasp and work with the concept of microaggressions. Future research and the construction of a

developmental model of counselors' awareness to microaggressions could help shed light on the

aspects and experiences that encourage recognition of microaggressions and ways to incite

movement towards empathizing with minority clients' sexual and racial realities.

Finally, repetition and future exploration of sexual orientation microaggressions

experienced by LGBQ psychotherapy clients is needed. With the continued move

towards social equality for LGBQ individuals and as overt forms of heterosexism and

homophobia become less and less tolerated, it will be interesting to reinvestigate the form

and delivery of sexual orientation microaggressions as our country becomes more

progressive.

References

Abelson, R. P., Dasgupta, N., Park, J., & Banaaji, M. R. (1998). Perceptions of the collective

other. *Personality and Social Psychology Review, 2,* 243-250.

Allen, L. (2006). Trying not to think 'straight': Conducting focus groups with lesbian and gay

youth. *International Journal of Qualitative Studies in Education*, 19, 163-176.

Allison, K. W., Crawford, I., Echemendia, R., Robinson, L., & Knepp, D. (1994). Human

diversity and professional competence: Training in clinical and counseling psychology

revisited. *American Psychologist, 49*, 792-796.

American Academy of Pediatrics, American Counseling Association, American Association of

School Administrators, American Federation of Teachers, American Psychological

Association, American School Health Association, et al. (1999). Just the facts about

sexual orientation and youth: A primer for principals, educators, and school personnel.

[Brochure]. Washington, DC: American Psychological Association

American Association for Marriage and Family Therapy. (2001). *Code of Ethics.* Washington,

DC: Author.

American Counseling Association. (2001). *Competencies of counseling gay, lesbian, bisexual*

and transgendered (GLBT) clients. The Association of Gay, Lesbian, and Bisexual

Issues in Counseling. Retrieved 3/30/09 from: www.Aglbic.org/comptncs.htm

American Counseling Association. (2005). *Code of ethics.* Alexandria, VA: Author.

American Counseling Association. (1999). *Racism: Healing it effects.* Alexandria, VA: Author.

American Psychiatric Association. (1973). Position Statement on Homosexuality and Civil

Rights. *American Journal of Psychiatry, 131* (4), 497.

American Psychological Association. (1998). Appropriate therapeutic responses to sexual

orientation of the American Psychological Association, Incorporated, for the legislative year 1997. *American Psychologist, 53,* 882-939.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597-1611.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organization change for psychologist. *American Psychologist, 58*, 377-402.

American Psychological Association (2007). Guidelines for psychological practice with girls and women. *American Psychologist, 62*, 949-975.

American Psychological Association (2009). *Membership statistics April 2009*. Retrieved 4/4/09 from: www://memforms.apa.org/apa/cli/mbdirsearch/memstat.cfm.

American Psychological Association, Division 44/Joint Committee on Lesbian, Gay and Bisexual Concerns Joint Tasks Force on Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients. (2000). Guidelines for psychotherapy with lesbian, gay, and bisexual clients. *American Psychologist, 55,* 1440-1451.

Appleby, G., & Anastas, J. (1998). *Not just a passing phase: Social work with gay, lesbian, and bisexual people.* New York, Columbia University Press.

Atkinson, D., Brady, S., & Casas, J. M. (1981). Sexual preference similarity, attitude similarity, and perceived counselor credibility and attractiveness. *Journal of Counseling Psychology, 28,* 504–509.

Atkinson, D. R., & Hackett, C. (1988). *Counseling nonethnic American minorities*. Springfield, IL: Charles C Thomas.

Avert. (2009). *How many gay people are there?* Retrieved 3/30/09 from:

http://www.avert.org/gay-people.htm.

Barrett, D. C. (1993). The influence of multiple identities on the health behaviors of gay

    men. *Dissertation Abstracts International, 54(4-A)*, 1553.

Barrett, K. A., & McWhirter, B. T. (2002). Counselor trainee's perceptions of clients based on

    client sexual orientation. *Counselor Education & Supervision, 41*, 219-232.

Bartlett, A., King, M., & Phillips, P. (2001). Straight talking: An investigation of te attitudes and

    practice of psychoanalysts and psychotherapists in relation to gays and lesbians. *British*

    Journal of Psychiatry, 179, 545-549.

Bayer, R. (1981). *Homosexuality and American psychiatry: The politics of diagnosis*. New York:

    Basic Books.

Bell, A. P., & Weinberg, M. S. (1978). *Homosexualities: A study of diversity among men and*

    women. New York: Simon & Schuser.

Ben-Ari, A. T. (1995). The discovery that n offspring is gay: Parent', gay men's, and lesbian's

    perspectives. *Journal of Homosexuality, 30,* 89-112.

Ben-Ari, A. T. (1998). An experiential attitude change: Social works students and

    homosexuality. *Journal of Homosexuality, 36,* 59-70.

Berkman, C. S. & Zinberg, G. (1997). Homophobia and heterosexism in social workers. *Social*

    Work, 42, 319-332.

Berkowitz, A. D. (2005). Coming out to my homophobia and heterosexism: Lessons learned in

    the journey of an ally. In J. M. Croteau, J. S. Lark, M. A. Lidderdal, Y. B. Chung (Eds.),

    Deconstructing heterosexism in the counseling professions: A narrative approach (pp. 29-

    33). Thousand Oaks, CA: Sage.

Berlau, J. (1997). Who has the right to go straight? *Insight on the News, 13*, 16.

Bidell, M. P.; Ragen, J. K. Broach, C. D., & Carrillo, E. A. (2007). First impressions: A multicultural content analysis of professional psychology program Web sites. *Training and Education in Professional Psychology, 1,* 204-214.

Bieschke, K. J., & Matthews, C. (1996). Career counselor attitudes and behaviors toward gay, lesbian, and bisexual clients. *Journal of Vocational Behavior, 48*, 243-255.

Bieschke, K. J., McClanahan, Tozer, Grzegorek, & Park. (2000). Programmatic research on the treatment of lesbian, gay and bisexual clients: The past, the present, and the course for the future. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of Counseling and psychotherapy with lesbian, gay and bisexual clients*. Washington, D.C.: APA.

Bieschke, K. J., Paul, P. L, & Blasko, K. A. (2007). Review of empirical research focused on the experience of lesbian, gay, and bisexual clients in counseling and psychotherapy. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, Gay, Bisexual, and Transgender Clients*. Washington, DC: APA.

Bieschke, K., J., Perez, R. M., & DeBord, K. A. (Eds.). (2007b). *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients (2nd ed.)* Washington, DC: APA.

Bloomberg, L. D., & Volpe, M. (2008). *Completing your qualitative dissertation*. Thousand Oaks, CA: Sage.

Bohan, J. S. (1996). *Psychology and sexual orientation: Coming to terms*. New York: Rutledge.

Bowers, A. M. V. & Bieschke, K. J. (2005). Psychologists clinical evaluation and attitudes: An

examination of the influence of gender and sexual orientation. *Professional Psychology Research and Practice, 36, 97*-103.

Bower, J., Gurevich, M., & Mathieson, C. (2002). (Con)tested identities: Bisexual women reorient sexuality. *Journal of Bisexuality, 2,* 23-52.

Bowers, R., Plummer, D., & Minichiello, V. (2005). Homophobia in counseling practice. *International Journal for the Advancement of Counseling, 27*, 471-489.

Bradford, J. (2004). The bisexual experience: Living in a dichotomous culture. *Journal of Bisexuality, 1,* 5-29.

Bradford, J., Ryan, C., & Rothblum, E. D. (1994). National lesbian health care survey: Implications for mental health care. *Journal of Consulting and Clinical Psychology, 62*, 228-242.

Broido, E. M. (2000). Constructing identity: The nature and meaning of lesbian, gay, and bisexual identities. In R.M. Perez, K. A DeBord, & K. J.. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay and bisexual clients* (pp. 12-33). Washington, DC: American Psychological Association.

Bronn, C. D. (2001). Attitudes and self-images of male and female bisexuals. *Journal of Bisexuality, 1*, 5-29.

Brown, L. S. (1988). Lesbians, gay men and their families: Common clinical issues. *Journal of Gay and Lesbian Psychotherapy, 1,* 65-77.

Brown, L. S. (1989a). Lesbian, gay men, and their families: Common clinical issues. *Journal of* Gay *& Lesbian Psychotherapy, 1*, 65-77.

Brown, L. S. (1989b). New voices, new visions: Toward a lesbian/gay paradigm for psychology. *Psychology of Women Quarterly*, *13*, 445–458.

Brown, L. S. (1996). Ethical concerns with sexual minority patients. In R. P. Cabaj, & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 897-916). Washington, DC, US: American Psychiatric Association.

Brown, L. S. (1998). *Two-spirit people.* New York: Haworth Press.

Brown, M., & Amoroso, D. (1975). Attitudes toward homosexuality among West Indian male and female college students. Journal of Social Psychology, 97, 163-168.

Brown, T. (2002). A proposed model of bisexual identity development that elaborates on experience differences of women and men. *Journal of Bisexuality, 2,* 67-91

Browning, C., Reynolds. A. L., & Dworkin, S. H. (1991). Affirmative psychotherapy for lesbian women. *Counseling Psychologist, 19*, 177-196.

Buckard, A. W., & Knox., S. (2004). Effects of therapist color-blindness on empathy and attritions in cross-cultural counseling. *Journal of Counseling Psychology, 51*, 387-397.

Buhrke, R., A. (1989). Female student perspectives on training in lesbian and gay issues. *The Counseling Psychologist, 17,* 629-636.

Buhrke, R. A., Ben-Ezra, L. A., Hurley, M. E., & Ruprecht, L. J. (1992). Content analysis and methodological critique of articles concerning lesbian and gay male issues in counseling journals. *Journal of Counseling Psychology, 39*, 91-99.

Buhrke, R. A., & Douce, L. A. (1991). Training issues for counseling psychologists working with lesbian women and gay men. *The Counseling Psychologist, 19*, 216-234.

Bullough, V. L. (1977*). Sin, sickness and sanity: A history of sexual attitudes*. New York: New American Library.

Butler**,** R. (2001). A break from the norm: Exploring the experiences of queer crips. *In K.*

Backett-Milburn, & L. McKie (Eds.), *Constructing gendered bodies* (pp. 224-242). New York, NY: Palgrave Macmillan, 2001.

Cabaj, R. P. (1996). Sexual orientation of the therapist. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 513-524). Washington, DC: American Psychiatric Press.

Carrubba, M. D. (2005). Invisibility, alienation, and misperceptions: The experience of being bisexual. In J. M. Croteau, J. S. Lark, M. A. Liddle, & Y. B. Chung (Eds.), *Deconstructing heterosexism in the counseling professions: A narrative approach* (pp. 41-45). Thousand Oaks, CA: Sage.

Cass, V. C. (1979). Homosexual identity formation: A theoretic model. *Journal of Homosexuality, 14,* 69-80.

Chan, K. (2005). Transforming heterosexism: Starting from myself In J. M. Croteau, J. S. Lark, M. A. Liddle, & Y. B. Chung (Eds.), *Deconstructing heterosexism in the counseling professions: A narrative approach* (pp. 47-52). Thousand Oaks, CA: Sage.

Clarke, W. M., & Serovich, J. M. (1997). Twenty years and still in the dark" content analysis of articles pertaining to gay, lesbian, and bisexual issues in marriage and family therapy journals. *Journal of Martial and Family Therapy, 23*, 239-253.

Cochran, S. D. (2001). Emerging issues in research on Lesbians' and Gay Men's mental health: Does sexual orientation really matter? *American Psychologist,* 931-946.

Cochran, S. D., Bybee, D., Gage, S., & Mays, V. M. (1996). Prevalence of self-reported sexual behaviors, sexual transmitted disease, and problems with drugs and alcohol in three large surveys of lesbian and bisexual women. *Women's Heath: Research on Gender Behavior and Policy, 2,* 11-34.

Cochran, S. D., Keenan, C., Schober, C., & Mays, V. M. (2000). Estimates of alcohol use and clinical treatment needs among homosexually active men and women in the U.S. population. *Journal of Consulting and Clinical Psychology, 68*, 1062-1071.

Cochran, S. D., & Mays, V. M. (1994). Depressive distress among homosexuality active African American men and women. *American Journal of Psychiatry, 151*, 524-529.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*, 53-61.

Coleman, E. (1982). Developmental stages of the coming-out process. *Journal of Homosexuality, 7,* 31-43.

Coleman, E. (1990). Toward a synthetic understanding of sexual orientation. In D. McWhirter, S., Sanders, & J. Reinich (Eds.), *Homosexuality/heterosexuality: Concepts of sexual orientation*, (pp. 275-273), New York, Oxford University Press.

Collins, J. F. (2000). Biracial-bisexual individuals: Identity coming of age. *International Journal of Sexuality and Gender Studies, 3*, 221-253.

Conger, J. J. (1975). Proceedings of the American Psychological Association, Incorporated, for the year 1974: Minutes of the Annual Meeting of the Council of Representatives. *American Psychologist, 30*, 620-651.

Constantine, M. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselor's general and multicultural counseling competence. *Journal of Counseling Psychology, 49*, 255-263.

Constantine, M. (2007). Microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*, 1-16.

Constantine, M. G., Smith, L., Redington, R. M., & Owens, D. (2008). Racial microaggressions against Black counseling and counseling psychology faculty: A central challenge in the multicultural counseling movement. *Journal of counseling & Development, 86,* 348-355.

Constantine, M, & Sue, D. W. (2007). Perception of racial microaggressions among black supervisees in cross-racial dyads. *Journal of Counseling Psychology, 54*, 142-153.

Corey, G. (2001).*Theory and practice of counseling and psychotherapy*. Pacific Grove, CA: Brooks/Cole.

Corey, G., & Corey, M. S. (2006). *Becoming a helper.* Pacific Grove, CA: Wadsworth.

Corey, G., Corey, M. S., & Callanan, P. (1998). *Issues and ethics in the helping professions* (5th ed.), Pacific Grove, CA: Brooks/Cole.

Corliss, H. L., Cochran, S. D., & Mays, V. M. (2002). Reports of parental maltreatment during childhood in a United States population-based survey of homosexual, bisexual, and heterosexual adults. *Child Abuse Neglect: The International Journal, 26,* 1165–1178.

Cramer, D. W., & Roach, A. J. (1988). Coming out to mom and dad: A study of gay males and their relationships with their parents. *Journal of Homosexuality, 15,* 79-91.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Creswell, J. W., Hanson, W. E., Clark, V. L., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The Counseling Psychologist, 35*, 236-264.

Croteau, J. M, Lark, J. S. & Lance, T. S. (2005). Our stories will be told: Deconstructing the heterosexist discourse in the counseling professions. In J. M. Croteau, J. S. Lark, M. A. Lidderdale, Y. B. Chung (Eds.), *Deconstructing heterosexism in the counseling professions: A narrative approach* (pp. 1-16). Thousand Oaks, CA: Sage.

D'Augelli, A. R. (1994). Identity development and sexual orientation: Toward a model of lesbian, gay, and bisexual development. In E. J. Trickett, R. J. watts, & D. Birman (Eds.), *Human diversity: Perspective on people in context*. San Francisco: Jossey-Bass.

D'Augelli, A. R. (1998). Developmental implications of victimization of lesbian, gay and bisexual youths. In G. M. Herek (Ed.), *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men and bisexuals* (pp.187-210). Thousand Oaks, CA: Sage.

Davis, J. A., & Smith, T. W. (1996). General social surveys, 1972-1996: Cumulative codebook. Chicago: National Opinion Research Center.

DeCecco, J. (1990). Confusing the actor with the act: Muddled notions about homosexuality. *Archives of Sexual Behavior, 19*, 409-413.

DeJesus-Torres, M. (2000). Microaggressions in the criminal justice system at discretionary stages and its impact on Latino(a)/Hispanics. *Justice Professional, 13*, 69-98.

Denzin, N. K. (2001). The reflexive interview and a performative social science. *Qualitative Research, 1,* 23-46.

Denzin, N. K. (1998). Where Does Ethnography Go Next? *PsycCRITIQUES, 43*, 332-334.

Dillon, J., & Rose, S. (1996, August). *Characteristics and impact of antigay/lesbian violence*. Paper presented at the annual convention of the American Psychological Association, Toronto, Ontario.

Dillon, F. R., & Worthington, R. L., Savoy, H. B. Rooney, S. C., Becker-Schutte, A., & Guerra, R. M. (2004). On Becoming allies: A qualitative study of lesbian-, gay- and bisexual-affirmative counselor training. *Counselor Education & Supervision, 43,* 162-178.

Dohrenwend, B. P. (2000). The role of adversity and stress in psychopathology: Some evidence

and its implications for therapy and research. *Heath and Social Behavior, 41*, 1-19

Drescher, J. (2002). Don't ask, don't tell: A gay man's perspective on the psychoanalytic
experience between 1973 and 1991. *Journal of Gay and Lesbian Psychotherapy, 6,* 45-
55.

Driver, S. (2008). *Queer youth cultures*. Albany, NY: State University of New York Press.

DuBay, W. H. (1987). *Gay identity: The self under ban.* Jefferson, NC: McFarland.

Eliason, M. J. (1997). The prevalence and nature of biphobia in heterosexual undergraduate
students. *Archives of Sexual Behavior*, *26*, 317–326

Eldridge, N. S., & Barnett, D. C. (1991). Counseling gay and lesbian students. In N. J. Evans &
V. A. Wall (Eds.), *Beyond tolerance: Gays, lesbians, and bisexuals on campus* (pp. 1147-
178). Alexandria, VA: American College Personnel Association.

Elliot, J. E. (1993). Career development with lesbian and gay clients. *The Career Development
quarterly, 41,* 210-226.

Exodus International. (2008). *Exodus International* [Online]. Available
www.messiah.edu/hpages/fac/staff/chase/h/exodus/

Fassinger, R. E. (1991). The hidden minority: Issues and challenges in working with lesbian
women and gay men. *The Counseling Psychologist, 19,* 157-176.

Fassinger, R. E. (2000). Gender and sexuality in human development: Implications for
prevention and advocacy in counseling psychology. In S. Brown & R. Lent (Eds.),
Handbook of counseling psychology (3rd ed., pp. 346-378). New York: Wiley.

Fassinger, R. E., & Arseneau, J. R. (2007). I'd rather get wet than be under that umbrella":
Differentiating the experiences and identities of lesbian, gay, bisexual and transgender
people.

Faulkner**,** A. H., & Cranston**,** K. (1998). Correlates of same-sex sexual behavior in a random

      sample of Massachusetts high school students. *American Journal of Public Health, 88*,

      262-266.

Fausto-Sterling, A. (1998). The five sexes: Why male and female are not enough. In D. L.

      Anselmi & A. L. Law (Eds.), *Handbook for social justice in counseling psychology:*

      Leadership, vision, and action (pp. 256-275).

Fein**,** S. B., & Nuehring, E. M. (1981). Intrapsychic effects of stigma: A process of breakdown

and

      reconstruction of social reality. *Journal of Homosexuality, 7*, 3-13.

Fife, B. L. & Wright, E. R. (2000). The dimensionality of stigma: A comparison of its impact on

      the self of persons with HIV/AIDS and cancer. *Journal of Health and Social Behavior,*

      41, 50-67.

Finn, P., & McNeil, T. (1987, October). *The response of the criminal justice system to bias*

      crime: An exploratory review. Washington, DC: National Institute of Justice, U.S.

      Department of Justice.

Firestein, B. A. (2007). Cultural and relations contexts of bisexual women: Implications for

      therapy . In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling*

      and psychotherapy with lesbian, Gay, Bisexual, and Transgender Clients. Washington,

      DC: APA.

Fleischer, J., & Fillman, J. (1995). Lesbian and gay youth: treatment issues. *The Counselor, 13,*

      27-28.

Franklin, A. J., & Boyd-Franklin, N. (2000). Invisibility syndrome: A clinical model of the

effects of racism on African-American males. *American Journal of Orthopsychiatry, 70,* 33-41.

Freedman, S. A., & Lips, H. M. (2002). Harsh judgments and sharp impressions: Audience response to participants in a study of heterosexual feminist identities. *Feminism and Psychology, 12,* 275-281.

Friedman, R. C., & Lilling, A.A. (1996). An empirical study of the beliefs of psychoanalysts about scientific and clinical dimensions of male homosexuality. *Journal of Homosexuality, 32,* 79-89.

Friend, R. A. (1990). Older lesbian and gay people: A theory of successful aging. *Journal of Homosexuality, 20,* 99-118.

Frith, H. (2000). Focusing on sex: Using focus groups in sex research. *Sexualities, 3,* 275-298.

Fouad, N., & Arredondo, P. (2007). *Becoming culturally oriented: Practical advice for psychologists and educators.* Washington, DC: American Psychological Association.

Fox, R. C. (1996). Bisexuality in perspective: A review of therapy and research. In B.A. Firestein (Ed.), *Bisexuality: The psychology and politics f an invisible minority* (pp. 3-52). Thousands oaks, CA: Sage.

Gaertner, S. L., & Dovidio, J. F. (1986). The aversive form of racism. In J. F. Dovidio & S. L Gaertner (Eds.). *Prejudice, discrimination, and racism,* (pp. 61-90). San Diego CA: Academic Press.

Garanzini, M. J. (1989). Psychodynamic theory and pastoral theology: An integrated model. *Journal of Homosexuality, 18,* 175-194.

Garnets, L., Hancock, K, A., Cochran, S. D., Goodchilds, J., & Peplau, L. A. (1991). Issues in

psychotherapy with lesbians and gay men: A survey of psychologists. *American Psychologist, 46,* 964-972.

Garofalo, R., Wolf, R. C., Kessel, S. Palfrey, S. J., DuRant, R. H. (1998). The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics, 101,* 895-972.

Gelberg, S., & Chojnacki, J. T. (1995). Developmental transitions of gay/lesbian/bisexual-affirmative, heterosexual career counselors *The Career Development Quarterly, 43,* 267-273.

Gelso, C. J., Fassinger, R. E., Gomez, M. J., & Latts, M. G. (1995). Countertransference reactions to lesbian clients: The role of homophobia, counselor gender, and countertransference management. *Journal of Counseling Psychology, 42,* 356–364.

Gentry, C. S. (1986). Social distance regarding male and female homosexuals. *Journal of Social Psychology, 127,* 199-208.

Giorgi, B. (2006). Can an empirical psychology be drawn from Husserl's phenomenology? In P. Ashworth & M. C. Chung (Eds.), *Phenomenology and psychological science: Historical and philosophical perspectives.* New York, New York: Springer.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* Mill Valley, CA: Sociological Press.

Goldfried, M. R. (2001). Integrating gay, lesbian, and bisexual issues into mainstream psychology. *American Psychologist, 56,* 975-988.

Gordon, J., & Johnson, M. (2003). Race, speech, and hostile education environment: What color is free speech? *Journal of Social Philosophy, 34*, 414-436.

Graham, D. L., Rawlings, E. I., Halpern, H. S., & Hermes, J. (1984). Therapists' needs for

training in counseling lesbian and gay men. *Professional Psychology: Research and Practice, 15,* 482-496.

Greene, B. (2007). Ethical psychological services to LGB clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, Gay, Bisexual, and Transgender Clients (pp. 81-199).* Washington, DC: APA.

Grove, J. (2003). Can heterosexual counselors or generic agencies help same sex couples? An exploratory study. *Counseling and Psychotherapy Research, 3,* 129-137.

Halberstam, J. (2008). What's that smell? Queer temporalities and subcultural lives. In S. Driver, *Queer youth cultures* (pp. 27-50). Albany, NY: State University of New York Press.

Haldeman, D. (1994). The practice and ethics of sexual orientation conversion therapy. *Journal of Counseling and Clinical Psychology, 62*, 221-227.

Haldeman, D. (1996). Spirituality and religion in the lives of lesbians and gay men. In R. P. Cabaj & T. S. Stein (Eds.), Textbook of homosexual and mental health (pp. 881-896). Washington, D.C. American Psychiatric Press.

Haldeman, D. (1999). The pseudo-science of sexual orientation conversion therapy. Angles: *The Policy Journal of the Institute for Gay and Lesbian Strategic Studies,* 4, 1-4.

Haldeman, D. (2000). Therapeutic responses to sexual orientation: Psychology's evolution. In B. Green & G L Croom (Eds.), *Education, research and practice in LGBT psychology: A resource manual* (pp. 244-262). Thousand Oaks, CA: Sage.

Haldeman, D. (2001). Psychotherapy with gay and bisexual men. In G. R. Brooks, & G. Good (Eds.), *The new handbook of psychotherapy and counseling with men: A comprehensive guide to settings, problems, and treatment approaches* (pp. 796-815). San Francisco, CA: Jossey-Bass.

Haldeman, D. (2002). Gay rights, patient rights: the implications of sexual orientation conversion therapy. *Professional psychology: Research and Practice, 33,* 260-264.

Harris, R. S., Jr. (2008). Racial microaggression? How do you know? *American Psychologist*, *63*, 275–276.

Harris, R. S., Jr. (2009). Racial microaggression? How do you know?—Revisited. *American Psychologist*, *64*, 220.

Helms, J. E., & Cook, D. A. (1999). *Using race and culture in counseling and psychotherapy: Theory and process.* Needham Heights, MA: Allyn & Bacon.

Helms, J. E. (1995). *The people of color (POC) racial identity attitude scale*. Unpublished manuscript, University of Maryland, College Park.

Hencken, J. D. (1984). Conceptualizations of homosexual behavior which preclude homosexual self-labeling *Journal of Homosexuality, 9,.* 53-63.

Hencken, J. D. (1982). Homosexuality and psychoanalysis: Toward a mutual understanding. *American Behavioral Scientist, 25,* 435-468.

Herek, G. (1993). The context of antigay violence: Notes on cultural and psychological heterosexism. IN L. D. Garnets & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian and gay male experiences* (pp. 89-107). New York,: Columbia University Press.

Herek, G. (1995). Psychological heterosexism in the United States. In A. D'Augelli & Patterson (eds.), *Lesbian, gay and bisexual identities over the lifespan: Psychological perspectives*. New York: Oxford University Press.

Herek, G. (2003). The psychology of sexual prejudice. In D. L. Garnets, & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian, gay, and bisexual experiences* (pp. 739-755). New York: Columbia University Press.

Herek, G. M., Cogan, S. C. & Gillis, J. R. (2002). Victim experiences of hate crimes based on sexual orientation. *Journal of Social Issues, 58*, 319-399.

Herek, G. M., Gillis, J. R., & Cogan, J. C. (2009). Internalized Stigma Among Sexual Minority Adults: Insights From a Social Psychological Perspective. *Journal of Counseling Psychology 56,* 32–43.

Hochberg, K. (2008). Be aware of microaggression in diversity communication: Notice nursing now. *ONS Connect, 23*, 20.

Huberman, A. M., & Miles, M. B. (1994). *Data management and analysis methods In:* Handbook of qualitative research. Denzin, Norman K.; Lincoln, Yvonna S.; Thousand Oaks, CA: Sage.

Hutchins, L., & Ka'ahumanu, L. (Eds.). (1991). *Bi any other name: Bisexual people speak out.* Los Angeles: Alyson Books.

Iasenza, S. (1989). Some challenges of integrating sexual orientation into counselor training and research. *Journal of Counseling & Development, 68,* 73-76.

Israel, T., Gorcheva, R., Walther, W. A., Sulzner, J. M., & Cohen, J. (2009). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. *Professional Psychology: Research and Practice, 39*, 361–368.

Israel, T., & Mohr, J. J. (2004). Attitudes toward bisexual women and men: Current research, future directions. Journal of Bisexuality, 4, 117-134.

Israel, T., & Selvidge, M. M. D. (2003). Contributions of multicultural counseling to counselor competence with lesbian, gay and bisexual clients. *Multicultural Counseling and Development, 31,* 84-98.

Ivy Planning Group. (2008). Fifty-eight little things that have a big impact: What's your

microtrigger? Rockville, MD: Author

Jackson, L. A., & Sullivan, (1990). Cognition and affect in evaluations of stereotyped group members. *Journal of Social Psychology, 129,* 659-672.

Jones, M. A., & Gabriel, M. A. (1999). Utilization of psychotherapy by lesbians, gay men, and bisexuals: Findings from a nationwide survey. *American Journal of Orthopsychiatry, 69*.

Jongsma, A. E., & Peterson, L. M. (1995). *The complete psychotherapy treatment planner.* Oxford, England: John Wiley & Sons.

Kates, S. M. (1999). Making the ad perfectly queer: Marketing "normality" to the gay men's community? *Journal of Advertising, 28*, 25-37.

Kaufmann, G., & Raphael, L. (1996). *Coming out of shame: Transforming gay and lesbian lives.* New York: Doubleday.

Kessler, R. C., Mickelson, K. D., & Williams, D. R. (1999). The relevance, distribution and mental health correlates of perceived discrimination in the Unites States. *Journal of Health and Social Behavior, 40*, 208-230.

Ketz, K., & Israel, T. (2002). The relationship between women's sexual identity and perceived wellness. In D. Atkins (Ed.), *Bisexual women in the twenty-first century* (pp. 227-242). New York: Harrington Park Press.

Kidd, A. E. (2005). Marriage and family therapists' working alliance with gay and lesbian clients: Effects of gender and homoprejudice. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 65(7-A),* 2502.

Kilgore, H., Sideman, L., Amin, K., Baca, L. & Bohanske, B. (2005). Psychologists' attitudes and therapeutic Approaches toward gay, lesbian, and bisexual Issues continue to improve: An update. *Psychotherapy: Theory, Research, Practice, Training, 42,* 395–400.

Kite, M. E. (1992). Individual differences in males' reactions to gay males and lesbians. *Journal of Applied Social Psychology 22,* 1222-1239.

Krueger, R. A. (1994). Focus groups: a practical guide for applied research (2ⁿᵈ ed.). Thousand Oaks, CA: Sage.

Janesick, V. (1998). The dance of qualitative research design: Metaphor, methodology and meaning. In N. K Denzin, & Y. S. Lincoln (Eds). Strategies of qualitative inquiry (pp. 35-55). Thousand Oaks: CA: Sage.

Jones, M. A., Botsko, M., & Gorman, B. S. (2003). Predictors of psychotherapeutic benefit of Lesbian, gay, and bisexual clients: the effects of Sexual orientation matching and other factors. *Psychotherapy: Theory, Research, Practice, Training 40*, 289–301.

Jones, M. A., & Gabriel, M. A. (1999). Utilization of psychotherapy by lesbian, gay men and bisexuals: Finds from a nationwide survey. American Journal of Orthopsychiatry, 69, 209-219.

LaMar, L., & Kite, M. E. (1998). Sex differences in attitudes toward lesbians and gay men: A multidimensional perspective. *Journal of Sex Research, 35*, 189-196.

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Harlow, England: Pearson.

Langs, R. (1978). *Technique in transition*. New York: Jason Aronson.

LeVay, S., & Nonas, E. (1995). *City of friends: A portrait of the gay and lesbian community in America*. Cambridge, MA: MIT Press.

Leslie, L. A. (1995). Psychotherapy: the evolving treatment of gender, ethnicity, and sexual orientation in marital and family therapy. *Family Relations, 44,* 359-378.

Levounis, P. (2003). Gay patient—gay therapist: A case report of Stephen. In (Eds.), J.

Drescher, A., D'Ercole, & E. Schoenberg, *Psychotherapy with gay men and lesbians: Contemporary dynamic approaches* (pp. 15-28) Binghamton, NY: Haworth Press.

Lewes**,** K. (1988). *The psychoanalytic theory of male homosexuality*. New York, NY, US: Simon & Schuster.

The LGBT Hate Crimes Project. (2009). *The LGBT Hate Crimes Project*. Retrieved 2/15/2009.

Hayes, J. A., & Gelso, C. J. (1993). Male counselor's discomfort with gay and HIV-infected clients. *Journal of Counseling Psychology, 40,* 86-93.

Liddle, B. J. (1996). Therapist sexual orientation, gender, and counseling practices as they relate to ratings of helpfulness by gay and lesbian clients. *Journal of Counseling Psychology, 43*, 394-401.

Liddle, B. J. (2007). Mutual Bonds: Lesbian Women's Lives and Communities. *In:* K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients (2nd ed.).* (pp. 51-69). Washington, DC: American Psychological Association.

Lips. H. M. (2005). Sex and Gender: An introduction. NY: McGraw Hill.

Liszcz, A. M., & Yarhouse, M. A. (2005). Same-sex attraction: A survey regarding client-directed treatment goals. *Psychotherapy: Theory, Research, Practice, Training, 42,* 111–115.

Litosseliti, L. (2003). *Using focus groups in research.* New York: Continuum.

Luchetta, T. (1999). Relationship between homophobia, HIV/AIDS stigma, and HIV/AIDS knowledge, in L. Pardie & T. Luchetta (Eds.), *The construction of attitudes toward lesbians and gay men,* (pp. 1-17). New York, Hawthorne Press.

Lynch, B. (1996). Religious and spirituality conflicts. In D. Davies & C. Neal (Eds.), *Pink*

therapy: A guide for counsellors and therapists working with lesbian, gay and bisexual clients (pp. 199-208). Philadelphia: Open Press University.

MacEwan, I. (1994). Differences in assessment and treatment approaches for homosexual clients. *Drug and Alcohol Review, 13,* 57-62.

Mair, D., & Izzard, S. (2001). Grasping the nettle: Gay men's experiences in therapy. *Psychodynamic Counselling, 7,* 475-490.

Markowitz, L. (1992). Homosexuality: Are we still in the dark? Confronting homophobia in the therapy room. In R. Simon (Ed.), *The evolving therapist: Ten years of the Family Therapy Networker*. Washington, DC: Guilford Press.

Marmor, J. (1980). Epilogue: Homosexual and the issue of mental illness. In J. Marmor (Ed.), *Homosexual behavior: A modern reappraisal.* New York: Basic.

Matthews, C. R. (2007). Affirmative lesbian, gay, and bisexual counseling with all clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord, (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual and transgender clients (2nd ed.).* Washington, DC: APA.

Maxwell, J. A. (1996). *Qualitative research design: An interactive approach*. Thousand Oaks, CA: sage.

Mayfield, W. A., Carrubba, M. D., & Louie, C. (1995, August). Development of an inventory to measure attitudes toward bisexuality. In M. J. Patton (Chair), *Performance-based outcomes of research training in counseling psychology* Symposium conducted at the 103rd Annual Convention of the American Psychological Association, New York.

May. E. P. (1974). Counselors', psychologists', and homosexuals' philosophies off human nature

and attitudes toward homosexual behavior. *The Homosexual Counseling Journal, 1,* 3 -25.

Mays, V. M, & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay and bisexual adults in the United States. *American Journal of Public Health, 91,* 1869-1876.

Mazure, C. M. (Ed.). (1995). *Does stress cause psychiatric illness?* Washington, DC: American Psychiatric Press.

McCarn, S. R., & Fassinger, R. E. (1996). Revisioning sexual minority identity formation: A new model of lesbian identity and its implications. *Counseling Psychologist, 24,* 508-534.

McDonald, G. J. (1982). Individual differences in the coming-out process for gay men:

Implications for theoretical models. *Journal of Homosexuality, 82,* 47-60.McGee, R. (2008).

Unintended consequences: the impact of microaggression on public relations.

PR Tactics, 15, 11.

McHenry, S. S., & Johnson, J. W. (1993). Homophobia in the therapists and gay or lesbian client: Conscious and unconscious collusions in self-hatred. *Psychotherapy, 30,* 141-151.

McLeod, J. (2001). *Qualitative research in counseling and psychotherapy*. Thousand Oaks, CA: Sage.

Miville, M. L., & Ferguson, A. D. (2004). Impossible choices: Identity and values at a crossroads. *The Counseling Psychologist, 32*, 760-770.

Mohr, J. J. Israel, T., & Sedlacek, W. E. (2001). Counselors' attitudes regarding bisexuality as predictors of counselors' clinician responses: An Analogue study of a female bisexual client. *Journal of Counseling Psychology, 48*, 212-222.

Moradi, B., Mohr, J. J., Worthington, R. L., & Fassinger, R. E. (2009). Counseling psychology

research on sexual (orientation) minority issues: Conceptual and methodological

challenges and opportunities. *Journal of Counseling Psychology, 56*, 5-22.

Mohr, J. J., & Rochlen, A. B. (1999). Measuring attitudes regarding bisexuality in homosexual

and heterosexual populations. *Journal of Counseling Psychology, 46,* 353-369.

Morgan, K. S., & Eliason, M. J. (1992). The role of psychotherapy in Caucasian lesbians' lives.

Women & Therapy, 13, 27-52.

Morgan, D. L. (1997). *Focus groups as qualitative research*. Thousand Oaks, CA: Sage.

Morgan, K. S. (1992). Caucasian lesbian's use of psychology. *Psychology Women Quarterly,*

16, 127-130.

Morin, S. F. (1977). Heterosexual bias in psychological research on lesbianism and male

Homosexuality. *American Psychologist, 32*, 629-637.

Morrow, D. F. (2001). Older gays and lesbians: Surviving a generation of hate and violence.

Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research, 13,

151-169.

Morrow, D. F., & Tyson, B. (2006). Religion and spirituality. In D. F. Morrow & L. Messinger

(Eds.), Sexual orientation and gender expression in social work practice: Working with

gay, lesbian, bisexual and transgender people 384-404. New York: Columbia University

Press.

Morrow, S. L. (2000). First do no harm: Therapist issues in psychotherapy with lesbian, gay and

bisexual clients. In R. M Perez, K. J. Bieschke (Eds), *Handbook of counseling and*

psychotherapy with lesbian, gay and bisexual clients (pp. 137-156). Washington D.C.:

APA.

Morrow, S. L. (2005). Quality and trustworthiness in quality research in counseling

psychology. *Journal of Counseling Psychology, 52,* 250-260.

Morrow, S. L. (2007).Qualitative Research in Counseling Psychology: Conceptual Foundations. *Counseling Psychologist, 35,* 209-235.

Morse, J. M. (2000). Theoretical congestion. *Qualitative Health Research, 10*, 715-717.

Moustakas, C. (1994). Phenomenological research methods. Thousand Oaks, CA: Sage.

Murphy, J. A., Rawlings, E. I., Howe, S. R. (2002). A survey of clinical psychologists on treating lesbian, gay and bisexual clients. *Professional Psychology: Research and Practice, 33,* 183-189.

National Association of Social Workers. (1999). *Code of ethics.* Washington, DC: Author.

Neville, H. A., Lilly, R. L., Duran, G., Less, R., & Browne, L. (2000). Construction and internal validation of the color Blind Racial attitudes scale (COBRAS). *Journal of Counseling Psychology, 47*, 59-70.

Noel, L. (1994). *Intolerance: A general survey.* Montreal: McGill-Queen's University Press.

Ochs, R. (1996). Biphobia: It goes more than two ways. In B. A. Firestein (ed.), *Bisexuality: the psychology and politics of an invisible minority* (pp. 217-239). Thousand Oaks: Sage.

Olkin, R. (1999). *What psychotherapists should know about disability.* New York: The Guilford Press.

Orel, N. A. (2004). Gay, lesbian, and bisexual elders: Expressed needs and concerns across focus groups. *Journal of Gerontological Social Work, 43*, 57-77.

Otis, M. D., & Skinner, W. F. (1996). The prevalence of victimization and its effect on mental well-being among lesbian and gay people. *Journal of Homosexuality, 30,* 93-121.

Page, E. (2004). Mental health services experiences of bisexual women and bisexual men: Am empirical study. *Journal of Bisexuality, 4,* 137-160.

Perez, R. M., DeBord, K. A., & Bieschek, K. J. (Eds.). (2000*). Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 309-336). Washington DC: American Psychological Association.

Phillips, J. C. & Fischer, A. R. (1998). Graduate students' training experiences with lesbian, gay, and bisexual issues. *The Counseling Psychologist, 26*, 712-734.

Phillips, J. C. (2000). Training issues and considerations. In R. M. Perez, K. A. DeBord, & K. J. Bieschek (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 337-358).

Pierce, C., Carew, J., Pierce-Gonzalez, D., & Willis, D. (1978). An experiment in racism: TV commercials. In C. Pierce (Ed.), *Television and education* (pp. 62–88). Beverly Hills, CA: Sage.

Pilkington, N. W., & Cantor, J. M. (1996). Perceptions of heterosexual bias in professional psychology programs: A survey of graduate student. Professional Psychology: Research and Practice, 27, 604-612.

Plummer, D. (1999). *One of the boys: Masculinity, homophobia and modern manhood*. New York: Haworth Press.

Polkinghorne, D. E. (1989). Narrative configuration in qualitative analysis. *Qualitative Studies in Education, 8*, 5-23.

Ponterotto, J. G. (1996). Multicultural counseling training: A competency model and national survey. In D. B. Pope-Davis and H. L. K. Coleman (Eds*.), Multicultural counseling competencies: Assessment, education and* training*, and supervision* (pp. 111-130). Thousand Oaks, CA: Sage.

Potoczniak, D. J. (2007). Development of bisexual men's identities and relationships. In K. J.

Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, Gay, Bisexual, and Transgender Clients*. Washington, DC: APA.

Pugh, W. W. T. (1998). "It's just my job to be 'out'": Tenure stories of lesbian, gay, and bisexual academics. *Journal of Gay, Lesbian, & Bisexual Identity, 3,* 93-112.

Queen, C. (1996). Bisexuality sexual diversity and the sex-positive perspective. In B.A. Firestein (Ed.), *Bisexuality: The psychology and politics f an invisible minority* (pp. 103-126). Thousand Oaks, CA: Sage.

Rainey, S., & Trusty, J. (2007). Attitudes of master's-level counseling students toward gay men and lesbians. *Counseling and Values, 52,* 12-24.

Reynolds, A. L. (2003). Counseling issues for lesbian and bisexual women. M. Kopala & M. A. Keitel (Eds.), *Handbook of Counseling Women* (pp. 53-73). Thousand Oaks, CA: Sage.

Reynolds, A. L., & Hanjorgiris, W. F. (2000). Coming out: Lesbian, gay, and bisexual identity development In R. M Perez, K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay and bisexual clients* (pp. 35-55). Washington D.C.: APA.

Ridley, C. R. (2005). Overcoming unintentional racism in counseling and therapy (2nd ed.). Thousand Oaks, CA: Sage.

Ritter, K., & O'Neill, C. (1989). Moving through loss: The spiritual journey of gay men and lesbian women. *Journal of Counseling Development, 68,* 9-14.

Rosario, M., Hunter, J., Maguen, S., Gwadz, M., & Smith, R. (2001). The coming-out process

and its adaptational and health-related associations among gay, lesbian, and bisexual youths: Stipulation and exploration of a model *American Journal of Community Psychology, 29,* 113-160.

Rostosky, S. S., Riggle, E. D. B., Horne, S. G., & Miller, A. D. (2009). Marriage amendments and psychological distress in lesbian, gay, and bisexual (LGB) adults. *Journal of Counseling Psychology, 56,* 56-66.

Rothblum, E. D. (1994). "I only read about myself on bathroom walls": the need for research on the mental health of lesbians and gay men. *Journal of Consulting and Clinical Psychology, 62,* 213-220.

Rothblum, E. D. (2000). "Somewhere in Des Moines or San Antonio": Historical perspectives on lesbian, gay and bisexual mental health. In K. J. Bieschke, R. M. Perez, & K. A. DeBord, (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual and transgender clients (1st ed.).* Washington, DC: APA.

Rothblum, E. D., & Factor, R. (2001). Lesbians and their sisters as a control group: Demographic and mental health factors. *Psychological Science, 12*, 63-69.

Rotheram-Borus, M. J., & Langabeer, K. A. (2001). Developmental trajectories of gay, lesbian, and bisexual youths. In A. R. D'Augelli, & C. J. Patterson, *Lesbian, gay, and bisexual identities and youth: Psychological perspectives* (pp. 97-128). New York, NY, US: Oxford University Press.

Rudolph, J. (1988a). Attitudes toward homosexuality in the year of AIDS: A brief report.

Rudolph, J. (1988ab). Counselor's attitudes toward homosexuality: A selective review of the literature. *Journal of Counseling and Development, 67*, 165-168.

Rudolph, J. (1990). Counselors' attitudes toward homosexuality: Some tentative findings.

Psychological Reports, 66, 1352-1354.

Russell**,** S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health, 9,* 1276-1281.

Rust, P. C. (1995). *Bisexuality and the challenge to lesbian politics: Sex, loyalty, and revolution.* New York: New York University Press.

Rust, P. C. R. (2000). *Bisexuality in the United States: A social science reader.* New York: Columbia University Press.

Rust, P. C. R. (2007). The construction and reconstruction of bisexuality: Inventing and reinventing the self. In B. A. Firestein (Ed.), *Becoming visible: Counseling bisexuals across the lifespan.* New York: Columbia University Press.

Saghir, M. & Robins, E., Walbran, B., & Gentry, K.A. (1970). Psychiatric disorders and disability in the male homosexual. *American Journal of Psychiatry, 126*, 1079-1086.

Savin-Williams, R. C. (1994). Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: Associations with school problems, running away, substance abuse, prostitution, and suicide. *Journal of Consulting and Clinical Psychology, 62,* 261-269.

Schacht, T. E. (2008). A broader view of racial microaggression in psychotherapy. *American Psychologist*, *63*, 273.

Schneider, M., Brown, L., & Glassgold, J. (2002). Implementing the resolution on appropriate therapeutic responses to sexual orientation: A guide for the perplexed. *Professional Psychology: Research and Practice, 33,* 265–276.

Schneider, M. & Tremble, B. (1985). Gay or straight: Working with the confused adolescent. *Journal of Social Work and Human Sexuality, 4*, 71-82.

Schneider, M. S., & Tremble**,** B. (1986). Training service providers to work with gay or lesbian adolescents: A workshop. ; *Journal of Counseling &* Development*, 65*, 98-99.

Schroeder, M., & Shidlo, A. (2003). Religiously based conversion therapy: The need to belong. *Division 44 Newsletter, 19*, 5.

Schuck, K. D., Liddle, B. J. (2001). Religious conflicts experienced by lesbian, gay, and bisexual individuals. *Journal of Gay & Lesbian Psychotherapy, 5,* 63-82.

Shuster, R. (1987). Sexuality as a continuum: The bisexual identity. In Boston Lesbian Psychologies Collective (Ed.), *Lesbian psychologies* (pp. 56–71). Urbana: University of Illinois Press.

Schwartz, A. E. (2003). A place of recognition: Commentary on a case report (Gay patient—gay therapist). In (Eds.), J. Dresher, A., D'ercole, & E. Schoenberg, *Psychotherapy with gay men and lesbians: Contemporary dynamic approaches* (pp. 29-37.) Binghamton, NY: Hawthorne Press.

Schwanberg, S. (1990). Attitudes toward homosexuality in American health care literature 1983-1987. *Journal of Homosexuality, 19,* 117-136.

Silverschanz, P. (2004). *Lesbian, gay, and bisexuals personas as bicultural: Review of the literature, a new conceptual model, and implications for social work.* Unpublished manuscript, University of Michigan.

Shelton, K., & Wells, E. (2007). *Resource guide for GBT youth*. Unpublished manuscript.

Sherry, A., Whilde, M. R., & Patton, J. (2005). Gay, Lesbian, and Bisexual Training Competencies in American Psychological Association Accredited Graduate Programs. *Psychotherapy: Theory, Research, Practice, Training, 42*, 116-120.

Shidlo, A., & Schroeder, M. (2001, May). *Clinical and religious attempts to change homosexual*

orientation: An empirical study. In Association of Gay and Lesbian Psychiatrists and the Committee of Gay, Lesbian, and Bisexual Issues (Sponsors), Clinical issues and ethical concerns regarding attempts to change sexual orientation of the American Psychiatric Association, New Orleans, LA.

Shuster, R. (1987). Sexuality as a continuum: The bisexual identity. In Boston Lesbian Psychologies Collective (Ed.), *Lesbian Psychologies* (pp. 56–71). Urbana: University of Illinois Press.

Singh, A. A., & Shelton, K. (2009). *Current trends in LGBT related qualitative research.* Manuscript submitted.

Smith, M., & Gordon, R. (1998). Personal need for structure and attitudes toward homosexuality. The *Journal of Social Psychology, 138*, 83-88.

Socarides, C. W. (1978). *Homosexuality: A psychoanalytic study of male homosexuals.* New York: Basic Books.

Solorzano, D. (2000). Critical race theory, racial microaggressions, and campus racial climate: The experiences of African American college students. *Journal of Negro Education, 69,* 60-73.

Speight, S. L. (2007). Internalized racism: One more piece of the puzzle. *Counseling Psychologist, 35,* 126-134.

Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? 200 subjects report a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior, 32*, 249-259.

Stewart, D., & Mickunas, A. (1990). *Exploring Phenomenology: Guide To Field & Is Literature.* Athens, Ohio: Ohio University Press.

Sue, D. W. (2003). *Overcoming our racism: The journey to liberation.* San Francisco, CA: Jossey-Bass.

Sue, D. W., Capodilupo, C. M., & Holder, A. M. B. (2008a). Racial microaggressions in the life experience of Black Americans. *Professional Psychology: Research and Practice*, *39*, 329–336.

Sue, D. W., Capodilupo, C. M., Nadal, K. L., & Torino, G. C. (2008b). Racial microaggressions and the power to define reality. *American Psychologist*, *63*, 277–279.

Sue, D. W. (2005). Racism and the conspiracy of silence. *The Counseling Psychologist, 33,* 100-114.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural competencies and standards. A call to the profession. *Journal of Counseling and Development, 70,* 477-486.

Sue, D. W., Bucceri, J. , Lin. A. L., Nadal, K. L., & Torino, G. C. (2007a). Racial microaggressions and the Asian American experience. *Cultural Diversity and Ethnic Minority Psychology, 13,* 72-81.

Sue, D. W. & Capodilupo, C. M. (2007). Racial, Gender and Sexual Orientation Microaggressions: Implications for Counseling and Psychotherapy. In D. W. Sue & D. Sue (Eds.), *Counseling the culturally diverse: Theory and Practice* (109-131). New York: Wiley.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., Esquilin, M. (2007b). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62,* 271-286.

Sue, D. W., Lin, A. I., Torino, G. C., Capodilupo, C. M., & Rivera, D. P. (2009). Racial

microaggressions and difficult dialogues on race in the classroom. *Cultural Diversity and Ethnic Minority Psychology, 15*, 183-190.

Sue, D. W., Nadal, K. L., Capodilupo, C. M., Lin, A. I., Torino, G. C., & Rivera, D. (2008). Racial microaggressions against Black Americans: Implications for counseling. *Journal of Counseling & Development, 86,* 330-338.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and Practice* (4th ed.).New York: Wiley.

Szymanski, D. M., & Gupta, A. (2009). Examining the Relationship Between Multiple Internalized Oppressions and African American Lesbian, Gay, Bisexual, and Questioning Persons' Self-Esteem and Psychological Distress. *Journal of Counseling Psychology*, 56, 110–118.

Thomas, K. R. (2008). Macrononsense in multiculturalism. *American Psychologist*, *63*, 274–275.

Udis-Kessler, A. (1996). Challenging the stereotypes. In Off Pink Collective (Eds.), *Bisexual horizons: Politics, histories, lives* (pp. 45–57). London: Lawrence & Wishart.

United States Census. (2002). *2000 Census of population and housing.* Retrieved July, 1, 2007 from: http://www.census.gov/main/www/cen2000.html.

van Manen, M. (1990). *Researching lived experience: Human science from an action sensitive pedagogy.* Ontario, Canada: University of Western Ontario.

Van Naerssen, A. X.; (1987). Theories on homosexuality among professional therapists. *Journal of Homosexuality, 13,* 145-154.

von Klesit, W. (1992). A survey of doctoral clinical and counseling psychology students' exposure in doctoral training programs to gay and lesbian issues and attitudes toward lesbian and gay men. *Dissertation Abstracts International, 53*, 6617-6618.

Wagner, G., Serafini, J., Rabkin, J., Remien, R., & Williams, J. (1994). Integration of one's religion and homosexuality: A weapon against internalized homophobia? *Journal of Homosexuality, 26*, 91-109.

Weinberg, G. (1972). *Society and the healthy homosexual*. Boston: Alyson.

Weise, E. R. (1992). Introduction. In E. R. Weise (Ed.), *Closer to home: Bisexuality and feminism* (pp. 281–310). Seattle, WA: Seal Press.

Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology: 52*, 167-177.

Weinberg, M. S., Williams C. J., & Pryor, D. W. (1994). *Dual attraction: Understand bisexual.* New York: Oxford University Press.

Wisniewski, J. J. & Toomey, B. G. (1987). Are social workers homophobic? *Social Work, 32,* 454-455.

Worthington, R. L., Savoy, H. B., Dillon, F. R., & Vernaglia, E. R. (2002). Heterosexual identity development: A multidimensional model of individual and social identity. *The Counseling Psychologist, 30,* 496-531.

Yeh, C. J., & Inman, A. G. (2007). Qualitative data analysis and interpretation in counseling psychology: Strategies for best practices. *The Counseling Psychologist, 35,* 369-403.

APPENDICES

Appendix A

Phone Script

Hello, my name is Kimber Shelton and I am doing a research study under the direction of Dr. Edward Delgado-Romero, in the Department of Counseling and Human Development Services in the University of Georgia. This research study is about gay, lesbian, bisexual and queer individuals experience in psychotherapy and subtle forms of discrimination that might be encountered in therapy. Information from this study may positively impact the quality of services provided to GLBQ psychotherapy clients. I have obtained your name/contact information from [the email you submitted on (date)/your phone call on (date)]. I would like to ask you some questions to determine if you might qualify for this study. This should only take 5 minutes of your time. You do not have to answer any questions you do not want to answer. You may stop this interview at any time. If you qualify for this study, you will be asked to participate in a focus group with approximately 6-9 other individuals discussing your experience in therapy. The focus group will last between 1-2 hours. If you do not qualify for this study, the information you give me today will be destroyed immediately. Do I have your permission to proceed?
INSERT SCREENING QUESTION(S)

1. Are you age 18 or older?
2. Do you self-identify as gay, lesbian, bisexual, or queer? If yes, which?
    a. Do you identify as transgender?
3. For the purpose of this study, a mental health professional is a psychologist, psychiatrist, licensed counselor, psychotherapist, social worker or marriage and family therapist. Have you had at least 1 individual counseling or therapy session with a mental health professional?
4. On a scale of 1-5 (1-low, 5-high), how well do you recall your experience in therapy or counseling?
5. Do you feel comfortable sharing information regarding your sexual identity and therapy experience with others?
6. Do you feel comfortable hearing about the sexual identity and therapy experience of others?

Thank you for answering my questions today. You do/do not qualify to participate in this research study. [If qualified to participate] The focus group will be held at the UGA LGBT Resource Center (give directions) on (date/time). When you arrive at the focus group, I will further discuss the purpose of this study and obtain your consent to participate. You will receive $20 for your participation in this study. Are you interested in participating in this study?

If you have any questions regarding this study, please call me at 716-400-8301 or e-mail me at kimber17_99@yahoo.com.

If you have any questions or problems about your rights as a research participant, please call The Chairperson, Institutional Review Board, University of Georgia at 706-542-3199.

Appendix B

IRB CONSENT FORM

I, _____, agree to participate in a research study titled "GAY, LESBIAN, BISEXUAL, AND QUEER CLIENTS EXPERIENCE IN THERAPY" conducted by Kimber Shelton from the Department of Counseling and Human Development Services at the University of Georgia (716-400-8301) under the direction of Dr. Edward Delgado-Romero, Department of Counseling and Human Development Services, University of Georgia (706-542-0500). I understand that my participation is voluntary. I can refuse to participate or stop taking part without giving any reason, and without penalty or loss of benefits to which I am otherwise entitled. I can ask to have all of the information about me returned to me, removed from the research records, or destroyed.

The reason for this study is to explore the therapeutic experience of gay, lesbian, bisexual and queer clients and to better understand subtle forms of heterosexism that occur in therapy. If I volunteer to take part in this study, I will be asked to do the following things:

1. Participate in a focus group interview that will last 2 hours or less; which will be audiotaped.

2. Answer questions, discuss ideas and experiences about my experience as a gay, lesbian, bisexual or queer therapy client, as well as listen to the ideas and experiences of others.

3. If I choose, the investigator will follow up with me after the data from this study has been analyzed to discuss themes that emerged from the focus group.

I understand that I may not receive any direct benefit from participating in this study but that my participation may help others in the future. The members of the research team have offered to answers questions I may have about the study and what I am expected to do.

No risk is expected but I may experience some discomfort or stress from sharing my experiences in psychotherapy or from listening to the psychotherapy experiences of others. Although this study is specifically designed for gay, lesbian, bisexual and queer individuals, there may be risk that other group members may share your sexual orientation with persons outside of this group whom you may not be out to. These risks will be reduced in the following ways:

1. I understand that because of this study, there could be violations of my privacy. To prevent violations of my own or other's privacy, I have been asked not to talk about any of my own or others private experiences that I would consider too personal or revealing.

2. I also understand that I have an obligation to respect the privacy of the other members of the group by not disclosing any personal information that they share during our discussion.

3. I understand that mental health referral sources are available for me if I desire additional services after the focus group ends.

This research is funded through the Center for Research and Engagement in Diversity (RED), the UGA Graduate School and the UGA Alumni Association. Your participation in this study in no way will affect your relationship with any of the above mentioned organizations. I will receive a

$20 financial gift for my participation in the focus group. Even if I do not complete the study or ask for my information to be withheld, I will still receive the monetary gift.

In order to process the payment for your participation, the researcher(s) need to collect your name, mailing address, and social security number on a separate payment form. This completed form will be sent to the Department of Counseling and Human Development Services' business office and then to the UGA Business Office. The researcher(s) has been informed that these offices will keep your information private, but may have to release your name and the amount of compensation paid to you to the IRS, if ever asked. The researcher(s) connected with this study will protect your private information and will keep this confidential by storing in a secured location. However, the researcher is not responsible once your name, social security number, and mailing address leave her office/laboratory for processing of your payment.

Besides the above mention exception, all records with identifiable information will be maintained only by the co-investigator. Once data is collected, participant names will be converted to numerical codes, which will only be identifiable to the co-investigator. Electronic information, including digital voice recordings, transcripts, and personal notes will be maintained on a password protected computer and will only be assessable by the co-investigator. The digital recording will be kept in a locked box owned by the co-investigator. Digital recordings will be erased after the transcription is created.

The investigator will answer any further questions about the research, now or during the course of the project.
I understand that I am agreeing by my signature on this form to take part in this research project and understand that I will receive a signed copy of this consent form for my records.

_____   _____   _____

Kimber Shelton   Signature   Date
kimleigh@uga.edu
716-400-8301

_____   _____   _____
Name of Participant   Signature   Date

Please sign both copies, keep one and return one to the researcher.

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu.

Appendix C

Demographic Form
Please complete the following questions

Identification Number:

1. **Age:** _____

2. **Gender**
   Female
   Male

3. **Sexual Orientation**
   Gay
   Lesbian
   Bisexual
   Queer
   Other: _____

4. **Race/Ethnicity** (ex. Black—African American, Native American—Cherokee)
   Asian descent—Specify _____
   Black—Specify:_____
   Hispanic/Latino—Specify: _____
   Native American—Specify: _____
   Multiracial—Specify: _____
   White—Specify: _____
   Other—Specify: _____

5. **Highest educational level attained**
   High School

   College
      Freshman
      Sophomore
      Junior
      Senior
      Graduate School

   Other: _____

6. **Major**:_____

7. **Occupation Title**: _____

8. **How many therapists have you had in your lifetime?**

9. **How many individual counseling/therapy sessions have you had in your lifetime?**

10. **After the data of this study is analyzed, would you like to be contacted to provide feedback? Y   N**

      If yes, how would you like to be contacted?

          By Email   Email address: _____

          By Phone   Phone number: _____

Appendix D

Interview Script & Questions

Thank you for coming here today to participate in this focus group. My name is Kimber Shelton and I am a Counseling Psychology doctoral candidate. Assisting me today is [Observer], a Clinical Psychology doctoral student. [Observer] will be a silent participant in our focus group today and will take notes about what she observes today. The purpose of this group is to gain a better understanding of the counseling experiences of gay, lesbian, bisexual and queer individuals and the subtle or covert forms of heterosexism and homophobia that may take place in the counseling environment. I am an ally who has clinical experience with gay, lesbian, bisexual and queer clients. [Name] I identify as _____ and I have clinical with gay, lesbian, bisexual and queer clients.

I am sure that you are familiar with overt forms of discrimination such as gay bashing or hate crimes. However, today we are interested in hearing about your experiences of subtle acts of discrimination that occurred in therapy, which you feel was based on your sexual identity. For example, a therapist may assume that all clients are heterosexual and use gender specific pronouns when inquiring about a client's partner, "Tell me about your wife/girlfriend, husband/boyfriend" or a therapist may be blind to sexual identity, "I see people as people, I don't think about sexual identity". This denies that the strengths and challenges of living as a sexual minority with our society. These experiences may have occurred in a current counseling setting or with a former therapist at anytime in your life. For the purpose of this discussion, we define sexual identity as a not exclusively heterosexual identity. This includes your desire and need to have relational, romantic, and intimate relationships with persons of the same-sex or both sexes.

I will be asking you some questions that I encourage you to answer to the best of your ability and I recognize that many of you will have unique experiences. All points of view, both positive and negative are important. There are no wrong answers but rather different points of view. Please feel free to share your point of view even if it differs for what others have said. What you discuss here will be very helpful for my individual research project and after today's session, you are welcome to ask me questions about the research and about our discussion.

Okay, so, I am going to give everyone a form now, which states that your participation in this group is entirely voluntary and that you may decline to participate and leave the group at any time. Please read this sheet carefully before signing it. It discusses potential risks to you as members of this group as well as the use of audio recording during this session. I'd like to give everyone the opportunity to ask any questions they may have before we begin the group.
Question/Answer…
Distribute informed consent forms

Statement of Confidentiality

We will be audio recording this session in an effort to maintain the integrity of your dialogue. However, your identities will not be revealed to anyone, and only the researchers will have access to this recording. We will be on a first name basis, and in our later reports there will not be real names attached to comments. This discussion is to be considered confidential, and we hope that you all will respect each other rights to privacy by not repeating any portion of this discussion outside of this session.

Opening Question

At this time, we would like for each of you to say your first name, your major or occupation and why you are interested in participating in this study.

General Questions

1. Please give us a general description about what your experience in therapy was like. Do not feel that you have to share why or the reasons you entered therapy.

2. Gay men, lesbian women, and bisexual and queer individuals often have experiences in which they are subtly invalidated, discriminated against, and made to feel uncomfortable because of their sexual identity. In thinking about your therapy experiences, could you describe a situation in which you feel you were subtly discriminated against because of your sexual orientation?

Interview Questions

1. Did you disclose your sexual identity/orientation to your therapist? Why or why not?

2. Think of some of the stereotypes that exist about gay men, lesbian women and bisexual and queer individuals. Has a therapists ever subtly expressed their stereotypical beliefs about you?

3. Were there any experiences in counseling in which you felt that your therapist did not understand the impact of your sexual identity on your presenting issue or concerns?

4. What are some subtle ways that therapists treated you differently because of your sexual identity?

5. What has a therapist done or said to invalidate your experiences of being discriminated against?

6. Describe a situation in which you felt uncomfortable, insulted, or disrespected by a comment made by your therapist that had homophobic overtones.

7. In what ways have therapists made you feel "put down" because of your sexual orientation?

8. How has a therapists subtly expressed that "heterosexuality is the norm"?

9. In what subtle ways has a therapist expressed that they think you are a second-class citizen or inferior to heterosexual individuals?

10. Has a therapists suggested or made you feel like you "do not belong here" because of your sexual identity?

Transition Questions/Statements

1. We want to hear as many stories as possible. Even if you think your experience is just like everyone else's, don't just say, I agree. We want to hear your story, because there's always something unique in each person's own experiences.

2. What are some of the ways that you dealt with these experiences?

Ending Questions

1. How do you think subtle forms of heterosexism and/or homophobia impacted the overall quality of your counseling experience?

2. What do you think the overall impact of your experiences has been on your lives?

3. So today, you shared several experiences of subtle discrimination. Some of you said…

4. What are some themes you heard from one another's experience?